CONSENT TO TREATMENT FOR TRANSGENDER AND INTERSEX CHILDREN

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[*More than a decade has passed since the landmark High Court decision in* Marion's Case,[1] *where the Court authorised the sterilisation of a young woman who suffered from a disability. Recently, the principles established in that case were applied by the Family Court in a different context – for the provision of hormonal treatment for a 13 year old child,*[2] *some aspects of which are irreversible. Previously, the Family Court had authorised gender reassignment surgery for a child suffering from a physical, congenital condition,*[3] *but notably in* Re Alex, *the subject child suffered no identified physical condition indicating treatment, but from an identified psychological condition, gender identity dysphoria.*

This article considers the issues raised by recent applications of the principles relating to the capacity of children to consent to medical treatment, including the decision in Re Alex *and the application of those principles to transgender and intersex children. While not all children or adults who identify as transgender or intersex choose the long and difficult path of gender reassignment, some will choose surgical gender reassignment or hormonal treatment at some stage of their lives. In cases where it is proposed that a minor undergo such treatment, the application of the principles of child consent poses particular difficulties.*]

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[1] *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.
[2] *Re Alex* (2004) 180 FLR 89; [2004] FamCA 297.
[3] *Re A* (1996) 16 Fam LR 715.

I BACKGROUND – THE CAPACITY OF CHILDREN TO CONSENT TO MEDICAL TREATMENT

It is necessary to begin a consideration of medical consent issues relating to children with an examination of the House of Lords' decision in *Gillick*,[4] because that decision was endorsed by the High Court in *Marion's Case*. In *Gillick*, the Department of Health and Social Security issued a circular to area health authorities advising doctors in relation to the prescription of contraceptive treatment to female minors under the age of 16. The circular indicated that although it would be usual and preferable to obtain parental consent to contraceptive treatment, in certain special circumstances it would be permissible to do so without the need for contact with, or permission from, a parent.

Mrs Gillick, as the mother of five daughters under the age of 16, sought assurance from the relevant Health Authority that her daughters would not be given contraceptive advice or treatment without her consent. When the Health Authority refused to provide such assurance, Mrs Gillick brought an action against the Health Authority and the Department seeking a declaration that the advice contained in the circular was unlawful on the basis that:

- it advised doctors to cause or encourage unlawful sexual intercourse with a minor (an offence); or
- it encouraged a doctor to become an accessory to unlawful sexual intercourse with a minor (also an offence); or
- that the provision of contraceptive advice to a minor was unlawful as being inconsistent with the plaintiff's parental rights.

In part, Mrs Gillick's case turned on the accuracy of the proposition that a child under the age of 16 years is incapable of giving consent to contraceptive treatment. The trial judge refused to grant the declarations sought by Mrs Gillick,[5] but that decision was overturned on appeal.[6] The Department appealed to the House of Lords.

By majority, the House of Lords found in favour of the Health Authority. They found that although it would certainly be unusual, in circumstances where a child is of sufficient intelligence and maturity, to understand fully the nature of the treatment being administered and to make a decision about that treatment, the child is capable of consenting to the treatment. Parental rights in relation to minors are not absolute; a parent begins by having control when a child is very young, but the right

[4] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
[5] *Gillick v West Norfolk and Wisbech Area Health Authority* [1984] QB 581.
[6] [1986] AC 112.

dwindles as the child becomes older or no longer needs protection, until it becomes little more than a right to advise.[7]

The decision of the House of Lords in *Gillick* was endorsed by the High Court of Australia in *Marion's Case*.[8] The parents of Marion (not her real name), a 14-year-old girl suffering from mental retardation, severe deafness and epilepsy, sought a court order authorising the sterilisation of their daughter or, in the alternative, a declaration that is was lawful for them to consent to the sterilisation. The purpose of the proposed procedure was to prevent pregnancy and menstruation, which had psychological and behavioural consequences for Marion, and to stabilise hormonal influxes for the purposes of eliminating consequential stress and behavioural responses.[9]

The various judgments in *Marion's Case* addressed three main issues: the capacity of a child to consent to medical treatment, the scope of parental consent to medical treatment and the power of the court to authorise medical treatment for a child. Although there was no question that Marion did not, and could never have, the capacity to consent to medical treatment, the majority of the Court saw fit to endorse the principle established in *Gillick* – that a child is capable of giving consent to medical treatment where the child is of sufficient intelligence and maturity to understand fully what is proposed.[10] On the other hand, Brennan J doubted whether *Gillick* afforded sufficient recognition to "the primacy of parental responsibility".[11]

The real issue in *Marion's Case* was the ability of parents to consent to sterilisation of their child in circumstances where that sterilisation was not required for the purposes of saving the life of the child or preventing serious harm. In determining this issue, the majority drew a distinction, albeit reluctantly, between therapeutic and non-therapeutic sterilisation. Therapeutic sterilisation is performed either for the purpose of, or as a by-product of, surgery to treat a malfunction or disease.[12] Non-therapeutic sterilisation, then, is sterilisation carried out for another purpose. The test was also endorsed by Brennan J[13] and Deane J.[14]

The High Court, with the exception of Deane J, held that parents could never consent to sterilisation for non-therapeutic purposes. Justice Deane would have allowed parental consent for non-therapeutic sterilisation only in a narrowly-defined set of circumstances, namely:[15]

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[7] [1986] AC 112, 172–173 (Lord Fraser of Tullybelton) 183–4 (Lord Scarman).
[8] *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992) 175 CLR 218.
[9] (1992) 175 CLR 218, 221.
[10] Ibid 237–8 (Mason CJ, Dawson, Toohey and Gaudron JJ), 311 (McHugh J).
[11] Ibid 280–1 (Brennan J).
[12] Ibid 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).
[13] Ibid 273–4 (Brennan J).
[14] Ibid 296–7 (Deane J).
[15] Ibid 305 (Deane J).

(i) where the child is so profoundly intellectually disabled that she will never be able to have a mature human relationship involving informed sexual intercourse, of responsible procreation or of caring for an infant;
(ii) where the surgery is necessary to avoid grave and unusual problems and suffering associated with menstruation;
(iii) where the surgery is a treatment of last resort; and
(iv) where there is medical advice from a multidisciplinary team acting on the basis of appropriate reports.

