IT'S MY BODY, ISN'T IT? CHILDREN, MEDICAL TREATMENT AND HUMAN RIGHTS*

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I INTRODUCTION

I am pleased to be delivering this year's Costello Lecture in a fertile human rights environment. The Government's consultation process continues apace and the media reports of the submissions made to the Human Rights Committee suggest, unsurprisingly, that we as a society remain deeply divided about whether or not to follow our common law neighbours in enacting a charter of rights. Tonight I will be discussing a subset of that larger debate – the right of children and young people to consent (or refuse) medical treatment. It is a complex and contentious area. Should young people have access to contraceptive advice without their parents being informed? Can teenagers legally volunteer to act as research subjects? Is it appropriate for a court to order a devout 16-year-old Jehovah's Witness to have a blood transfusion against his express wishes? Is it ever appropriate to permit a teenager with transsexualism to undertake sex affirmation surgery?

Some of you may have read the novel of Jodi Picoult *My Sister's Keeper*,[1] which is about a couple that conceives a child to save the life of a daughter with leukaemia. This novel has been recently turned into a movie which was released in June 2009.[2] The story line involved an infertility specialist who assisted the parent to select an embryo that did not carry the genetic abnormality that had occurred in their other child and was also a tissue match for their other daughter. The cord blood from the baby's placenta would be used for a blood transfusion that would save the life of the older child. The family were able to have other children who did not have the fatal disease and also to save the life of their eldest child who did. That was the reality upon which the fictional book, and later the movie, was based. In the book, unlike in real life, the younger child Anna by age 13 had undergone countless surgeries, transfusions and shots so that her older sister Kate could fight leukaemia which had plagued her since childhood. In the book and movie Anna was conceived as a bone marrow match for Kate, a life role that she had never questioned until she became a teenager and started to have doubts.

The book and film raise issues such as: is it morally correct to do whatever it takes to save a child's life – even if that means infringing on the rights of

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1 Jodi Picoult, *My Sister's Keeper* (2004).

2 Nick Cassavetes, *My Sister's Keeper* (2009) <http://www.mysisterskeepermovie.com/#home> at 19 October 2009. The movie has been released in Australia on 30 July 2009: The Internet Movie Database, *My Sister's Keeper* (2009) <http://www.imdb.com/title/tt1078588/> at 19 October 2009.

another? When Kate's kidneys fail Anna is expected to donate one of her own but hires a lawyer to be medically emancipated from her parents and to gain the right to make the decision herself. There is more to the film and to those who have not read the book or even to those who have it looks as if it will be an interesting and thought-provoking film and clearly not far-fetched. It is based at least on the true story that I have commenced with and it is not that different from a case which found its way to the Family Court in 2007.[3]

That case concerned an eight months old baby, Mansour, who suffered from infantile osteopetrosis. Without a bone marrow transplant he was likely to die as it was his only potential cure.[4] His cousin, Inaya, was just a little older than him, being one year old:

> The mother of Mansour is the sister of the father of Inaya. Mansour and Inaya are therefore cousins. Their parents are not only siblings, they are very close by virtue of family ties and culture. The parents of Inaya asked the Family Court to make an order authorising the taking of bone marrow from the one year old girl so that it could be specifically transplanted into her cousin.[5]

The bone marrow transplantation could potentially save his life.

In Victoria this kind of procedure is governed by the *Human Tissue Act 1982* (Vic) which provides prohibition against the removal of tissue from children except in certain circumstances,[6] 'tissue' being defined to include 'an organ, or part, of a human body'.[7] There is an exception for a class of children. A parent may give consent for the removal from the body of a child of specified regenerative tissue for the purpose of transplantation to the body of a brother, sister or parent of the child.[8] In addition, the registered medical practitioner, who has to certify in these circumstances, must be satisfied that the brother or sister is likely to die unless the tissue is transplanted.[9]

Despite the prohibition in the State legislation, because this was an application made to the Family Court under the *Family Law Act 1975* (Cth) ('*Family Law Act*'), it was open for the trial judge to find that the *Family Law Act* overrode the state legislation. Various questions arose for determination including the following: the *Human Tissue Act 1982* (Vic) would authorise the removal of tissue from the one-year-old but only in respect of her own treatment.[10] Could it be argued that the use of the words 'in the interests of the health of the person'[11] might include

3 *Re Inaya (Special Medical Procedure)* (2007) 38 Fam LR 546 ('*Re Inaya*').
4 Ibid 548 (Cronin J).
5 Ibid.
6 *Human Tissue Act 1982* (Vic) s 14.
7 *Human Tissue Act 1982* (Vic) s 3.
8 *Human Tissue Act 1982* (Vic) s 15(1).
9 *Human Tissue Act 1982* (Vic) s 15(2)(d)(i).
10 *Human Tissue Act 1982* (Vic) s 42(1).
11 *Human Tissue Act 1982* (Vic) s 42(1)(a)(i).

the future psychological health of the one year old child?[12] That is, if she were later to learn that she could have assisted in the recovery of her cousin but did not do so, would that have adverse effects on her?

