

Re Carla: An Error in Judgment

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*each person has a unique dignity which the law respects and which it will protect.*¹

I INTRODUCTION

As Justice Brennan succinctly explained in *Department of Health and Community Services v JWB & SMB (Marion's Case)*,² every person has a unique character and dignity that warrants respect and protection under the law. This extends to every member of society, whatever their race, gender, sexual orientation, sex characteristics or religion. If dignity is to be respected then the affected person should be at the centre of any enquiry, their preferences heard and their interests protected. Sadly however this ideal does not always translate into practice and a recent decision regarding surgical interventions on intersex children is an example of a situation in which the affected person's rights and future interests were not afforded clear priority. The decision of *Re: Carla (Medical Procedure)* [2016] FamCA 7 ('*Re: Carla*') saw the Court handing full authority for decision-making to the parents and the medical fraternity. This withdrawal of the need for external scrutiny of an invasive and potentially non-therapeutic medical procedure signalled a retreat by the judiciary from any meaningful engagement with the child's future preferences. In this article, we argue that this decision, whilst well intentioned is, quite simply, an error in judgment.

Before setting out what this article will do, it is important to identify what it will not do. The quality of the decision to approve Carla's medical procedure will not be addressed and neither will the assertions that the procedure was in Carla's best interests, these issues have been addressed elsewhere.³ Neither is this paper an in depth critique or analysis of well established authorities such as *Marion's Case*, instead an overview of these authorities is presented as essential background to our theme. Similarly, the broader discussions regarding the appropriateness of the medical response to intersex children are beyond the scope of this paper. Our focus is a relatively narrow one: we aim to critically review the legal principles as applied in *Re: Carla* and challenge the conclusion that these decisions are within the scope of parental powers.

Re: Carla has two fundamental flaws: the first is the conclusion that surgical interventions on intersex children are within parental authority and the second is the characterisation of these

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¹ *Department of Health and Community Services v JWB & SMB (Marion's Case)* (1992) 175 CLR 218, 266 (Brennan J) ('*Marion's Case*').

² *Ibid.*

³ For case note, see: Fiona Kelly and Malcolm K Smith, 'Should Court Authorisation Be Required for Surgery on Intersex Children? A Critique of the Family Court Decision in *Re Carla*' (2017) 31 *Australian Journal of Family Law* 118; see also Morgan Carpenter, 'The "Normalisation" of Intersex Bodies and "Othering" of Intersex Identities: The Experience in Australia' in Jens M Scherpe, Anatol Dutta, and Tobias Helms (eds), *The Legal Status of Intersex Persons* (Intersentia, 2018) 31–8; Morgan Carpenter, *The Family Court Case Re: Carla (Medical Procedure)* [2016] FamCA 7 (8 December 2016) Intersex Human Rights Australia <<https://ihra.org.au/31036/re-carla-family-court/>>.



procedures as therapeutic and necessary. There are two clear assertions that sit at the base of the arguments presented in this paper: the first is that intersex is not a disease and neither is it life threatening, it is a legal status, as reflected in the relevant anti-discrimination legislation.⁴ The second flows directly from the first, and is that this is a status that warrants respect, it is not a medical condition that needs to be fixed. There is nothing fundamentally wrong with these children and to empower parents to authorise invasive and irreversible procedures without external scrutiny exposes the children to unnecessary risk. We are not, however, arguing that all surgical intervention of these children is unwarranted, rather it is our position that there needs to be a process whereby the risks and benefits of surgical intervention are carefully balanced and imminent and potential harms are appropriately identified.

The discussion will begin with an overview of two key, and contradictory, decisions about parental power and intersex children. *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226 (*‘Re Lesley’*) saw the Family Court concluding that surgical intervention of intersex children falls within the *Marion’s Case* test and is not within the scope of parental authority, whilst *Re: Carla* reached the opposite conclusion. This detailed consideration of the differing judicial approaches to the issues will, of necessity, contain some explanation of the *Marion’s Case* test and will assert that there continues to be a need for external scrutiny of decision-making in these situations. The themes emerging from the two decisions will then be considered and it will be demonstrated that at the heart of this debate sits a vulnerable population that warrants some form of protection. We will then conclude with a recommendation that perhaps it is time to re-think the approach to surgical interventions on intersex children and be more creative in our protection of them. Our concluding recommendation will be that the rights and interests of intersex minors would be best served through the introduction of an interdisciplinary panel that supports the parents through their decision-making processes at the same time as protecting the best interests of the child. This would remove the discussion from the adversarial process and support the family in navigating the complex decision-making process.⁵

II DEFINITIONS AND SCOPE

In 2013, the *Sex Discrimination Act 1984* (Cth) was amended to provide a legal definition of intersex in the following terms:

- 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

⁴ See, for eg, *Sex Discrimination Act 1984* (Cth) s 4, where reference is made to ‘intersex status’.

⁵ A model of such a panel can be found in the South Australian *Mental Health Act 2009* (SA) s 41Aff. It is important to note here that this recommendation *does not* imply in any way that intersex people are suffering from a mental illness, rather we are pointing to the mechanism. Also of note is that a recommendation consistent with this approach was made in the 2013 Senate Community Affairs References Committee report: Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia* (October 2013) [5.30] <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Involuntary_Sterilisation/Sec_Report/index>. For the Government response, see: Australian Government, *Australian Government Response to the Senate Community Affairs References Committee Reports: Involuntary or Coerced Sterilisation of People with Disabilities in Australia and Involuntary or Coerced Sterilisation of Intersex People in Australia* (May 2015) <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Involuntary_Sterilisation/Government_Response>.

(c) neither female nor male.⁶

This definition signalled a retreat from the accepted view of intersex as a medical condition or disorder and characterised it as a status. The significance of this characterisation is discussed in some depth by O'Dwyer and will not be analysed in any depth here.⁷ Rather, our discussion proceeds on the basis that, whilst at times those with intersex status have corresponding medical conditions that may (or may not) require clinical treatment, the status in and of itself is not a medical condition.