These requirements were considered by Deane J to distinguish ordinary non-therapeutic sterilisation from sterilisation that is obviously required according to general community standards.[16]

II OVERSEAS AUTHORITIES

It is relevant before embarking on a discussion of the principles of child consent and their applicability to the transgender or intersex child to consider two cases from the United Kingdom dealing with the capacity of a child to *refuse* consent to medical treatment. To the authors' knowledge, this issue has not arisen for judicial consideration in Australia. In both cases, the English courts limited the *Gillick* principle in two important ways. First, they found that a child who is *Gillick* competent, while able to consent to medical treatment, is not similarly able to *refuse* consent to medical treatment, and in circumstances where a parent authorises treatment against the wishes of a minor, the parental consent will be sufficient to authorise the treatment. The second limitation was a finding that even where a child is *Gillick* competent, the Court in its exercise of the *parens patriae* jurisdiction retains the right to override either a consent or a refusal of the child to medical treatment where that is in the child's best interests.

A Re R

Re R involved a 15-year-old ward of the state who was admitted to a treatment centre.[17] She had a disturbed childhood and experienced periods of erratic and violent behaviour interspersed with periods of lucidity and rationality. During an episode of the latter description, she expressed her wishes to a counsellor that she did not wish to take the drugs that the unit personnel wanted to give her and had given her on previous occasions. The local authority commenced wardship proceedings and applied for leave for the unit to administer medication regardless of R's consent or absence thereof.

[16] (1992) 175 CLR 218, 305 (Deane J).
[17] *Re R* [1991] 4 All ER 177.

Although a consideration of the scope of parental authority was not relevant to the decision, Lord Donaldson considered the principle from *Gillick* and found that it did not extend to a right reposed in a minor to refuse consent to medical treatment. With regard to consent, he used the analogy of child and parent as keyholders, each of whom was entitled to "unlock the door" to medical treatment of the minor. In circumstances where the child refused consent to medical treatment, the parents could still override that consent and authorise medical treatment.[18] To find otherwise would result in doctors being faced with the "intolerable dilemma" of having to determine who possessed a right of consent at any particular time, with the threat of being sued if a wrong decision was made.[19]

The Court found that R was not *Gillick* competent, on the basis that she was only competent for periods of time before lapsing into phases of irrationality and violence. However, the Court still went on to consider the power of the Court in relation to a child determined to be *Gillick* competent. The Court found that it could, in exercise of its wardship or statutory jurisdiction in relation to minors, override the decision of a *Gillick* competent minor to consent or refuse treatment.[20] In the circumstances it was held to be in the best interests of R that the unit be authorised to administer any treatment to R that it considered necessary.

B Re W

Re W concerned a 16-year-old girl suffering from anorexia nervosa.[21] W, who was found by the trial judge to be *Gillick* competent, was being treated at a facility for patients with eating disorders. Her condition was deteriorating steadily, to the extent that doctors feared she might soon suffer damage to her reproductive system and danger to her life if treatment were not administered. W refused consent to her being moved to an alternative treatment centre in London where a more rigorous program of treatment would be administered.

The Court of Appeal unanimously held that the court, in exercising its unlimited inherent jurisdiction in relation to minors, could override the wishes of a competent child in the best interests of the child, objectively considered.[22] The Court also found that a minor did not have a power of veto in relation to treatment authorised by someone with parental responsibilities for the minor. A power of veto was not provided by s 8 of the *Family Law Reform Act 1969*[23] and although the issue of

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[18] Ibid 184–5 (Lord Donaldson MR).
[19] Ibid 188 (Staughton LJ).
[20] Ibid 188 (Lord Donaldson MR), 189–90 (Staughton LJ), 192 (Farquharson LJ).
[21] *Re W (a minor) (medical treatment)* [1992] 4 All ER 627.
[22] Ibid 643 (Balcombe LJ), 646 (Nolan LJ).
[23] Ibid 634 (Lord Donaldson MR), 643 (Balcombe LJ), 647 (Nolan LJ). Section 8 of the *Family Law Reform Act 1969*, entitled 'Consent by persons over 16 to surgical, medical and dental treatment' reads:

> (1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of

parental power to veto was not at issue in *Re W*, the Court also doubted that the principle in *Gillick* extended to allowing a child an absolute right of refusal in relation to medical treatment.[24] Lord Donaldson, regretting his use of the keyholder analogy in *Re R*, used the analogy of a "legal flak jacket" which would protect the doctor from litigation in relation to a medical procedure, whether provided by the child or by someone with parental responsibilities.[25] Despite the fact that W was *Gillick* competent, the Court authorised the proposed treatment on the basis that it was in her best interests, given the serious consequences to her health if treatment were not administered.

III CONSENT TO MEDICAL TREATMENT OF THE TRANSGENDER OR INTERSEX CHILD

A Re A[26] – *Surgical treatment for congenital adrenal hyperplasia*[27]

1 *Relevant facts*

A, a 14-year-old child, was diagnosed at birth with congenital adrenal hyperplasia, a disorder which resulted in the over-production of male sex hormones which causes masculinisation of the genitalia.[28] A was assessed as a genetic female with an extreme degree of masculinisation. As an infant, A had genital reconstruction surgery to give him a feminine appearance. He was also given hormone replacement treatment to prevent further masculinisation.[29]

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this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

(2) In this section 'surgical, medical or dental treatment' includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

[24] *Re W* [1992] 4 All ER 627, 633 (Lord Donaldson MR), 642–3 (Balcombe LJ).

[25] Ibid 635 (Lord Donaldson MR).

[26] *In Re A* (1993) 16 Fam LR 715.

[27] It should be noted that, on the basis of A's condition (congenital adrenal hyperplasia) A would probably be characterised as 'intersex' rather than 'transgender'. Intersex persons typically have physical sexual characteristics of both sexes, while transgenderism usually denotes a person who, although having the physical characteristics of one sex, identifies as a member of the opposite sex. However, because of the similarity of the principles involved, this case is usefully considered in conjunction with *Re Alex*.

[28] *In Re A* (1993) 16 Fam LR 715, 716.

[29] Ibid 717.

The level of the hormone therapy, however, was inadequate, and A suffered further masculinisation. This was accompanied by a change in A's attitude, so that he preferred to be male.