All concerned, that is, both families and the Independent Children's Lawyer, supported the making of the orders.[13] The procedure itself carried some risks for the one-year-old. (This was not the first such case to be determined by the Family Court. Similar cases had been determined as early as in 1997: for example, one involving an application for a bone marrow transplant between a willing and knowledgeable child and an adult aunt;[14] and another one in 1999.[15]) The judge found that there was inconsistency between the State and Federal legislation and therefore the Federal legislation – the *Family Law Act* – applied.[16] There was psychological evidence about the family and its culture; and the relationship between the two children whose families were living together. The psychologist ultimately opined that the one-year-old might 'suffer psychological harm derived from guilt, self-blame and exposure to a traumatised and grief-stricken family and community … if the procedure was not performed'.[17] The trial judge found that it was in the best interests of the one-year-old to make the order for bone marrow harvesting.[18]

I do not intend today to go into the issues about how the jurisdiction can be exercised, or to further explore all kinds of cases that will conceivably arise in the foreseeable future, but these cases underline what I want to talk about today which is the *rights of the child* as opposed to the child's best interests. One of the responsibilities of being a judge is to decide such cases. I have done so myself, in the case of *Re Alex (No 2)*[19] involving an application to permit a double mastectomy to be performed on a teenager who was biologically female but whose affirmed sex was male.

Litigation in this area is characterised by 'conflict of rights' arguments: the right to bodily integrity and self-determination versus parents' right to ensure that children are protected from harm and from making impetuous decisions inimical to their best interests. This conflict is particularly acute where teenagers are involved, who with increasing maturity and insight are arguably able to make their own decisions about medical treatment. The resolution of this conflict occurs without the assistance of a statutory human rights framework. This is in contrast to virtually all other common law countries. Later in my presentation I will be comparing the Australian position pertaining to young people and medical treatment with that of the United Kingdom, which has had the *Human Rights Act*

12 *Re Inaya* (2007) 38 Fam LR 546, 549 (Cronin J).

13 Ibid 550.

14 *In the Marriage of GWW and CMW* (1997) 21 Fam LR 612.

15 *E v E* [1999] FamCA 2403.

16 Section 109 of the *Australian Constitution* provides that a law of the Commonwealth overrides a law of a State to the extent of any inconsistency.

17 *Re Inaya* (2007) 38 Fam LR 546, 560 (Cronin J).

18 Ibid.

19 [2009] (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009).

1998 (UK) c 42 ('*Human Rights Act*') in force for 10 years. My contention is that legislating to protect human rights in Australia would see young people's right to autonomy, privacy, and self-determination emerge with far greater clarity in this very difficult area of the law.

II INTERNATIONAL HUMAN RIGHTS IN AUSTRALIAN LAW

Although Australia does not have a Bill of Rights and the *Australian Constitution* contains few express rights, it does not mean that human rights principles are alien to our municipal law.[20] We have ratified the *International Covenant on Civil and Political Rights*[21] and the *International Covenant on Economic, Social and Cultural Rights.*[22] Successive Australian governments have enacted specific legislation to give effect to Australia's international obligations in the areas of racial discrimination, sex discrimination, disability discrimination and age discrimination.[23] The Australian Human Rights Commission[24] (formerly known as the Human Rights and Equal Opportunity Commission ('HREOC')) administers these four Acts, as well as the *Australian Human Rights Commission Act 1986* (Cth).[25]

A particularly important human rights instrument affecting children is the *United Nations Convention on the Rights of the Child* ('UNCROC'),[26] the most ratified of all the international human rights treaties. The Australian Government ratified UNCROC on 17 December 1990 and it entered into force on 2 September 1990.[27] To date, however, no government has passed legislation that seeks to give domestic effect to the rights of the child as embodied in the Convention. The High Court of Australia confirmed in the decision *Minister for Immigration and*

20 Those rights in the *Australian Constitution* include the right to vote per s 40; the right to freedom of religion per s 116; the right to freedom from disabilities or discrimination on the basis of State residence per s 117. There is, however, a large body of jurisprudence on implied rights and freedoms in the *Australian Constitution*: see *Australian Capital Television Pty Ltd v Commonwealth* (1992) 177 CLR 106 on the implied right of political freedom; *Chu Kheng Lim v Minister for Immigration, Local Government and Ethnic Affairs* (1992) 176 CLR 1 on the right to due process under the law.