Before discussing why there are concerns regarding the medicalisation of intersex and the surgical interventions that flow from that characterisation, the nature of those interventions must be understood. Intersex children often undergo modification of their atypical sex characteristics and whilst some of these modifications are performed for therapeutic reasons, to prevent or cure physical conditions where such procedures cannot be postponed, this is not always the case. We do not challenge the former situation but have concerns where the procedures are best characterised as genital 'normalising' and lack critical clinical urgency.

Medical interventions for intersex children often include hormonal procedures, and surgical modification which remove components of sex organs, such as the gonads (gonadectomy or orchiectomy).⁸ Masculinising procedures, which are intended to make the genitalia appear and function like typically male genitals, may include penile reconstruction, penile augmentation to enlarge penile size, or hypospadias repair to position the urethra at the tip of the penis.⁹ These procedures may also include the removal of a uterus or fallopian tubes, repair of undescended testes (orchiopexy or cryptorchidism repair), or the insertion of testicular prostheses into the scrotum.¹⁰ Feminising procedures, which are intended to make the genitalia appear and function like typically female genitals, include genitoplasty to construct or reconstruct the vagina (vaginoplasty), and may include labial reconstruction.¹¹ These procedures also include construction or reconstruction of the clitoris (clitoroplasty) and clitoral

⁶ *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth) s 7, amending *Sex Discrimination Act 1984* (Cth).

⁷ Skye O'Dwyer, "'Treatment' of Intersex Children as a Special Medical Procedure" (2017) 24 *Journal of Law and Medicine* 870.

⁸ Rafael V Pieretti and Patricia K Donahoe, 'Disorders of Sexual Development' in Arnold G Coran et al (eds), *Pediatric Surgery* (Saunders Elsevier, 7th ed, 2012) vol 1, 1565, 1568; Karen Lin-Su and Maria I New, 'Ambiguous Genitalia in the Newborn' in Christine A Gleason and Sherin U Devaskar (eds), *Avery's Diseases of the Newborn* (Saunders Elsevier, 9th ed, 2012) 1286, 1305; John M Gatti, 'Disorders of Sexual Differentiation' in George Whitfield Holcomb III, J Patrick Murphy, and Daniel J Ostlie (eds), *Ashcraft's Pediatric Surgery* (Saunders Elsevier, 5th ed, 2010) 805, 810–14; Thomas F Kolon, 'Disorders of Sexual Development' in Philip M Hanno, S Bruce Malkowicz and Alan J Wein (eds), *Penn Clinical Manual of Urology* (Saunders Elsevier, 2007) 827, 847–50.

⁹ Pieretti and Donahoe, above n 8, 1582–4; John M Hutson, 'Surgical Treatment in Infancy' in John M Hutson, Garry L Warne and Sonia R Grover (eds), *Disorders of Sex Development — An Integrated Approach to Management* (Springer-Verlag, 2012) 173, 180; Rodrigo L P Romao and Joao L Pippi Salle, 'Update on the Surgical Approach for Reconstruction of the Male Genitalia' (2017) 41 *Seminars in Perinatology* 218; Gatti, above n 7, 811, 814; Rachel Bluebond-Langner and Richard J Redett, 'Phalloplasty in Complete Aphallia and Ambiguous Genitalia' (2011) 25(3) *Seminars in Plastic Surgery* 196.

¹⁰ Lin-Su and New, above n 8, 1305; Gatti, above n 8, 811; Kolon, above n 8, 847–8; Christopher P Houk et al, 'Summary of Consensus Statement on Intersex Disorders and Their Management' (2006) 118 *Pediatrics* 753, 755.

¹¹ Lin-Su and New, above n 8, 1304–5; Pieretti and Donahoe, above n 8, 1577–82; Kolon, above n 8, 845–6.

recession, to reduce the size of the clitoris.¹² Vaginal dilation may occur later in life to increase the size of the vaginal cavity to accommodate sexual penetration.¹³

We focus on non-essential medical interventions, which are performed in the absence of medical urgency and without the consent of the minor. We do not seek to challenge medical procedures performed on intersex children in cases of medical necessity to treat abnormalities requiring medical treatment. We likewise do not seek to challenge the Family Court’s decision to authorise the removal of both kidneys and testes in *Re Sean and Russell (Special Medical Procedures (Special Medical Procedures))* (2010) 44 Fam LR 210 which were performed to eliminate the high risk of renal failure and cancer for both children involved.¹⁴ Sean, aged 3½, was already treated for renal failure; Russell, who was 18 months at the time of the Court’s decision, was expected to suffer renal failure by the age of 4.¹⁵ However, prior to court proceedings, Russell underwent penile reconstruction to ‘correct’ his ambiguous genitalia. Although born with hypospadias and intra-abdominal testes, it was not established that penile reconstruction was medically necessary.¹⁶

It is important to understand however that whilst we adopt the position that many of the surgeries are driven by social as opposed to clinical indications, and thus cannot be defined as ‘therapeutic’, we are not going to debate this issue in any depth. Rather, we point to the wide body of literature that does cogently support this view and ask: if the characterisation of these procedures as therapeutic is so open to debate then surely the *Re: Carla* decision to empower parents to make the decisions, contra the guidance provided by the High Court in *Marion’s Case*, is taking things a step too far.¹⁷

This article thus poses a direct challenge to the *Re: Carla* approach to decisions around medical interventions on intersex children. However, the discussion is broader than many that occur in the judicial setting, we take a step back to the earliest interventions and mount a challenge to the all too common ‘genital enhancements’ which have not been viewed as controversial by the courts but in fact represent a significant invasion of bodily integrity. The very young child is, in these instances, treated as an extension of the parents who simply want a ‘normal’ child, and there is little, to no, consideration of the impact that decisions made at this time will have on the future adult. It is this point in the decision-making that is the focus of our critique. These ‘gender forming’, non-essential, non-therapeutic and invasive interventions that are best

¹² Pieretti and Donahoe, above n 8, 1577–82; Gatti, above n 8, 814–15; Kolon, above n 8, 845–6.

¹³ Pieretti and Donahoe, above n 8, 1587; John C Achermann and Ieuan A Hughes, ‘Pediatric Disorders of Sex Development’ in Shlomo Melmed et al (eds), *Williams Textbook of Endocrinology* (Elsevier, 13th ed, 2017) 893, 953; Gatti, above n 8, 814.