In 1993, A's mother brought an application before the Family Court seeking authorisation for A to undergo surgical treatment. In particular, authorisation was sought for:

- bilateral mastectomies;
- a hysterectomy;
- an oophorectomy (removal of ovaries);
- unfolding of the clitoris to increase its length and to relieve pain caused by erections;
- closure of the labia to create the appearance of a scrotum; and
- insertion of prosthetic testes.[30]

2 *The decision of the Court*

(a) *Whether A was competent to consent to the proposed treatement*

Referring to the High Court's approval (in *Marion's Case*) of the House of Lords' decision in *Gillick*, Mushin J noted that a minor is capable of giving informed consent when he or she 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.[31] On the evidence, the Court found that although A understood the problem and, in general, the proposed resolution to the problem, he did not have 'sufficient capacity and maturity to fully appreciate the matter and to assess the options available to him'.[32]

(b) *Whether A's parent was able to consent to the proposed treatment*

The Court then turned to consider whether the proposed treatment was outside the scope of A's parent to consent to on behalf of A. The Court noted that the purpose of intervention was to assign to A male sexual organs, and sterilisation would be incidental to the treatment. The Court concluded that the decision to proceed with the proposed treatment did not fall within the ordinary scope of parental power to consent to medical treatment, noting first the significant risk of making the wrong decision about what was in A's best interests and secondly that the consequences of the decision were particularly grave.[33]

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[30] Ibid 717.
[31] Ibid 719.
[32] Ibid 719.
[33] Ibid 719–720.

(c) *Whether the Court ought to consent to the proposed treatment*

The Court then addressed the question of whether the consent should be granted. Noting that the most important concern was A's emotional and psychological state, the Court found it was clear that the treating experts regarded the proposed treatment as highly desirable in A's interests. Further, the Court noted the probability of very serious negative consequences to A if the application were rejected. In the circumstances, the Court concluded that it was "overwhelmingly" in A's interests to accede to the application.[34] The Court made final orders authorising all of the aspects of the proposed treatment, as well as any further or other necessary and consequential procedures to give effect to the treatment of the condition of congenital adrenal hyperplasia.[35]

B Re Alex – *Treatment for Gender Identity Dysphoria*

1 *Relevant facts*

Alex was born overseas, the only child of his[36] married parents. As a young child he was very close to his father, who died suddenly when Alex was five or six years old. Several years later, Alex's mother re-married and the family moved to Australia. Alex's step-father had children from a prior relationship who lived with the family. Alex had difficulties adjusting to his new situation and demonstrated violence both at school and at home towards his step-siblings on a number of occasions.

When Alex was 10 years old, a child protection alert was made to the relevant government department, which resulted in final orders being made assigning guardianship responsibility for Alex to a government department. Since those orders, Alex had been living with his aunt, apart from a three month period during which he was placed in foster care. Alex had had no contact with his mother, and although his mother was served with the application, she did not seek to be heard on the application.[37]

It was common ground in the evidence presented before the Court that Alex had:

- no ambiguity in sexual characteristics;
- normal female chromosomes;
- hormone levels typical of an adolescent female;

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[34] Ibid 722.
[35] Ibid.
[36] Nicholson CJ noted in *Re Alex* that Alex wanted to be referred to as a male, and adopted that terminology in his judgment: (2004) 180 FLR 89, 94. We have done the same for all references in this article.
[37] *Re Alex* (2004) 180 FLR 89, 93.

- female reproductive organs;[38] and
- a long-standing, unwavering and present identification as a male.[39]

Alex was diagnosed with "gender identity dysphoria",[40] a definition of which is provided by the *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM-IV):

> A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children the disturbance is manifested by four (or more) of the following:
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> § repeated stated desire to be, or insistence that he/she is, the other sex;
> § in boys, preference for cross-dressing or simulating female attire; in girls, insistence on only wearing stereotypical masculine clothing;
> § strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex;
> § intense desire to participate in the stereotypical games and pastimes of the other sex;
> § strong preference for playmates of the other sex.

2 *Application to the Family Court*

The applicant, Alex's guardian, filed an originating application[41] in the Family Court seeking, by way of final orders, a declaration pursuant to s 67ZC(1) and (2) of the *Family Law Act 1975* (Cth) (the Act) that the applicant[42] be authorised to consent on Alex's behalf to certain medical treatment. The respondents to the application were Alex's aunt and mother[43] and, at the Court's invitation, the Human Rights and Equal Opportunities Commission (the Commission) intervened without objection pursuant to s 92 of the Act.[44] The application originally sought authorisation only for the first stage of the treatment, but the applicant requested the Court to consider the treatment as a whole process and the final orders related to a single treatment plan incorporating all stages of treatment. The relevant medical treatment was:

(a) that Alex be administered a combination of oestrogen and progestogen on a continuous basis until he turned 16;

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[38] Ibid 103.
[39] Ibid.
[40] Alex was diagnosed as such in two reports: one of Professor P, an Associate Professor in the Department of Psychiatry at a university faculty of medicine and a consultant child psychiatrist at a hospital for children, and one of Dr N, a Consultant Psychiatrist and specialist in child and adolescent psychiatry, particularly gender issues. This diagnosis was confirmed by the evidence of Ms R, Alex's caseworker.
[41] The application was filed on 12 December 2003.
[42] The specified person being the Secretary of the government department with guardianship responsibility for Alex.
[43] *Re Alex* (2004) 180 FLR 89, 93.
[44] Ibid 93–94.

(b) ongoing psychiatric assessment for Alex; and
(c) that, after Alex reached the age of 16, he be treated with LRHR analogue and testosterone administered either in oral form, by monthly injection or by six-monthly subcutaneous implant.

The administration of the pill (the treatment referred to at (a) above) would result in the suppression of Alex's menses. This aspect of the treatment was completely reversible, although continuous treatment for three years might have an irreversible effect on Alex's ovarian function and fertility. The treatment referred to at (c) above involved the administration of LRHR analogue, a drug which suppresses the release of gonadotrophins from the pituitary gland, and would suppress all ovarian menstruation. The administration of testosterone, a male sex hormone, would have certain irreversible effects such as deepening of Alex's voice, the promotion of facial and body hair, muscular development and enlargement of the clitoris.[45] Authorisation was not sought for any treatment with irreversible effects to be administered until Alex reached the age of 16.