21 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976). Australia has ratified it on 13 August 1980: United Nations Treaty Collection (2009) <http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en#EndDec> at 19 October 2009.

22 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976). Australia has ratified it on 10 December 1975: United Nations Treaty Collection (2009) <http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en> at 19 October 2009.

23 *Racial Discrimination Act 1975* (Cth); *Sex Discrimination Act 1984* (Cth); *Disability Discrimination Act 1992* (Cth); *Age Discrimination Act 2004* (Cth).

24 Australian Human Rights Commission, *About the Commission* (2009) <http://www.hreoc.gov.au/about/index.html> at 19 October 2009.

25 Formerly, it was titled the *Human Rights and Equal Opportunity Commission Act 1986* (Cth).

26 *United Nations Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990). Australia has ratified it on 17 December 1990: United Nations Treaty Collection (2009) <http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en#EndDec> at 19 October 2009.

27 Ibid.

Ethnic Affairs v Teoh[28] that the fact that UNCROC has not been incorporated into Australian law does not mean that its ratification is of no significance. In their Honours' joint judgment, Mason CJ and Deane J said:

> Where a statute or subordinate legislation is ambiguous, the courts should favour that construction which accords with Australia's obligations under a treaty or international convention to which Australia is a party, at least in those cases in which the legislation is enacted after, or in contemplation of, entry into, or ratification of, the relevant international instrument. That is because Parliament, prima facie, intends to give effect to Australia's obligations under international law.[29]

The Full Court of the Family Court also considered the interaction between international human rights instruments, domestic law and the Family Court's jurisdiction in the case of *B and B: Family Law Reform Act 1995*.[30] HREOC and the Commonwealth Attorney-General were intervenors in the proceedings. At trial, an issue that assumed considerable significance was whether amendments to the *Family Law Act* made in 1995 were made in consideration or reliance upon UNCROC and the role of UNCROC in construing domestic law, in particular the *Family Law Act*.[31] The Full Court opined that UNCROC has 'received almost universal international acceptance'[32] and, as such, it must be given 'special significance'[33] for the purpose of interpreting domestic law. The fact that UNCROC was expressed as a schedule to the *Australian Human Rights Commission Act 1986* (Cth) was perceived by the Full Court to imbue it with even more significance in Australian law.[34]

Therefore, although the Convention does not of itself create legally enforceable rights exercisable by Australian children and young people, it is nevertheless a source of fundamental rights and freedoms in municipal law. The ascertainment of children's rights arising at common law or under statute should be undertaken by reference to the Convention. To my mind, those articles of UNCROC of particular relevance to 'special medical procedure' applications include:

- Article 12: The right of children to express views and have those views respected
- Article 13: The right to freedom of expression
- Article 16: The right to privacy
- Article 8: The right to preservation of identity
- Article 6: The right to survival and development

28 (1995) 183 CLR 273.
29 Ibid 287.
30 (1997) 21 Fam LR 676.
31 Ibid 683.
32 Ibid 742.
33 Ibid 743.
34 Ibid.

Article 3 of UNCROC states: 'the best interests of a child shall be a primary consideration'. That understanding is embodied in s 60CA of the *Family Law Act*: 'In deciding whether to make a particular parenting order in relation to a child, a court must regard the best interests of the child as the paramount consideration'. Decisions about children's medical treatment, and, in particular, whether the court should authorise the performance of a special medical procedure on a child, is a species of parenting order.