¹⁴ *Re Sean and Russell (Special Medical Procedures)* (2010) 44 Fam LR 210, 213–14.

¹⁵ *Ibid* 212–13, 228.

¹⁶ *Ibid* 213, 232.

¹⁷ For the literature that does not support that view, see Carpenter, above n 3, ‘The “Normalisation” of Intersex Bodies and “Othering” of Intersex Identities: The Experience in Australia’ [3.1]–[3.2]; Elizabeth Reis, ‘Intersex Surgeries, Circumcision, and the Making of “Normal”’ in George C Denniston, Frederick M Hodges, and Marilyn Fayre Milos (eds), *Genital Cutting: Protecting Children from Medical, Cultural, and Religious Infringements* (Springer, 2013) 137, 138–43; Swiss National Advisory Commission on Biomedical Ethics, *On the Management of Differences of Sex Development — Ethical Issues Relating to ‘Intersexuality, Opinion No 20/2012’* (November 2012) 16–18 <https://www.nek-cne.admin.ch/inhalte/Themen/Stellungnahmen/en/NEK_Intersexualitaet_En.pdf>; Australasian Paediatric Endocrine Group, Submission No 88 to Senate Community Affairs References Committee, *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, 27 June 2013, 4; Lynn H Gillam, Jacqueline K Hewitt and Garry L Warne, ‘Ethical Principles for the Management of Infants with Disorders of Sex Development’ (2010) 74(4) *Hormone Research in Paediatrics* 412, 415; Houk et al, above n 10, 755.

characterised as cosmetic should be beyond parental authority, and subject to disinterested, third party scrutiny. It is here that we recommend the introduction of a specialist panel that can support and inform appropriate decision-making on behalf of the child. This proposal is outlined in more detail as a part of our vision of a ‘way forward’.

A final point to be made with regards to the use of terminology in this discussion is the decision to adopt the term intersex. We are aware that there is debate surrounding the term but we have decided to adopt a pragmatic approach, and use the term intersex.¹⁸ This decision was made purely on the grounds of ease of reference and is not meant with any disrespect for those who disagree. And finally, we are not addressing the other, entirely legitimate argument that we remove the existing binary characterisation of humans as either male or female, this is a different debate, to be had elsewhere, and is well beyond the scope of this discussion.¹⁹

III TWO CONTRASTING POSITIONS: *RE LESLEY* AND *RE: CARLA*

There have been eight reported intersex cases in the Family Court, each relying to some extent on the seminal decision of *Marion’s Case*. All of the decisions apply the same legal principles and point to the authority of *Marion’s Case*, that there are certain medical decisions which are beyond the scope of parental authority. This can be briefly stated as the principle that where the medical procedure is characterised as invasive, irreversible and non-therapeutic it must be scrutinised by a Court, as it falls outside of the bounds of parental authority. Before considering *Re: Carla* in detail, it is important to consider the steps taken prior to this decision. These will be summarised through a brief overview of the crucial introductory step of *Marion’s Case* followed by the interim one of *Re Lesley*. It is against this background that the final step of *Re: Carla* is considered and our assertion that it represents a step too far presented.

A *Back to Basics: Department of Health & Community Services v JWB & SMB (Marion’s Case)*

Marion’s Case is factually different from the intersex cases but the legal principles set out in the judgment provide the foundational authority for discussions regarding the outer limits of parental authority and the intersex cases sit at those outer limits. Marion was 14 years old and suffered from significant mental and physical disabilities. Her parents came to the court with two queries: the first was to seek authorisation for the performance of a hysterectomy and ovariectomy; and the second was for guidance on the legality of parental consent to these procedures. Because of the extent of her disabilities, Marion was incapable of caring for herself, and the onset of puberty and menstruation was challenging for her and her carers. Additionally, her inability to care for herself meant that she would not be able to care for a child, and the

¹⁸ For an overview of the tensions surrounding terminology, particularly ‘intersex’ and ‘disorders of sex development’ (DSD), see: Georgiann Davis, *Contesting Intersex — The Dubious Diagnosis* (New York University Press, 2015) ch 4, 137–41; Emilie K Johnson et al, ‘Attitudes Towards “Disorders of Sex Development” Nomenclature among Affected Individuals’ (2017) 13 *Journal of Pediatric Urology* 608.e1; Julie A Greenberg, *Intersexuality and the Law — Why Sex Matters* (New York University Press, 2012) 92–3, 118; Elizabeth Reis, *Bodies in Doubt — An American History of Intersex* (Johns Hopkins University Press, 2009) 153–62.

¹⁹ For example, see: Heath Fogg Davis, ‘Sex-Classification Policies as Transgender Discrimination: An Intersectional Critique’ (2014) 12(1) *Perspectives on Politics* 45; Olga Tomchin, ‘Bodies and Bureaucracy: Legal Sex Classification and Marriage-based Immigration for Trans* People’ (2013) 101 *California Law Review* 813, 861; Michelle Cottier, ‘Feminist, Transgender and Intersex Visions of a Gender-Free Society and the Legal Category of Sex’ (Paper presented at International Conference — Law and Society in the 21st Century, Humboldt University Berlin, 25–28 July 2007).

surgical interventions, resulting in sterilisation of Marion, were aimed at stopping her menstrual cycle and preventing her from becoming pregnant.

Whilst the facts are significantly different from the intersex cases, the foundational questions are the same: what is the extent of parental authority and how can the best interests of a child be determined? The starting point of the majority judgment presented by Mason CJ, Dawson, Toohey and Gaudron JJ was to identify the source of parental power and therefore characterise it. The question at the heart of *Marion’s Case* — and indeed, the intersex decisions — is whether there are kinds of medical intervention that are, ‘as a general rule, excluded from the scope of parental power to consent to’.²⁰ Of note here is the emphasis placed upon the nature of the enquiry as being around parental power, it was not about exploring the limits arising out of the child’s lack of capacity to give consent.