3 *The decision of the Court*

In January 2004, pending final judgment, the Court made interim orders authorising Alex's guardian to consent to the administration of oestrogen and progestogen (commonly known as the pill) on a continuous basis, with the consequence that Alex began secondary school known as a male. The Court's judgment was delivered in full on 13 April 2004.

(a) *Jurisdiction*

At the outset, the Court noted that s 67ZC of the Act provided the statutory basis of the Court's jurisdiction to approve or refuse permission for special medical procedures.[46] Section 67ZC provides:

(1) In addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children.
(2) In deciding whether to make an order under subsection (1) in relation to a child, a court must regard the best interests of the child as the paramount consideration.

This section provides the Family Court with the *parens patriae* or welfare jurisdiction explained by the High Court in *Marion's Case*.[47]

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[45] Ibid 94.
[46] Ibid 93, citing *Re W* (1997) 136 FLR 421 and *B v Minister for Multicultural and Indigenous Affairs* (2003) 173 FLR 360.
[47] Ibid 115. See also *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 206 ALR 130.

(b) *Whether Alex was competent to consent to the proposed treatment*

The Court then stated that the question of whether a child is competent to consent to medical treatment required consideration of whether the child had achieved a sufficient understanding and intelligence to enable him or her to understand fully what was proposed.[48] The Court considered the evidence before it, particularly those aspects of the psychiatric evidence which went to Alex's comprehension of the treatment and its effects. Noting that although Alex may have had a general understanding of what was proposed and its effect, the Court stated that it was quite another thing to conclude that Alex had "sufficient maturity to fully understand the grave nature and effects of the proposed treatment".[49] The Court concluded that Alex was not competent to consent to the treatment on his own behalf.

(c) *Whether Alex's guardian was able to consent to the proposed treatment*

Having concluded that Alex did not have capacity to consent to the treatment, the Court went on to consider whether the nature of the proposed procedure was one that required the consent of the Court.[50] The Court expressed the view that the requirement of court authorisation was not limited to treatment involving surgical intervention.[51] Noting the physiological and psychological basis of gender identity dysphoria, the Court concluded that the current state of knowledge did not support a finding that the treatment would be for a "malfunction" or "disease" as explained by the majority in *Marion's Case*.[52] The Court concluded, however, that the nature of the proposed treatment was such that court authorisation was required.

(d) *Whether the Court ought to consent to the proposed treatment*

The Court went on to consider whether it ought to grant the authorisation to consent to the proposed treatment, noting that some aspects of the treatment had reversible effects and some irreversible. The Court stated that where reversible medical treatment is in specific anticipation of irreversible medical treatment which would require court authorisation, it would ordinarily be prudent, as in this case, for the application to be made pursuant to s 67ZC at the outset of the clinical intervention.[53] After a summary of the expert evidence in the case, the Court considered the '*Re Marion*' matters:

(i) the particular condition of the child which required the procedure or treatment;

(ii) the nature of the procedure or treatment proposed;

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[48] *Re Alex* (2004) 180 FLR 89, 116, referring to *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 237-8.
[49] *Re Alex* (2004) 180 FLR 89, 118.
[50] Ibid120.
[51] Ibid 121. The Court here agreed with the comments of Hannon J in *Re W* (1997) 136 FLR 421.
[52] *Re Alex* (2004) 180 FLR 89, 124.
[53] Ibid 124-5.

(iii) the reasons for which it is proposed the procedure or treatment be carried out;
(iv) the alternative courses of treatment that are available in relation to the condition;
(v) the desirability of and effect of authorising the procedure for treatment proposed rather than available alternatives;
(vi) the physical effects on the child and the psychological and social implications for the child of authorising the proposed procedure or treatment or not authorising the proposed procedure or treatment;
(vii) the nature and degree of any risk to the child or young person of authorising the proposed procedure or treatment or not authorising the proposed procedure or treatment; and
(viii) the views (if any) expressed by the guardian(s) of the child, a person who is entitled to custody of the child, a person who is responsible for the daily care and control of the child and the child himself, to the proposed procedure or treatment and to any alternative procedure or treatment.[54]

Further, the Court considered whether to make an order which would be least likely to lead to the institution of further proceedings (as required by s 68F of the Act) and therefore concluded that the authorisation for all stages of the treatment proposed ought to be granted.[55] The Court justified the authorisation of all stages of the treatment on the basis that it was least likely to lead to the institution of further proceedings, but kept the proceedings on foot and adjourned in the event that a party could re-open the matter if Alex's situation was altered.[56]

IV COMMENT: CAPACITY OF THE TRANSGENDER OR INTERSEX CHILD TO CONSENT (OR REFUSE CONSENT) TO TREATMENT

There are a number of issues that arise from a consideration of the principles of child consent in the context of transgender and intersex children. What follows is a discussion of three issues:

1. Despite the Court's endorsement of *Gillick*, are there in fact some types of treatment which are so serious in nature that a minor can *never* consent to them? Would gender reassignment and irreversible hormonal therapy fall into this category?
2. Should a distinction be drawn between the capacity of a minor to consent to medical treatment on the one hand and her or his capacity to *refuse* consent to medical treatment on the other?

[54] *Re Alex* (2004) 180 FLR 89, 125-127.
[55] Ibid 127.
[56] Ibid.

3. How should the principles of child consent be applied in the special context of treatment for the transgender or intersex child, given the particular consequences which may result both from administering treatment and withholding treatment?

A *Can a minor consent to treatment for the purposes of gender reassignment?*

The first issue for consideration is the question of whether there are some types of treatment that are so serious in nature that a minor can never give an effective consent for that treatment. The principle enunciated by the House of Lords in *Gillick* and endorsed by the High Court in *Marion's Case* is that a child is capable of giving consent to medical treatment in circumstances where the child possesses sufficient intelligence and maturity to understand fully the treatment that is being proposed. In *Marion's Case* there was no suggestion that the subject child, who suffered from a severe intellectual disability, had (or ever would have) the capacity to consent to her proposed sterilisation. However, *Re A* and *Re Alex* concerned two children with normal intellectual capacity who wished to undergo medical treatment, some of the consequences of which were irreversible: Alex for the purpose of changing his biological sex and A for the purpose of choosing between the ambiguous sexual characteristics he was born with.[57]

In both cases the Court found that although the children possessed a general understanding of the kinds of treatment that were being proposed, they did not possess the requisite intelligence and maturity to give them the capacity to consent to treatment. However, an examination of the reasons for this finding in *Re Alex* evidences more of a concern about the propriety of a 13-year-old being responsible for such a serious decision than a true inquiry into Alex's capacity to consent to medical treatment.