III THE FAMILY COURT AND SPECIAL MEDICAL PROCEDURE APPLICATIONS

But, you may ask, why is this so? Why does the Family Court need to be involved at all? Surely, making decisions about a child's medical treatment is one of the responsibilities of parenthood and it should be up to parents and guardians to give their consent to medical treatment, including surgical intervention. As far as it goes, this is true. The *Family Law Act* presumptively vests parental responsibility in each parent[35] or parental responsibility can be allocated by court order.[36] The exercise of that responsibility undoubtedly includes making decisions about children's medical treatment. However, there are some procedures for which by their very nature parents are deemed legally incapable of providing consent; and the permission of a court is required, whether that be the Family Court of Australia or a State or Territory Supreme Court. Jurisdictionally, this is an exercise of what is known as courts' *parens patriae*, or welfare power. The power found in common law and in statute enables the Court to make any order that it considers proper for the care, welfare and protection of a child, within constitutional limits.

The term 'special medical procedure' does not have a fixed meaning. We know, however, from the High Court's decision in *Marion's Case*,[37] which concerns an application by parents to sterilise a 14 year old child said to be intellectually disabled,[38] that medical treatment becomes a 'special medical procedure' where it is for non-therapeutic purposes. The invasiveness of the procedure, its attendant risks to the child and whether or not it is reversible are also relevant considerations.[39] The Family Court developed an introductory guide to special medical procedure applications in 1998 which refers to sterilisation and 'medical treatments which may not in themselves be grave and irreversible but may be of significant risk, ethically sensitive or disputed'.[40]

Ultimately, the decision whether or not to authorise a particular procedure is dependent upon whether so doing would be in the best interests of the child. The

35 *Family Law Act 1975* (Cth) s 61C.

36 *Family Law Act 1975* (Cth) s 61D.

37 *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218 ('*Marion's Case*').

38 Ibid 263 (Brennan J).

39 Ibid 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).

40 Family Court of Australia, the Office of the Public Advocate of Victoria and Victoria Legal Aid, *A Question of Right Treatment: The Family Court and Special Procedures for Children: An Introductory Guide for Use in Victoria* (1998) vii.

Family Law Act directs the Court to consider particular matters in considering what is in a child's best interests[41] and, thus, whether or not to authorise that a special medical procedure be performed. Importantly, these include any views expressed by the child and any factors (such as the child's age and maturity) that are relevant to the weight the Court should give to the child's views.[42] Nevertheless, as Nicholson CJ observed, the 'best interests' test is by its very nature paternalistic[43] and protective. Arguably, the 'best interests' test is at odds with a child's right to privacy, autonomy, self-determination and freedom of expression.

IV THE *GILLICK* PRINCIPLE

There is, however, an important qualification, established by the seminal decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*[44] ('*Gillick*'). That case arose out of a challenge by Mrs Gillick, 'the mother of five girls under the age of 16 years',[45] to a circular issued by the Department of Health and Social Services in England which authorised doctors to give contraceptive advice and treatment to girls under the age of 16 without parental consent. The decision has been described as one 'rightly seen by observers the world over as a landmark in children's rights jurisprudence'.[46]

Mrs Gillick's appeal was rejected by a 3:2 majority. In speaking for the majority, Lord Scarman said:

> As a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[47]

The House of Lords rejected Mrs Gillick's application that the courts recognise parents' exclusive rights to decide issues of medical treatment for children under the age of 18. Lord Scarman rejected any suggestion that competent decision-making was a function of attaining a particular age, stating that 'if the law should impose upon the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism'.[48] That principle was approved by the High Court in *Marion's Case*.[49] It is now well

41 *Family Law Act 1975* (Cth) s 60CC.

42 *Family Law Act 1975* (Cth) s 60CC(3)(a).

43 *Re Alex (Hormonal Treatment for Gender Dysphoria)* (2004) 31 Fam LR 503 [154] ('*Re Alex*').

44 [1986] AC 112 ('*Gillick*').

45 Ibid 113.

46 Michael Freeman, 'Rethinking *Gillick*' (2005) 13 *International Journal of Children's Rights* 201, 201.

47 *Gillick* [1986] AC 112, 188–9.

48 Ibid 186.

49 (1992) 175 CLR 218, 237-8 (Mason CJ, Dawson, Toohey and Gaudron JJ):

> A minor is, according to this principle, 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'. This approach, though lacking the certainty of a fixed age rule, accords with experience and with psychology. It should be followed in this country as part of the common law.

established in Australia that the Family Court does not have jurisdiction to make orders about the medical treatment of a minor if the Court has formed the view that the young person is of sufficient maturity and understanding to give a valid consent to the procedure.