The majority emphasised that the ‘overriding criterion to be applied in the exercise of parental authority on behalf of a child is the welfare of the child objectively assessed.’²¹ The complex question then arises: how are the best interests of the child to be ‘objectively’ assessed and what criteria are to be applied? It is this part of the enquiry that we suggest is flawed in the application of the *Marion’s Case* principles in *Re: Carla* and other intersex cases, which focus on the medicalisation of intersex and social norms, and thus fail to adopt a truly objective test.

The complexities of these kinds of cases was acknowledged by the majority and it was emphasised that ‘questions such as the ones before the court in these cases [in *Marion’s Case* it was sterilisation] is not susceptible of easy answer.... And the circumstances in which it arises may result from or involve an *imperfect understanding of the issues or an incorrect assessment of the situation*’.²² A further note of caution was sounded when the rationale for ‘isolating the decision to sterilise a child as a special case requiring authorisation from a source other than the child’s parents’ was broader than the ‘fundamental right of bodily inviolability’ and included considerations of the ‘gravity of the procedure and its ethical, social and personal consequences’.²³ This conclusion was repeatedly emphasised with reference to ‘the significant risk of making the wrong decision’ the consequences which were described as ‘particularly grave’.²⁴ The significance of the ‘social and psychological implications concerning the person’s sense of identity, social place and self esteem’²⁵ were referred to along with the ‘far-reaching consequences of a general rule of law allowing guardians to consent to all kinds of medical treatment’.²⁶ In short, *Marion’s Case* stands as authority that invasive procedures performed on a child with unclear therapeutic benefit is beyond the scope of parental authority because the risk of ‘getting it wrong’ is high, leading to ongoing social and psychological harm that impacts on sense of self and identity.

It is important to once again emphasise here that we are not challenging the need for medical intervention in certain circumstances but we are challenging the apparent retreat by the court in *Re: Carla* from the cautious approach established in *Marion’s Case*. The difficulty with all of these cases is that what is in the child’s best interests is difficult to determine and, as Justice Brennan explained, the influence of ‘anxious goodwill’²⁷ cannot be overlooked. In seeking to

²⁰ *Marion’s Case* (1992) 175 CLR 218, 237 (Mason CJ, Dawson, Toohey and Gaudron JJ).

²¹ *Ibid* 240.

²² *Ibid* (emphasis added).

²³ *Ibid* 249.

²⁴ *Ibid* 250.

²⁵ *Ibid* 252.

²⁶ *Ibid*.

²⁷ *Ibid* 272 (Brennan J).

come to the best possible decision, there are ‘too many factors which tend to distort a dispassionate and accurate assessment of the true interests of the child. There are some powerful if unarticulated influences affecting, albeit in good faith, the presentation of information on which a decision as to the best interests of the child is to be made and the making of that decision’.²⁸ It is essential therefore that there is external scrutiny of any decisions that impact on an individual’s ‘social and biological identity.’²⁹ The conclusion of *Marion’s Case* was that such decisions fall outside of the scope of parental authority and must be referred to the Courts,³⁰ and application of this principle is found in *Re Lesley*.

B *Applying Marion’s Case: Re Lesley (Special Medical Procedure) [2008] FamCA 1226*

In *Re Lesley*, a hospital petitioned the Court seeking authorisation for a gonadectomy for 4-year-old Lesley who was born with 17-β/HSD deficiency.³¹ Lesley was born with ambiguous genitalia with a vagina and labia, but without uterine or ovarian tissue. Lesley had ‘gonads bilaterally in the labial area and the basis of penile tissue with a corpora cavernosa of each side’.³² Due to the appearance of Lesley’s external genitalia, ‘she’ was assigned, and subsequently reared as female.³³ Lesley’s family was supportive of the assignment of female identity, which was deemed unlikely to change during Lesley’s lifetime.³⁴ The hospital sought authorisation to perform a gonadectomy to prevent masculinisation at the onset of puberty. Following the procedure Lesley would be required to undergo ongoing hormone therapy, and this would be essential to induce female adolescence.³⁵ On account of being 4 years old, Lesley was not competent to consent to the proposed procedure.³⁶

In delivering his decision, Barry J concluded that the proposed procedure fulfilled the *Marion’s Case* criteria and therefore fell outside the ordinary scope of parental authority and required court authorisation.³⁷ It is important to note here that whilst this procedure could be characterised as sterilisation, it was not defined as a sterilising procedure because Lesley would otherwise be sterile, even without the surgical intervention.³⁸ In authorising the procedure, Barry J emphasised his conclusion that the risk of no intervention significantly exceeded any associated risks of the proposed procedure notwithstanding its ‘lifelong and irreversible consequences’.³⁹ Significantly, although there was an identified risk of cancer in the absence of medical intervention, the risks, as emphasised by Barry J, were largely psychosocial, and included potential social and psychological consequences as a result of masculinisation.⁴⁰ It was concluded that the proposed gonadectomy was in Lesley’s best interests, and the surgical procedure, along with the necessary hormone therapy, were authorised.⁴¹

²⁸ Ibid.

²⁹ Ibid 252 (Mason CJ, Dawson, Toohey and Gaudron JJ), referring with approval to *In Re Grady* (1981) NJ 426 A 2d, 471–2.

³⁰ The parents’ other question was answered in the affirmative as it was determined that the proposed surgery was in Marion’s best interests.

³¹ *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226 (12 December 2008) [4], [15].

³² Ibid [21], [26].

³³ Ibid [15]–[16].

³⁴ Ibid [16].

³⁵ Ibid [18], [30], [32].

³⁶ Ibid [38] (Barry J).

³⁷ Ibid.

³⁸ Ibid [31] (Barry J).

³⁹ Ibid [49] (Barry J).

⁴⁰ Ibid [18], [28]–[29] (Barry J). The nature of these risks is discussed further below.

⁴¹ Ibid [46], [Orders 3] (Barry J).