The Court found that the question of Alex's capacity to consent was an academic question, given that the expert evidence as to the proposed treatment was in accordance with Alex's wishes, nevertheless the Court still gave consideration to the issue. The judgment refers to the evidence of only three people on this point: Mr T (who prepared the family report), Professor P (an Associate Professor in the Department of Psychiatry at a university) and Dr N (Consultant Psychiatrist and specialist in child and adolescent psychiatry). Professor P, in particular, reported that Alex fully understood the mechanism of action for the proposed hormone treatment and its side effects and benefits. Both Mr T and Professor P indicated, however,

[57] It is important to note again that there is a difference between Alex's case and A's case. A was born with congenital adrenal hyperplasia resulting in him having the outward appearance of a male but having the sexual organs of a female. Alex was born a biological female with no ambiguous sexual characteristics but identified as a male from an early age. The cases have been considered together in this article because both involve a consideration of the capacity of minors to consent to serious, irreversible procedures designed to alter their sexual characteristics.

that they did not consider it appropriate that at age 13 Alex should be wholly responsible for the decision to undergo hormone treatment.[58]

Although holding that a finding of *Gillick* competence did not preclude a court from authorising medical treatment of a minor against her wishes, the judgments in *Re W* evidence a similar reluctance to accept the competence of the minor in question. Despite the trial judge, who heard from W, concluding that W was competent, the Court still felt inclined to doubt whether W was truly *Gillick* competent. Lord Donaldson found that 'it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective.'[59]

One can understand the reluctance of the courts to allow the kinds of treatment being considered (or potentially refused) in these cases to be administered on the basis of the child's consent alone or withheld solely on the basis of the child's refusal. However, if it truly is the case that some treatment is of such a serious nature, or the refusal of treatment would have such serious consequences, that a competent child's right of consent or refusal should not be absolute, then that should be enunciated clearly as a matter of legal principle.

The Court hinted at such a proposition in *Re Alex*. In the course of argument, the Commission made a submission that a court has no power to override either the informed consent or informed refusal of a competent child to medical treatment or, if such a power does exist, the court should not as a matter of discretion exercise that power except perhaps in extreme circumstances.[60] The Court doubted the correctness of that proposition and went on to state, 'It is highly questionable whether a 13 year old could ever be regarded as having the capacity for the latter, and this situation may well continue until the young person reaches maturity.'[61]

The suggestion here is that there are some types of medical treatment which are so serious that even a child who has a sufficient understanding and maturity to understand fully the nature of the treatment and the consequences of her or his decision, should not be allowed an absolute right to consent to that treatment. Treatment in the nature of gender reassignment surgery and treatment preparatory to that, which is serious in nature and irreversible in consequence, would probably fall into this category.

In the United Kingdom, the power of the courts is unlimited in their exercise of *parens patriae* jurisdiction. Even where a child assessed to be competent has given consent to a medical procedure, a court has the power to override that competent consent where that is considered to be in the child's best interests.[62] The English

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[58] *Re Alex* (2004) 180 FLR 89, 117–118.
[59] *Re W* [1992] 4 All ER 627, 637 (Lord Donaldson MR). See also 640 (Balcombe LJ).
[60] Ibid 119.
[61] Ibid 120.
[62] *Re W (a minor) (medical treatment)* [1992] 4 All ER 627, 646 (Nolan LJ).

cases considered above appear to reflect the idea that although competent adults are entitled to consent to or refuse treatment as they see fit, regardless of the consequences, there should be some overarching protection of a *Gillick* competent child to shield her or him from the consequences of an unfettered right to decide whether or not to accept medical treatment. For example, in *Re W*, Balcombe LJ stated that in exercising its ultimate jurisdiction over children the child's wishes would be a material consideration, however:

> there comes a point at which the court, while not disregarding the child's wishes can override them in the child's own best interests, objectively considered. Clearly such a point will have come if the child is seeking to refuse treatment in circumstances which will in all probability lead to the death of the child or to severe permanent injury.[63]

The language of s 67ZC of the Act would appear to support the existence of a similarly unlimited jurisdiction in the Family Court of Australia. Indeed, it has been noted that the United Kingdom position probably applies in Australia.[64] In *Marion's Case*, the majority stated that 'more contemporary descriptions of the *parens patriae* jurisdiction over infants invariably accept that in theory there is no limitation upon the jurisdiction'.[65] They went on to note, however, that the jurisdiction springs from the direct responsibility of the Crown for those who cannot look after themselves.[66] Given that this is the source of the *parens patriae* jurisdiction, it would seem illogical for it to extend to overriding the wishes of a competent minor. More consideration needs to be given to the issue of whether a child is capable of consenting to serious and irreversible treatment such as treatment for the purposes of gender reassignment, or whether there are certain procedures that only a court can consent to for a minor regardless of whether the minor understands fully the nature and consequences of the treatment. Either through legislation, or through judicial decision, the role of the court needs to be clarified: is its task simply to verify that a child has the requisite capacity to make the decision in question, or is the role of the court to ensure that the best interests of the child are always served, regardless of the competent child's wishes?

B *Consent to treatment vs refusal of consent*

Another notable feature in the cases and jurisprudence concerning child capacity to consent to medical treatment is the question of whether a distinction should be drawn between capacity to consent to treatment on the one hand and the capacity to refuse consent to treatment on the other (as is suggested in some of the United

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[63] *Re W* [1992] 4 All ER 627, 643 (Balcombe LJ).
[64] Alastair Nicholson, Margaret Harrison and Danny Sandor, 'The Role of the Family Court in Medical Procedure Cases' (1996) 2 *Australian Journal of Human Rights* 7.
[65] Ibid.
[65] Ibid 258 (Mason CJ, Dawson, Toohey and Gaudron JJ), citing *Re X (a minor)* [1975] 1 All ER 697, 699-700, 703, 705.
[66] Ibid.
[66] Ibid 258 (Mason CJ, Dawson, Toohey and Gaudron JJ).