As an aside, you may have noted the reference in Lord Scarman's judgment to a child 'below the age of 16'.[50] That is there because, in the UK, under s 8 of the *Family Law Reform Act 1969* (UK) c 46 ('*Family Law Reform Act*'), persons who have attained the age of 16 years are presumed to be capable of giving effective consent to any 'surgical, medical or dental treatment'. That is not the case in Australia,[51] which means that a court's assessment of a young person's '*Gillick* competence' can occur up until he or she turns 18.

V HOW HAS *GILLICK* BEEN APPLIED TO SPECIAL MEDICAL PROCEDURE APPLICATIONS IN THE FAMILY COURT?

The question of competence to consent, self-evidently, assumes greater significance in decisions involving teenagers, who are more likely than younger children to possess 'sufficient understanding and intelligence' to make their own decisions. In that handful of cases that have come before the Family Court of Australia, there has not yet been a finding that the Court lacks jurisdiction to make orders about medical treatment because the young person concerned is capable of deciding for themselves. However, the Court does seem to be moving in that direction and I hope to illustrate this by reference to those special medical procedure cases that involve sex affirmation treatment.

The first of these was *Re A*,[52] decided in 1993, a year after *Marion's Case*. The mother of a 14 year old female child[53] applied to the Court for an order authorising surgery to assist in the physical reassignment of the child as male.[54] The child was born with a condition known as congenital adrenal hyperplasia, which caused masculinisation of the genitalia.[55] Genital surgery was performed on the child when young and hormone treatment was administered. However, the hormone replacement was inadequate and the masculinisation of the child's physical structures continued. The child identified himself as male and sought surgery to affirm his chosen gender. The application was not opposed. The trial judge found that it would be in the child's best interests for surgery to be performed[56] and that the child understood the problem in general terms and expressed a desire that it be

50 *Gillick* [1986] AC 112, 188-9.

51 *Family Law Act 1975* (Cth) s 4: 'child … means a person under 18'.

52 (1993) 16 Fam LR 715.

53 Ibid 715.

54 See discussion in Karen Gurney, 'Sex and the Surgeon's Knife: The Family Court's Dilemma … Informed Consent and the Specter of Iatrogenic Harm to Children with Intersex Characteristics' (2007) 33 *American Journal of Law and Medicine* 625.

55 *Re A* (1993) 16 Fam LR 715, 716.

56 Ibid 721-2.

resolved.[57] He was not satisfied that the child had sufficient capacity and maturity to fully appreciate all aspects of the matter and to be able to assess objectively the various options available to him.[58] It was not clear from the judgment on what basis the trial judge reached that conclusion.

There was no other application involving a sex and gender diverse child until 2004, in the case of *Re Alex (Hormonal Treatment for Gender Identity Dysphoria)*[59] ('*Re Alex*'). The child in this case was 13 at the time of the application. It was for the administration of hormones and, later, of subcutaneous testosterone implants, to a child who was born biologically female but who had identified as male since birth. No surgery was contemplated before the child turned 18. The child, who lived and presented as male, to the extent that he would wear nappies to school rather than use the girls' toilets,[60] had a strong, clear and consistently expressed wish to undergo the treatment. The case was heard by Nicholson CJ and his Honour invited HREOC to intervene in the proceedings, which HREOC duly did.

Nicholson CJ authorised the administration of hormonal treatment,[61] with testosterone to commence when the child turned 16. The expert evidence before the Court, including reports from Alex's treatment team, addressed the issue of whether Alex was legally competent to provide his own consent. Their collective view was that it was not appropriate for a 13-year-old to be wholly responsible for the decision whether or not to undergo hormone therapy (which to my mind is not necessarily a consideration that goes to the question of the child's *Gillick* competence). Nicholson CJ concluded that Alex 'may in fact have *Gillick* capacity or may reach that standard soon'.[62] However, he went on to find that the evidence did not establish that Alex had the capacity to consent to the procedure himself.[63] On the basis of the uncontroverted evidence that the proposed procedure was entirely consistent with Alex's wishes and in his best interests, Nicholson CJ said he would treat Alex's capacity to give his own consent as an academic question unless he was going to refuse authorisation.[64] In an aside, Nicholson CJ then said that it was 'highly questionable whether a 13 year old could ever be regarded as having the capacity'[65] to determine on a course of changing his or her sex. In my view that, of course, depends on the individual child.