Decisions such as this are driven by a need to carefully balance risks, harms and benefits in such a way as to identify and then serve, the best interests of the child. Underpinning this assessment are characterisations of what is ‘correct’ and ‘normal’ bodily characteristics, and this in turn is informed by the characterisation of intersex as a disorder, as opposed to a status. The Court strove to obtain disinterested third party evidence and heard from a child psychiatrist, unaffiliated with the hospital seeking authorisation. The psychiatrist supported gonadectomy to prevent masculinisation at the onset of puberty in several years time on the basis of protecting Lesley from ‘serious psychological and social consequences’.⁴² It was asserted that there was a significant risk of Lesley developing anxiety or depression at that time.⁴³ The evidence indicated that Lesley was likely to maintain a female identity throughout life and although it was accepted that there was a risk of long-term psychological and social harm related to the procedure, it was concluded that the risks of not having the procedure were greater.⁴⁴

When considering the nature of the risks associated with intervention and non-intervention, the Court placed greater emphasis on the psychological and social risks than potential physical harms. Consistent with all of the intersex cases, the Court uncritically accepted the medical evidence and concluded that if Lesley did not undergo medical intervention at this stage, the potential masculinising bodily changes, including the presence of an enlarged and ‘abnormal’ clitoris, deviating from ‘normal’ femaleness and femininity would cause Lesley to suffer both psychologically and socially to an extent that warranted intervention.

Barry J favoured early intervention, on the evidentiary view that masculinisation would result in ‘devastating’ effects on Lesley. His Honour considered the alternatives to the proposed procedure, including no intervention, and the administration of hormones to block the production of testosterone and then replacing the hormone with oestrogen, which carried significant risk to liver and adrenal function.⁴⁵ Barry J relied on medical evidence in support of surgical intervention, and eliminated these alternatives. His Honour concluded that such alternatives were appropriately considered ‘not in the subjective fashion by somebody with particular interest’, but in ‘objective’ scientific and medical environments.⁴⁶ Crucially for the discussion here, despite the reliance on the accepted characterisation of intersex as a disorder that required treatment, Barry J recognised the significance of early surgical intervention and declined to place it within the scope of parental (and medical) authority. He applied the *Marion’s Case* test and concluded that this procedure was invasive, irreversible and (potentially) non-therapeutic.

C *Distinguishing Marion’s Case: Re: Carla (Medical Procedure)* [2016] Fam CA 7

1 *Facts and Decision*

The 2016 decision of *Re: Carla*) signalled a retreat from the clear position adopted in *Re Lesley*, and it was concluded that surgical interventions on intersex minors fell within the scope of parental authority. In this instance, parents (with the support of the treating hospital) sought approval for the performance of a gonadectomy on their child, 5-year-old Carla who had been

⁴² Ibid [18], [14].

⁴³ Ibid [18].

⁴⁴ Ibid [16]–[17].

⁴⁵ Ibid [40].

⁴⁶ Ibid [44] (Barry J).

born with 17- β -hydroxysteroid dehydrogenase 3 deficiency.⁴⁷ Although genetically male, Carla was born with undermasculinised genitalia which presented with a female external appearance. Internally however, Carla lacked female reproductive organs and had intra-abdominal male gonads.⁴⁸ Prior to this application Carla underwent genital normalising surgery in the form of clitoral recession and labiaplasty, to feminise Carla's genitalia, this was described as a procedure designed to 'enhanc[e] the appearance' of the genitalia.⁴⁹ This initial procedure was not subject to any external scrutiny and was accepted as falling within the scope of parental authority. The applicants also sought authorisation for oestrogen to be administered when Carla reaches 12 years of age in order to induce female puberty, and Carla would then require lifelong oestrogen replacement.⁵⁰ Carla was raised as female since birth and medical opinion maintained that this gender identity was unlikely to change.⁵¹ It was argued that the proposed procedure would eliminate Carla's 'intermediate risk of malignancy', prevent masculinisation and any associated psychological risks, and would enable Carla to live 'a healthy life as a female' in accordance with the identity and gender of rearing.⁵²

The question of fertility is often raised in these cases and it was no different here. The court accepted the evidence that, whilst the proposed gonadectomy would unquestionably result in infertility, Carla would most likely be infertile or sub-fertile as a result of intersex variation.⁵³ Medical evidence was that no viable alternatives to the proposed procedure were available, and if the gonads were not removed, then risks of masculinisation and malignancy would endure.⁵⁴ Should the procedure be deferred, the gonads may need to be repositioned outside the abdomen, and it was argued that this would result in psychological consequences for Carla.⁵⁵ On account of being 5 years old, Carla was not competent to consent to the proposed procedure.⁵⁶ However, Forrest J characterised the proposed procedure as therapeutic, and necessary to treat a bodily malfunction, and therefore it did not meet the criteria of the *Marion's Case* test for medical procedures requiring court authorisation.⁵⁷ Forrest J subsequently issued a parenting order indicating that Carla's parents may consent to Carla's gonadectomy and the administration of oestrogen.⁵⁸

2 *Prioritising Risks and Meeting Social Norms*

The relevant legal test rests on the characterisation of the proposed surgical intervention as therapeutic, yet the Court prioritised the concern of psychological risks over physical risks of Carla's intersex variation and its proposed 'treatment'. *Re: Carla* revealed a medico-legal desire for socio-cultural assimilation and Carla's medical team actively pursued such assimilation by way of medical intervention. The Court complied with this desire by defining

⁴⁷ *Re: Carla (Medical Procedure)* [2016] FamCA 7 [1], [17].

⁴⁸ *Ibid* [1]–[2], [19].

⁴⁹ *Ibid* [2], [16].

⁵⁰ *Ibid* [18].

⁵¹ *Ibid* [13]–[15].

⁵² *Ibid* [3], [19], [22], [25].

⁵³ *Ibid* [29].

⁵⁴ *Ibid* [19], [22].

⁵⁵ *Ibid* [20].

⁵⁶ *Ibid* [51].

⁵⁷ *Ibid* [50], [52]–[53] (Forrest J). This was in direct contrast to the conclusion reached by Barry J in *Re Lesley*, outlined above. It is important to note that Carla and Lesley share the same intersex variation and Barry J determined that the proposed procedure for Lesley fell 'squarely within the principles enunciated in *Marion's Case*': *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226 (12 December 2008) [38] (Barry J).