Kingdom decisions discussed above). The rationale for drawing a distinction between the two is the serious consequences that may result where a child is found competent to refuse consent to life-saving medical treatment, for example by refusing consent to a blood transfusion on religious grounds.

Competent adults, of course, have the ability to consent to, and refuse, a range of medical treatments even where the consequences of that may be serious injury or death. The refusal of life-saving medical treatment on any ground and for any reason is the clearest example. Debates about arbitrary age limits for activities such as voting and driving draw on the argument that although some children are undoubtedly of sufficient intelligence and maturity to vote, some adults do not appear to be. It is generally understood that arbitrary age qualifications such as 18 (for voting and drinking alcohol) are largely a matter of practical convenience, as it would be logistically impossible to assess each individual to determine her or his maturity and intellectual fitness for these activities. Considerations of practical convenience are, of course, irrelevant to the issue of capacity to consent to medical treatment of a serious nature, which is not common and also turns very much on the circumstances of the particular individual seeking treatment, as well as the nature of the treatment itself.

There remains to be considered in the Australian context whether any distinction should be drawn between a child's capacity to consent to medical treatment and a child's capacity to refuse consent. The established position in the United Kingdom is that a *Gillick* competent child may effectively consent to medical treatment, however a refusal of treatment may be overridden by the consent of someone with parental responsibility. This finding is notwithstanding the proposition that 'in logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment'.[67] However there *is* a difference between the two and the distinction lies in the importance of "medical ethics" and the role it plays in the administration of treatment. When a child, or any person for that matter, "consents" to medical treatment there is added protection for that person in that the consent does not impose any positive *obligation* on a medical practitioner to administer the treatment or perform the procedure being consented to. A medical practitioner always has a choice as to whether to perform a procedure and is not obligated to treat a patient in circumstances where the practitioner believes that is not in the person's best interests.[68] Lord Donaldson made reference to this when he stated in his summary of principles in *Re W* that '[n]o question of a minor consenting to or refusing medical treatment arises unless and until a medical or dental practitioner advises such treatment and is willing to undertake it.'[69]

Consideration of the role of medical ethics has been a feature of some of the judgments referred to above. For example, in *Re W*, Lord Donaldson considered it

[67] *Re W* [1992] 4 All ER 627, 643 (Balcombe LJ).
[68] The authors note that some exceptions to the first limb of this sentence exist in the realm of emergency treatment. The kinds of procedures and treatment discussed here do not fall within that category.
[69] *Re W* [1992] 4 All ER 627, 639 (Lord Donaldson MR).

"inconceivable" that a doctor would proceed with a serious procedure (a transplant operation being the example used) unless both child and parents gave their consent to the procedure. Lord Donaldson pointed out that a doctor has a professional duty to act in the best interests of the patient and to advise the patient on that basis. As an additional example, Lord Donaldson and Balcombe LJ indicated that, taking into account medical ethics, there was no real possibility that an abortion would be carried out on a minor against her wishes, unless the procedure was truly in her best interests.[70]

The same inherent safeguard does not apply to a refusal of treatment. In circumstances where treatment is objectively necessary in the patient's best interests, but the person will not consent to that treatment, the harm results from the absence of treatment rather than from the proposed treatment itself. Therefore, it is potentially more significant to allow a child an absolute right to refuse medical treatment than it is to allow the child to consent to medical treatment, as the consent to treatment will only have effect if there is a doctor who is willing to administer the treatment or perform the procedure.

It has been suggested that, where a child is found competent to consent to medical treatment, the child's reasons for refusing medical treatment should be taken into consideration so that, for instance, a decision to refuse treatment which would only prolong a painful and incurable condition should be regarded as a competent one while a decision to refuse treatment on religious grounds would be regarded as invalid as being objectively unreasonable.[71] The authors do not consider that there is much to recommend this proposal. An appraisal of competence is not and should not be concerned with the reasons for decisions but rather with the capacity of the person making the decision to understand the nature of the proposed treatment and the consequences of consenting or withholding consent. If it is to be the case that a competent child is able to refuse consent to medical treatment, then that should be without regard to the motives behind that decision. In the same way that the refusal of treatment by a competent adult is not subject to a requirement that such refusal be reasonable (however that reasonableness could be assessed), a competent child's refusal of treatment should also be unfettered.

Further, we do not consider that there is merit in following the approach taken in the United Kingdom, which enables a child to consent to medical treatment but allows a parent or guardian to override a refusal of treatment by a competent child. Despite the distinction between consent and refusal discussed above, and the added protection that medical ethics provides to the patient in the case of the former, it still should not be presumed that the best interests of the child will always favour administration of treatment rather than the absence of treatment. This is particularly relevant where the treatment is to deal with congenital adrenal hyperplasia, the condition involved in *Re A*.

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[70] Ibid 635 (Lord Donaldson MR), 645 (Balcombe LJ).
[71] David Lanham, *Taming Death by Law* (1993) 106.

The consent/refusal dichotomy is particularly relevant in the context of transgender children, where the consequences of administering treatment, sometimes through procedures which have irreversible consequences and may render the patient infertile, can be just as serious as the consequences of failing to administer treatment, which may result in grave psychological problems and result in the minor experiencing emotional problems and even exhibiting suicidal tendencies (as in *Re Alex*). For this reason, it is necessary to discuss the two issues considered above in the particular context of transgender and intersex children.

C *The special nature of treatment for transgender and intersex children*

Questions about the proper way of "treating" people with congenital adrenal hyperplasia, gender identity dysphoria and other similar "conditions" do not have easy answers. Debate currently rages over whether intersex children should have their genitalia surgically altered to make their external appearance match their internal sexual organs.[72] Despite increasing recognition that such procedures performed on small children can have devastating effects in later life, some parents continue to make the decision to subject their children to invasive and irreversible procedures in the interests of helping them to live more "normal" lives.[73]

Allowing a parent or a court to override the consent of a competent child can, in the context of this kind of treatment, have very serious consequences. It was considered by the English Court of Appeal in *Re W* that it would be unlikely that a doctor would perform an invasive procedure (e.g. an abortion) on a minor against the minor's wishes, however it was indicated that an exception might arise where the procedure was clearly "in the child's best interests".