Re Alex (No 2)[66] came before me in 2007, when Alex was almost 17 years old. At that stage Alex had been receiving hormonal treatment for a number of years and analogue treatment had commenced on his 16th birthday. Alex had developed some breast tissue early in puberty, before the hormonal treatment commenced,

57 Ibid 719.
58 Ibid.
59 (2004) 31 Fam LR 503.
60 Ibid 518.
61 Ibid 544.
62 Ibid 531.
63 Ibid.
64 Ibid.
65 Ibid 532.
66 [2009] (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009).

and his guardian sought the Court's permission to perform a double mastectomy. Again, the expert evidence before me was unanimous in asserting the surgery was in Alex's best interests and it was certainly strongly desired by Alex himself. I granted permission for the surgery to be performed. I was not satisfied that Alex was not *Gillick* competent but because there was no evidence before me directed to that issue, nor were any submissions made, I adopted the same approach as the former Chief Justice in treating it as an academic question. In coming to my conclusions I had regard to the publication *Children's Rights and the Developing Law* by Jane Fortin[67] (particularly, chapter three – 'Adolescent Decision-making, *Gillick* and Parents'[68]) and international human rights instruments.

VI CODIFYING RIGHTS, FREEDOMS AND RESPONSIBILITIES: AUSTRALIA AND THE UNITED KINGDOM COMPARED

It is instructive to compare the way the Family Court of Australia treats the issue of a child's '*Gillick* competence' with that of family courts in Britain, where a *Human Rights Act* is in force. My interest lies in determining whether and to what extent the *Human Rights Act* has been relied upon to imbue *Gillick* with new meaning. The *Human Rights Act* was enacted 'to give further effect to rights and freedoms guaranteed under the European Convention on Human Rights'.[69] The articles of the *European Convention on Human Rights*[70] form a schedule to the *Human Rights Act* and are protected.[71] Rights are enforceable against public authorities and all public authorities must act in a way that is compatible with those rights unless required to do so by other legislation.[72] The *Human Rights Act* also provides, in s 3, that where possible, all legislation is to be interpreted in accord with Convention rights.[73] As far as children and medical treatment is concerned, the preponderance of the litigation has involved article 8, which states:

> *Right to respect for private and family life*
>
> 1 Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder

67 Jane Fortin, *Children's Rights and the Developing Law* (2nd ed, 2005).

68 Ibid 71.

69 *Human Rights Act 1998* (UK) c 42 preamble.

70 *European Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) ('*European Convention on Human Rights*').

71 *Human Rights Act 1998* (UK) c 42, ss 1, 2.

72 *Human Rights Act 1998* (UK) c 42 s 6.

73 See Jonathan Herring, 'The *Human Rights Act* and the Welfare Principle in Family Law – Conflicting or Complementary?' [1999] *Child and Family Law Quarterly* 223.

> or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The post-*Gillick* but pre-*Human Rights Act* jurisprudence on children and medical treatment has been controversial. Two decisions of the United Kingdom's Court of Appeal in particular have been criticised as a 'retreat' from *Gillick*. Interestingly, both cases, *Re R (A Minor) (Wardship: Medical Treatment)*[74] and *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*,[75] were heard and determined without any reference to *European Convention on Human Rights*, Strasbourg jurisprudence or UNCROC.

Re R[76] concerned a 15 year old girl who had been placed in a psychiatric unit and where it had been decided she ought to be treated with antipsychotic drugs. R refused this course of treatment and the local authority instituted wardship proceedings. The Court of Appeal held that R was not *Gillick* competent because she did not have a full understanding of the nature of the proposed treatment, nor a full understanding of the consequences of the treatment or of failing to administer treatment. Although Staughton LJ considered that it was unnecessary to decide whether and in what circumstances *Gillick* permitted a parent of a competent child to override the child's wishes,[77] Lord Donaldson was not so restrained. His Honour distinguished between what he said Lord Scarman discussed in *Gillick* – 'the parent's right "to determine whether or not [a child] will have medical treatment"'[78] – and the right to consent to such treatment. Consent was described by Lord Donaldson as 'a key which unlocks a door',[79] with *Gillick* competent children *and* their parents or legal guardians possessing joint and several rights to 'turn the key and unlock the door'.[80] In essence, Lord Donaldson was saying that parents had the right to impose medical treatment on *Gillick* competent children against their express wishes, a position seemingly at odds with that of Lord Scarman in *Gillick*, who expressly referred to parental rights yielding to a child's right to make his or her decisions.