⁵⁸ *Re: Carla (Medical Procedure)* [2016] FamCA 7 (20 January 2016) [56], [Orders 3] (Forrest J).

the proposed procedure as therapeutic and necessary to treat a bodily malfunction, thus characterising it as necessary medical treatment of a disorder. This conclusion endorsed bodily normativity by making Carla conform to ‘normal’ femaleness. Again we see the significance of the characterisation of intersex as a disorder rather than a recognised status, the priority being normalisation of ‘sufferers’ as opposed to acceptance of difference.

The objective of assimilation consisted of three distinct phases, the first of which, the ‘genital enhancement’, was completed prior to the family and hospital coming to court. The second phase was the proposed gonadectomy, which was the principal procedure, and the final phase was the administration of hormones. Medical opinion maintained that Carla would in the future need oestrogen to induce female puberty, which would provide positive social and psychological benefits, and would then be followed by life-long oestrogen replacement.⁵⁹ This hormone regimen, in conjunction with gonadectomy, would enable Carla to become a ‘normal’ female.⁶⁰ Forrest J also recognised that Carla ‘may also require other surgery in the future to enable her vaginal cavity to have adequate capacity for sexual intercourse’.⁶¹ Here the decision was driven by the court’s desire to facilitate the ‘normalisation’ of Carla and to ensure that Carla fit within an accepted social, cultural and biological standard.

The desire for the embodiment of female bodily normativity enabled Carla’s medical team, and by extension the Court, to express substantial concern for the risks to Carla’s psychological well-being. Carla was at intermediate risk of malignancy due to the location of the gonads. This risk would be eliminated by their removal.⁶² Forrest J indicated that risk of cancer was ‘one of, if not the major’ justification for Carla’s proposed procedure, which inferred that such risk was not the sole justification.⁶³ The Court did not elaborate on additional justifications. The assumption, however, was that Carla would experience increased social and psychological well-being as a result of conforming to ‘normal’ femaleness through the removal of the gonads and the prevention of any associated psychological risks of masculinisation.⁶⁴

In *Re: Carla*, medical opinion maintained the view that Carla had a female gender identity which was unlikely to change.⁶⁵ This view was based on observations indicating Carla’s interests in stereotypically female toys and colours including ‘pink curtains, a Barbie bedspread and campervan, necklaces, lip gloss and fairy stations’.⁶⁶ In addition to these interests, Carla ‘happily wore a floral skirt and shirt with glittery sandals and Minnie Mouse underwear and had her long blond hair tied in braids’.⁶⁷ It was explained that Carla does not attempt to ‘stand while urinating’, does not prefer to be known by male pronouns, and prefers ‘female toys, clothes and activities’.⁶⁸ Each of these indicia could best be described as externally driven, Carla’s parents strove to establish a ‘normal’ gender profile for Carla and here we see a practical demonstration of the entirely understandable ‘anxious goodwill’ that Brennan J cautioned against in *Marion’s Case*.⁶⁹

⁵⁹ Ibid [18].

⁶⁰ Ibid [3].

⁶¹ Ibid [18] (Forrest J).

⁶² Ibid [19].

⁶³ Ibid (Forrest J).

⁶⁴ Ibid [22].

⁶⁵ Ibid [15].

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Ibid.

⁶⁹ *Marion’s Case* (1992) 175 CLR 218, 272 (Brennan J).

The external manifestation of such gendered characteristics provided the justification for surgical intervention. Medical evidence relayed the view that gonadectomy of five-year-old Carla should be performed to prevent the possibility of masculinisation, which could occur during puberty in several years time and result in irreversible bodily changes.⁷⁰ It was argued that such changes would be undesirable and negatively impact on Carla's stable female gender identity. It was asserted that although masculinisation could be suppressed, doing so would delay female puberty and would likely result in detrimental social, psychological and physical effects, including effects on Carla's bone health.⁷¹ Additionally, masculinisation could also result in clitoral enlargement. Forrest J indicated that despite medical confidence in the stability of Carla's identity, clitoral enlargement would then 'require' that additional surgery be performed 'to create male genitalia', which would be supplemented by testosterone therapy throughout Carla's life.⁷²

The view that such bodily changes would require surgical intervention illustrates the fragility of socio-cultural and medical norms of 'correct' femaleness, which are destabilised by the presence of atypical and 'abnormal' female genitalia. However, this view also reveals the medical jurisdiction over the intersex body and the intolerance of bodily diversity. The Court endorsed the medical jurisdiction and intolerance of bodily diversity when it considered Carla's potential fertility. Should gonadectomy be deferred, Carla's potential fertility would raise 'significant social and emotional complexities given that Carla identifies as a female and... is likely to continue to, whilst any fertility she could potentially attain is based on male gametes'.⁷³

Medical evidence indicated that the psychological risks of no intervention outweighed the risks of the proposed procedure, and that gonadectomy should therefore be performed without delay.⁷⁴ However, medical opinion did not convey urgency in Carla's need for intervention.⁷⁵ Forrest J accepted the medical prioritisation when he maintained that notwithstanding the absence of urgency, the proposed procedure 'should be carried out before the onset of pubertal changes in order to ameliorate real and not insubstantial risks to Carla's physical and emotional health'.⁷⁶ Such risks would occur as a result of masculinisation which Carla would likely undergo at the onset of puberty. However, the medico-legal defence of intervention without delay was based on the assumption that Carla would experience physical and emotional risks as a result of deviation from bodily normativity in the interim prior to puberty. In the absence of urgency, the Court endorsed medical views rooted in assumptions about 'normal' femaleness and the associated risks of non-normative bodies.

⁷⁰ *Re: Carla (Medical Procedure)* [2016] FamCA 7 (14 January 2016) [22].

⁷¹ *Ibid* [24].

⁷² *Ibid* [23] (Forrest J).

⁷³ *Ibid* [28] (Forrest J). Cryopreservation was ruled out as a viable alternative to treatment: [27], [33].

⁷⁴ *Ibid* [22], [26], [30].