It is not beyond the realms of possibility that anxious parents of a child with ambiguous sexual characteristics might wish their competent child to undergo hormone therapy or even gender reassignment surgery, against the child's wishes, and find a doctor willing to support their decision. Although in Australia, as a result of the decision in *Marion's Case*, it is unlikely that a parent would be able to consent to treatment of the nature of that proposed in *Re A* and *Re Alex*, the distinction

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[72] Intersex conditions are of two general types: (1) failure to meet the typical criteria within one sex-determining factor; or (2) inconsistency between one or more sex-determining factors. Examples of the first type include chromosomal ambiguities (divergence from the typical pattern of XY or XX), gonadal ambiguity (atypical or combination ovaries and testes), external morphologic sex (ambiguous genitals such as an enlarged clitoris or micropenis), internal morphologic sex (incomplete or absent internal sex organs), hormonal sex (atypical production or reception of androgen, estrogen, or progesterone) and phenotypic sex (incongruent characteristics such as facial hair and breast development). Ambiguities of the second category occur when there is an incongruence among factors (some may be typically male, some typically female and some a combination of both): see Alyssa Connell Lareau, 'Who Decides? Genital-Normalizing Surgery on Intersexed Infants' (2003) 92 *Georgetown Law Journal*129, fn 4.

[73] See Mireya Navarro, 'When Gender isn't a Given', *New York Times*, 19 September 2004, Available on-line at: <http://www.nytimes.com/2004/09/19/fashion/19INTE.html>.

between therapeutic and non-therapeutic treatment endorsed by the courts leaves scope for a decision to be made by parents about treatment in circumstances which might be argued to be in the nature of treatment for a disease or illness and therefore therapeutic with the consequence that court consent would not be required.

Even where the consent of the court is required, given the lack of public awareness in relation to transgender and intersex persons, it is possible that a court might consider such treatment to be in a child's best interests even where the child refuses to consent to the procedure. In relation to the treatment of intersex children, concerns have been raised that cosmetic genital surgery is often performed for social and psychological reasons rather than being medically necessary.[74] Although surgery is often performed in the early years of a child's life, when there is no capacity to give consent, the case of *Re A* demonstrates that these issues are also of relevance to intersex young persons who may be developing the capacity to consent to medical treatment for themselves.

One critic of the decision in *Re A* has pointed out the leap in logic that was made by the Court from the fact that A's sexual preference was for females to the conclusion that A was intrinsically male.[75] The same author draws attention to the absence of any discussion of the possibility that A may actually have been a lesbian, or even simply experiencing lesbian tendencies rather than truly identifying as a member of the opposite sex.[76] In *Re A* the treatment that was eventually ordered included bilateral mastectomies, a hysterectomy and oophorectomy, unfolding of the clitoris, closure of the labia to create the appearance of a scrotum and the insertion of prosthetic testes. In A's case, the treatment eventually consented to by the court was in line with the minor's wishes. However, is it possible that a court might sanction treatment where the child is the only person who does not agree?

It is suggested that further consideration should be given to these issues by courts considering cases in the nature of *Re A* and *Re Alex*, and indeed, by the legislature. Is proper weight and consideration being given to the circumstances of the children in these cases and their capacity to consent? Or are the courts simply operating on the unspoken assumption that a child can never independently consent to treatment of this nature and consequently merely paying lip service to the ability of the child to consent to medical treatment? If the latter, it is respectfully suggested that the courts elaborate on the circumstances in which children will *never* be capable of consenting to treatment and the rationale for such a decision. Inevitably, circumstances will one day arise where a child in Alex's or A's position will quite clearly

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[74] Lareau, above n 73.

[75] Jenni Millbank, 'When is a Girl a Boy? Re A (a child)' (1995) 9 *Australian Journal of Family Law* 173.

[76] We note that Nicholson CJ in *Re Alex* referred to Millbank's criticism of the decision in *Re A* and stated that Professor P, Dr N and Ms R expressly considered the possibility that Alex's desire for treatment might emanate from his attraction to girls. His Honour noted that Alex responded in a hostile manner to the suggestion that he may be a lesbian, and stated that he was satisfied that the ongoing psychological and psychiatric treatment would be sufficient to monitor whether Alex's self-image changes from 'really' male to 'really' a female lesbian. See *Re Alex* (2004) 180 FLR 89, 108-109.

possess the requisite intelligence and maturity to satisfy the *Gillick* test and the court will then, if the concerns we have addressed above are correct, be placed in the position of having to resile from its established endorsement of the *Gillick* principle.

New South Wales legislation regulates the administering of certain "special medical treatment" on children, defined as persons under 16 years of age. The *Children and Young Persons (Care and Protection) Act 1998* prohibits a person from carrying out special medical treatment on a child other than with the consent of the NSW Guardianship Tribunal. Special medical treatment is defined as meaning:

- medical treatment that is intended or is reasonably likely to render a person permanently infertile (not including treatment that is intended to remediate a life-threatening condition and from which permanent infertility or the likelihood of it is an unwanted consequence);
- any medical treatment involving the administration of a long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation;
- any medical treatment in the nature of a vasectomy or tubal occlusion; or
- any other medical treatment declared by the Regulations to be special medical treatment for the purposes of this section.[77]

The Regulations further declare the following treatments to be special medical treatment:

- any medical treatment involving the administration of a drug of addiction over a period of more than 10 days in any 30 day period;
- any medical treatment involving an experimental procedure that does not conform to the *National Statement on Ethical Conduct in Research Involving Humans*; or
- any treatment involving the administration of a psychotropic drug to a child in out-of-home care for the purpose of controlling the child's behaviour.[78]

The first three types of medical treatment referred to above are all kinds of medical treatment that might be involved in a gender reassignment or treatment preparatory to gender reassignment. It is suggested that legislation along these lines at a Commonwealth level should be enacted to clarify the position in relation to child consent if it is considered that minors should not be able to consent to procedures of this nature.