The second case, *Re W*,[81] involved a 16 year old girl (who was thus competent to consent to medical treatment by virtue of s 8 of the *Family Law Reform Act*) who suffered from anorexia nervosa. Her parents were deceased and she was in the care of the local authority. When her condition deteriorated, the local authority sought to transfer her to a facility specialising in eating disorders, where treatment would be administered against her wishes, including artificial feeding. W resisted the application on the basis that s 8 of the *Family Law Reform Act* conferred on her the same rights as an adult to refuse medical treatment. The Court of Appeal disagreed. Lord Justice Balcolme found that the Court should not lightly override the decision[82] of a minor of sufficient age and understanding to make an

74 [1992] Fam 11 ('*Re R*').
75 [1993] Fam 64 ('*Re W*').
76 [1992] Fam 11.
77 Ibid 28.
78 Ibid 23.
79 Ibid 22.
80 Ibid.
81 [1993] Fam 64.
82 Ibid 88.

informed decision. Nevertheless, where in the Court's view the child's wishes are in conflict with his or her best interests, the child's wishes may be overridden. Lord Donaldson found that any minor of any age who is *Gillick* competent has a right to consent to that treatment.[83] The consent cannot be overridden by a person exercising parental responsibility but can by a court.[84] Lord Donaldson substituted the 'flak jacket' analogy for that of the 'keyholder' in asserting that no minor of whatever age has the power to override a consent to treatment. Consent to medical treatment is the 'flak jacket' protecting doctors from the 'claims of the litigious'[85] and may be acquired from a *Gillick* competent minor or from another person having parental responsibility. According to Lord Donaldson, a doctor needs only one 'flak jacket'.[86] Thus, in the event of a conflict between a parent who wishes their child to undergo treatment and a *Gillick* competent child who resists it, parental consent will prevail.

This line of reasoning continued in subsequent cases, whereby a 15 year old Jehovah's Witness was compelled to undergo blood transfusions she described as being 'like rape';[87] a heart transplant was ordered to be performed against the wishes on a 15 year old girl who was found to be clearly *Gillick* competent;[88] and a hospital was granted leave to administer blood products to an almost 17 year old male who was a committed Jehovah's Witness.[89] There was no reference to the *European Convention on Human Rights* or UNCROC in these decisions. Michael Freeman, an academic, concluded his analysis of these cases with the following statement:

> the law now discriminates and does so on grounds of age when the clear intention of the highest court in *Gillick* was to adopt a functional, rather than a status-based, approach. An elderly schizophrenic in Broadmoor can refuse treatment: an intelligent 15 year old girl cannot.[90]

VII POST-*HUMAN RIGHTS ACT* LITIGATION – *AXON* AND THE REINVIGORATION OF *GILLICK*

When the *Human Rights Act* was first introduced in 1998, there was concern that it would do little to enhance the protection of children's rights.[91] In fact, some academic commentators expressed reservations that the Act could potentially

83 Ibid 83-4.

84 Ibid 83.

85 Ibid 78.

86 Ibid.

87 *Re S (A Minor) (Consent to Medical Treatment)* [1994] 2 FLR 1065.

88 *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097.

89 *Re P (Medical Treatment: Best Interests)* [2004] 2 FLR 1117.

90 Freeman, above n 46, 212.

91 Rachel Taylor, 'Reversing the Retreat from *Gillick*? *R (Axon) v Secretary of State for Health*' [2007] *Child and Family Law Quarterly* 81. See also Sonia Harris-Short, 'Family Law and the *Human Rights Act 1998*: Judicial Restraint or Revolution?' [2005] *Child and Family Law Quarterly* 329; Shazia Choudhry and Helen Fenwick, 'Taking the Rights of Parents and Children Seriously: Confronting the Welfare Principle under the *Human Rights Act*' (2005) 25 *Oxford Journal of Legal Studies* 453.

damage children's rights by strengthening the rights of parents over their children.[92] This concern was informed by the decision of the European Court of Human Rights in *Nielsen v Denmark*,[93] where by a 9:7 majority the Court held that holding a child in a closed psychiatric ward for five and a half months at his mother's request, despite there being no evidence he suffered from a psychiatric condition, was a responsible exercise of the mother's parental rights.