⁷⁵ This is to be contrasted with some earlier decisions in which medical opinion advised against delaying surgical intervention in *Re Sean and Russell (Special Medical Procedures)* (2010) 44 Fam LR 210, 229, due to the associated risks of Denys-Drash Syndrome. Although such opinion did not express a state of exigency, the risk of renal failure elevated the urgency of authorising medical intervention for Sean and Russell as opposed to the proposed procedure for Carla. See also: *In Re A* (1993) 16 Fam LR 715, 721 in which Mushin J noted the degree of urgency in authorising treatment for A.

⁷⁶ *Re: Carla (Medical Procedure)* [2016] FamCA 7 (14 January 2016) [51] (Forrest J).

IV AN ERROR IN JUDGMENT

A *Social Norms*

The intersex child does not sit comfortably within accepted social norms, they cannot be easily identified as either male or female and there has (and continues to be) an overriding urge to protect them from future harms, loosely characterised as psychological, social and physical. The medicalisation of intersex has meant that the accepted approach, as aptly described by Kennedy, has been ‘erasure and eradication of ambiguity which threatens to undercut the reliability of established dichotomies of sex, gender and sexuality’.⁷⁷ There has been an unquestioning adoption of the characterisation of intersex as a disorder, indeed the dominant term in the medical literature is ‘disorders of sex development’ (or DSD) and this value laden characterisation identifies intersex as something to be addressed, to be fixed or, at its simplest, to be ‘ordered’. This approach and characterisation grew out of a very particular medical and social view, there has (and continues to be) a perceived need to hide these children not only from society but also from themselves; and in the past, many lived unaware of their earlier characteristics and interventions until it became medically necessary for them to find out.

Turning once more to the two judgments under consideration here, we see that the medicalisation of the discussion has meant that the debate has been viewed as inherently objective, and this has enabled the Court to accede to medical jurisdiction over the intersex body which, in turn, enables clinicians to determine the course of action for intersex people.⁷⁸ In *Re Lesley* this framing was rooted in the understanding that the proposed procedure was in Lesley’s best interests because it was the result of deliberations flowing from medical objectivism. However, absent from this view is the consideration of subjective norms, interests, and potential limitations of the medical enterprise. The framing of medical environments as inherently ‘objective’ does not appreciate that clinicians within such environments may not consider the impact of healthcare on the rights of patients, particularly children (and the future adult). This framing may also impede the Court’s ability to explore whether proposed procedures are based on patients’ needs or the medical prioritisation of the need for intersex people to conform to socio-cultural and medical norms. The conclusion in *Re Lesley* reflected and endorsed socio-cultural and medical norms, and upheld the medical jurisdiction over the intersex body. Whilst the court strove to identify and then focus on Lesley’s best interests, those interests were largely defined by the medical community and were based upon one very specific world view. Thus, whilst the conclusion that it was essential for the court to oversee these significant medical decisions was sound, the deference to the traditional medical view of the intersex ‘disorder’ meant that Lesley’s interests were defined within unchallenged social and cultural norms as defined by the medical community. It is this application that is troubling. The absence of critical engagement with medical evidence was even more evident in *Re: Carla*. In this instance the Court took one step further and accepted that the medical community, in consultation with the parents, was best suited to make decisions about these kinds of interventions. The procedure was characterised as necessary and therapeutic, and therefore outside of the *Marion’s Case* parameters. We see here a court that was willing to uncritically rely on medical evidence. Of particular note is the complete absence of any contrary evidence, there were no opposing views or cross-examination. In some respects, the decision acted as an audit review of a preferred intervention path as opposed to an objective assessment of Carla’s

⁷⁷ Aileen Kennedy, ‘Fixed at Birth: Medical and Legal Erasures of Intersex Variations’ (2016) 39(2) *University of New South Wales Law Journal* 813, 814.

⁷⁸ For discussion on medical jurisdiction over the intersex body, see: Davis, above n 18, ch 3.

best interests. Carla did not have a voice raised in dissent, there was no challenge to the accepted medical position or the wishes of the parents for a ‘normal’ child. The absence of opposing views raises the question of whether or not the Court can truly provide an ‘independent safeguard’⁷⁹ for children’s rights and interests as the only ‘reality’ presented to the court is one that reflects the accepted medical and social paradigm that presents intersex as a disorder that can only be addressed through medical intervention. The practical outcome is that despite assertions that the court is protecting the best interests of the child, the conception of best interests is distorted by external expectations and conceptions of what is right in the circumstances. The child at the centre of the judicial scrutiny has no real voice and the ideal of best interests is not effectively addressed.

B *Best Interests*

The focus on eradication of ambiguity, as explained above, has meant that the concept of best interests has been viewed through a blurred lens. It is based upon a flawed assumption that it is the best interests of the intersex child (and future adult) to conform, to fit within a cultural and societal norm. There is no attention paid to the fact that it is in the best interests of every individual to embrace and accept who they are and, in the case of an intersex person, as they mature, to determine for themselves if they wish to identify with a particular gender or accept their sex characteristics. For any decision regarding children and their welfare, a guiding principle for the Family Court is that of best interests. This foundational consideration is readily apparent in both *Re Lesley* and *Re: Carla* where best interests is prioritised, but it is the application of the test that is flawed. Both judgments pay deference to opinions formulated in a ‘high level medical environment’⁸⁰ and understandable parental wishes that the questions before the court be ‘resolved expeditiously’,⁸¹ but fail to engage with any view that contradicts that of the parents and the treating hospital. There is no opportunity for a dissenting view to be raised, there is no independent alternate view of best interests and the decision is therefore driven by medical opinion and parental ‘anxious goodwill’.

It is crucial therefore that an independent voice be heard, and that there is an opportunity for other options to be considered. As it stands, the critical voices in the debate are those in the medical and scientific communities advocating medical intervention, along with parents who are advised by those communities and understandably seek to protect their children from perceived future harms. The discussions in the Family Court to date have therefore been unbalanced, there has been a focus on one view and one conception of what is in the best interests of the child. In no other legal debate is such a one-sided presentation of argument accepted, there needs to be a presentation of a dissenting voice, an opportunity to actively engage with viable alternatives. The decision in *Re: Carla* to hand authority back to parents in these circumstances is therefore troubling, and fails to heed the caution of the High Court in *Marion’s 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 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.⁸²

⁷⁹ Felicity Bell, ‘Children with Gender Dysphoria and the Jurisdiction of the Family Court’ (2015) 38(2) *University of New South Wales Law Journal* 426, 450.