By contrast, the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides that a person of or over 16 years of age may make decisions about her or his own medical treatment as validly and effectively as if that person were an adult.[79] With respect to children under the age of 16, treatment can be administered

[77] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175.
[78] *Children and Young Person (Care and Protection) Regulation 2000* (NSW) s 15.
[79] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6.

either where a parent or guardian consents or where the child consents and the medical practitioner is of the opinion that the child is capable of understanding the nature, consequences and risks and that the treatment is in the best interests of the child's health and well-being and that opinion is supported by the written opinion of at least one other medical practitioner who has personally examined the child.[80] No distinction is drawn between ordinary medical treatment and special medical treatment of the kind discussed above, meaning that hormonal therapy could be administered to a child under the age of 16 against her or his will on the basis of the legislation.

The jurisdiction of the Family Court in relation to the welfare of children derives from the *Family Law Act 1975* (Cth) and is based on the powers contained in s 51(xxi) (the marriage power) and s 51(xxii) (divorce and matrimonial causes) of the Constitution.[81] To the extent that there is any inconsistency between the powers vested in the Family Court by federal legislation and restrictions on treatment contained in state legislation, the Family Court's powers will prevail by virtue of s 109 of the *Constitution*.[82] This has the effect that the Family Court may authorise treatment with respect to a child even where the administration of that treatment would otherwise be unlawful under general state provisions.[83] It is therefore necessary that measures be taken to clarify the position at a federal level, to ensure that a consistent approach applicable to all jurisdictions is developed in relation to these issues.

If it is to be the case that certain procedures for minors require the consent of a court or tribunal, then consideration needs to be given also to what is the most appropriate body to be making these types of decisions. The kinds of issues involved in these cases are complex and extend beyond medical considerations and the wishes and opinions of those immediately involved. Ideally, the process for making decisions should take into account the broader experiences of those who have had the same experiences, and as much as possible take into consideration the range of options available to persons who identify as transgender or intersex. A specialised tribunal might therefore be a more appropriate body for making such decisions than a court.[84]

That is not to suggest, however, that it is appropriate for a court, or any other body, to make the ultimate decision where the child concerned is competent to decide for her or himself. One commentator has suggested that where a child is found to be

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[80] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 12.

[81] It should be noted that while these heads of legislative power have been held to support the legislation insofar as it applies to a child of a marriage, it is yet to be determined whether it would support the application of the legislation to a child born outside of marriage. The orders that the Family Court may make in relation to the general welfare of a child under s 67ZC are expressly confined to the welfare of a child of a marriage: *Family Law Act 1975* (Cth) s 69ZH(2).

[82] *P v P* (1994) 120 ALR 545, 557-8 (Mason CJ, Deane, Toohey and Gaudron JJ).

[83] However, this would not apply where the activity in question was prohibited by the ordinary criminal law of the state: *P v P* (1994) 120 ALR 545, 556 (Mason CJ, Deane, Toohey and Gaudron JJ).

[84] Cf Nicholson, Harrison and Sandor, above n 64.

competent, there should be no distinction drawn between the ability to consent to medical treatment and the ability to refuse consent to treatment. However, an additional safeguard is proposed, namely that there be a requirement that the child provide an *informed* consent, a higher threshold test than that applied to adults. This is consistent with the *Gillick* test which requires of the minor a sufficient intelligence and maturity to *understand fully* the treatment that is proposed.[85] The court's role in such cases would be limited to ensuring that the minor is competent and has made an informed decision.[86]

The authors consider that there is merit in this proposition. Requiring a higher threshold test than that which adults must satisfy is consistent with a recognition of the fact that children generally lack the experience of adults in making difficult decisions and also takes into account the serious consequences that can result where invasive and irreversible procedures are carried out on children. However, it also takes into account that minors, as they approach the age of majority, increase in maturity and that there may be little difference in capacity between a mature 15 or 16-year-old and an 18-year-old.

Ultimately, the procedures of the kinds addressed in *Re A* and *Re Alex* are special in that they are not simply for the purpose of curing an illness or improving health, but are inextricably associated with the patient's self-identity. The consequences of not allowing treatment where that is sought or alternatively, of carrying out treatment where that is not wanted, can be terrible, having consequences lasting throughout a person's lifetime and affecting not only health, fertility and the ability to have a fulfilling sex life, but also psychological well-being and identity. For these reasons, the authors consider that any test ultimately laid down by the courts or the legislature should be one which gives sufficient weight and consideration to the wishes of the minor involved.

V CONCLUSION

The issues raised by *Re Alex* and *Re A* are of real significance. Recently it was reported that Alan Finch, a 37-year-old man who had his penis and testicles amputated on the recommendation of psychiatrists at a state-funded Melbourne clinic but later reverted to being a male, is claiming damages against the Victorian government and the doctors who work at the clinic. He claims that the doctors followed a rigid ideology of treating gender identity problems by means of surgical intervention without properly considering the possibility of psychotherapy or psychological approaches.[87]

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[85] *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 237 (Mason CJ, Dawson, Toohey and Gaudron JJ).
[86] Leanne Bunney, 'The Capacity of Competent Minors to Consent to and Refuse Medical Treatment' (1997) 5 *Journal of Law and Medicine* 52.
[87] Richard Yallop, 'Damages claim for sex change', *The Australian* (Sydney), 14 September 2004, 4.

Similarly, a number of congenital adrenal hyperplasia sufferers who underwent surgery as children have recently appeared before the San Francisco Human Rights Commission to testify about the effects that the surgery has had on them, including medical complications, suffering lack of sexual sensation and living lives of secrecy and shame.[88]

These reports highlight the fact that there can be devastating consequences where irreversible procedures of this nature are performed without the consent of the person or where the patient has consented but subsequently changes her or his mind. This is of particular significance when the patient is a child who, even where possessing sufficient intelligence and maturity to satisfy the *Gillick* test, may not have sufficient experience of life or awareness of the various ways of living a transgender or intersex life, to consent to irreversible treatment of this nature. It remains for the courts or the legislature to clarify the limits, if any, on the operation of the *Gillick* principle in Australia, both generally and in the specific context of transgender and intersex children.

[88] Mireya Navarro, 'When Gender isn't a Given', *The New York Times*, 19 September 2004, <http://www.nytimes.com/2004/09/19/fashion/19INTE.html>