⁸⁰ *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226 [44].

⁸¹ *Ibid* [35].

⁸² *Marion’s Case* (1992) 175 CLR 218, 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).

Decisions regarding surgical interventions on intersex children fall squarely within the *Marion’s Case* test; there must be external review of any proposed procedure if we are to truly protect the interests of this vulnerable group.

V CONCLUSION: A WAY FORWARD

There is no clear path for decision-making in the context of intersex children but there must be a retreat from the conclusion reached in *Re: Carla* where there was unquestioning reliance on one particular conception of the best interests of the child. It has been suggested that with respect to the medical intervention of intersex children, ‘it is time to stand back and rethink every aspect of its management’,⁸³ and the same holds true for the legal test of how to determine the best interests of intersex children.

At the very least, authority for decision-making regarding surgical intervention must be placed back in the hands of the Family Court. However, there needs to be an adjustment of the existing approach which defers to medical evidence and consists of a relatively narrow enquiry. The existing judicial approach is grounded in the definition of intersex as a disorder, a position that was highlighted in *Re: Carla* by the unquestioning acceptance of earlier ‘enhancement’ of Carla’s genitalia. There was no indication that this surgical intervention had been clinically indicated, Carla simply looked different and the surgery was provided in order to ‘normalise’ Carla. Therefore, these kinds of procedures must be drawn back under the umbrella of the *Marion’s Case* principles and defined as special medical procedures requiring external scrutiny.

This external scrutiny does not necessarily have to take place within the framework of the Family Court and the complexities confronting a family when required to navigate an unfamiliar (and daunting) court process. As foreshadowed in the introduction, one potential way forward is to move these enquiries into an entirely different framework and provide appropriate support to clinicians, parents and children from the beginning of the intervention journey. Once a child is identified as having intersex characteristics they could be referred to a specialist panel that has relevant expertise to consider each case individually and, where clinically indicated, approve appropriate intervention. The proposed panel is modelled on the Prescribed Psychiatric Treatment Panel, created pursuant to sections 41A–41D of the *Mental Health Act 2009* (SA). Again, we emphasise that this recommendation in no way suggests that intersex is a mental health condition, rather it is simply reflecting on a particular legislative model that has been created to protect the best interests of a vulnerable sector of society. The Prescribed Treatment Panel is authorised to review and approve specific medical procedures. The panel membership is prescribed under the Act and has representatives with specific skills and insights including the following:

- patient (or former patient),
- carer (or former carer),
- senior psychiatrist,
- neurosurgeon,
- legal practitioner, and
- someone with credential and experience in bioethics.

⁸³ Sarah Creighton and Catherine Minto, ‘Managing Intersex: Most Vaginal Surgery in Childhood Should be Deferred’ (2011) 323(7324) *British Medical Journal* 1264, 1264.

For present purposes, a similar legislatively endorsed panel (the ‘Intersex Intervention Panel’) would have a broad membership, including adult intersex representatives, clinical specialists, parent representatives and other appropriately skilled individuals would provide support, objective assessment and specialist insight into proposed clinical (and non-clinical) paths. The panel would support the intersex child (and their family) from birth through to majority and all interventions would be open to scrutiny, this would include early ‘genital enhancements’. The panel would support the parents of the children through helping them to recognise that, whilst their children do not fit within narrow definitions of ‘normal’, they are within a broader conception of ‘normal’ and intersex is a status and does not necessarily warrant early and radical intervention. Of course, where treatment is required for the health of the child, then the parents and child would be supported through this process. In addition, the existence of a specialist panel would assist the treating team who would be able to direct the parents to a supported decision-making process without the added trauma of having to go through a court process.

An appropriately broad panel would introduce additional voices to the discussion, with the ultimate goal being a retreat from the existing deference to the medicalisation of intersex children. The panel would be expected to address the ‘status’ of intersex as opposed to the ‘medical deformity’ warranting treatment. The role of the panel would be a supportive one; parents and families would gain insight beyond the clinical view, and would be guided and supported through the journey towards a point when, where possible, the child themselves are able to voice a preference. It is envisaged that there would be no absolute prohibitions on interventions. The role of the panel would be to interact with the specific individual characteristics of the child before them and this would include existing manifestations of a gendered identity, clinical need, family relationships, psychological health and social need. The enquiry would be a broad one and therefore neither overly legalistic nor medical in nature. The introduction of such a panel is not without jurisdictional complexities as it would be a state-based approach which could give rise to unacceptable variation. Furthermore, if specific interventions were characterised as ‘special medical procedures’ then the jurisdiction of the Family Court would remain.

The introduction of a specialist panel is, however, but one potential solution to the ethically, legally and, at times, clinically, complex question of how to appropriately support the medical and social needs of intersex children. And whilst the introduction of such a panel presents technical jurisdictional difficulties, these are not insurmountable. The reality is that there is only one certainty with regard to the diverse needs of intersex children: there is a complete lack of consensus on what should or should not be done. There continues to be a view that intersex is a disorder requiring treatment and an imperative to intervene and correct the deviation from the ‘norm’. Whilst the perception that there is a need for ‘correction’ is flawed, it is currently a reality and it is a reality within which we must function. The creation of an independent review panel, one that is purely to meet the needs and interests of intersex children would address this perceived need and help us to move forward with acceptance of these children and their families. As outlined above, there needs to be a breadth of experience available to the review panel, medical specialists, representative of interest groups, parents, intersex adults, and legal representatives. The role of the panel would be to look after the individual child — if there is a clear and unchallenged clinical indication for intervention then proceed, however where it is open for debate take the time to pause, discuss and think about the implications of proceeding – and this includes the currently accepted ‘genital enhancement’. Focus on the child, their individual characteristics and needs, look beyond the glittery sandals,

understandable parental wishes for a happy and healthy child and see the individual and assess, on a case by case basis, what is in their best interests. There should be a number of guiding principles but the core one, the one that drives all decisions is what is best for that person. And if it is not readily apparent, then wait until it is.