As noted rights theorist Jane Fortin has observed, many of the human rights embodied in the *European Convention on Human Rights*, and, therefore, in the *Human Rights Act*, reflect a belief in liberty and autonomy.[94] On this basis, a reappraisal of the protective approach adopted by the Court of Appeal in *Re R* and *Re W* may be warranted. That 'reappraisal' has emerged in the shape of the decision in *Axon*[95] – the first post-*Human Rights Act* reassessment of *Gillick*.[96]

The facts of *Axon* are strikingly similar to those in *Gillick*. Mrs Axon sought to attack, by judicial review, some best practice guidelines developed for use by doctors in providing advice and treatment for young people on contraception, sexual and reproductive health. Mrs Axon contended that the guidelines were unlawful in excluding parents from decision-making about their children's lives and, significantly, the guidelines breached parents' article 8 of the *European Convention on Human Rights*: 'right to respect for private and family life'. The tension between a child's article 8 right to autonomy and privacy and a parent's article 8 right to family life, including the obligation to make decisions in the best interests of their children, was at the crux of the dispute. Mrs Axon argued, in effect, that the duty of confidentiality owed by doctors to their patients, including minors, was limited: parents can only discharge their obligations as parents if they have information available to them to do it. In support of this contention, Mrs Axon cited the decision of the European Court of Human Rights in *Nielsen v Denmark*.

Mrs Axon asserted that the best practice guidelines were a 'plain interference' with parents' right to respect for family life and parental rights under article 8 of the *European Convention on Human Rights.* Silber J rejected this argument. His Honour distinguished *Nielsen v Denmark* on the basis that it was concerned with article 5 rights and not with any alleged parental right to be informed of medical advice or treatment sought by a child. Silber J's conclusions on the asserted article 8 right to exercise parental rights were fortified by reference to the *Gillick* principle. He concluded:

92 Jane Fortin, 'The HRA's Impact on Litigation Involving Children and Their Families' [1999] *Child and Family Law Quarterly* 217, 251.

93 (1989) 11 Eur Court HR (ser A) ('*Nielsen v Denmark*').

94 Jane Fortin, 'Accommodating Children's Rights in a Post *Human Rights Act* Era' (2006) 69 *Modern Law Review* 299, 317.

95 *R (On the Application of Sue Axon) v Secretary of State for Health* [2006] QB 539 ('*Axon*').

96 For a discussion of *Axon* see Jo Bridgeman, 'Young People and Sexual Health: Whose Rights? Whose Responsibilities?' (2006) 14 *Medical Law Review* 418; Ananda Hall, 'Children's Rights, Parents' Wishes and the State: The Medical Treatment of Children' (2006) 36 *Family Law* 317; Taylor, above n 91.

> any right to family life on the part of a parent dwindles as their child gets older and is able to understand the consequence of different choices and then to make decisions relating to them. As a matter of principle, it is difficult to see why a parent should still retain an article 8 right to parental authority relating to a medical decision where the young person concerned understands the advice provided by the medical professional and its implications.[97]

Silber J again referred to *Gillick* in his consideration of the Strasbourg jurisprudence, which, he found, did not confer any right of parental power or control through article 8 that was broader than that conferred by domestic law. He quoted the words of Lord Scarman as describing the parameters of parental rights as existing 'primarily to enable the parent to discharge his duty of maintenance, protection and education until he reaches such an age as to be able to look after himself and make his own decisions'.[98]

Article 12 of UNCROC, which protects children's right to express their views and have their views taken into account in accordance with their age and maturity, was also the subject of argument. Silber J found article 12 to be inconsistent with Mrs Axon's submissions as to how parents and children should relate to one another, which he described as paternalistic.[99] Silber J quoted with approval from the decision of Thorpe LJ in *Mabon v Mabon*,[100] which concerned the right of children to instruct their own counsel in private family law proceedings:

> Unless we in this jurisdiction are to fall out of step with similar societies as they safeguard article 12 rights, we must, *in the case of articulate teenagers, accept that the right to freedom of expression and participation outweighs the paternalistic judgment of welfare*.[101]

Silber J concluded: 'the right of young people to make decisions about their own lives by themselves at the expense of the views of their parents has now become an increasingly important and accepted feature of family life'.[102]

VIII APPLICATION TO AUSTRALIA – WHAT MIGHT A HUMAN RIGHTS ACT MEAN HERE FOR YOUNG PEOPLE AND CONSENT TO MEDICAL TREATMENT?

Axon is a significant and important judgment, not only for its reaffirmation of the 'dwindling parental rights' approach laid down by the House of Lords in *Gillick* but for its use of international human rights principles in giving effect to children's rights in domestic law. To me, the decision adumbrates, or, at least, raises for

97 *Axon* [2006] QB 539, 579.
98 Ibid 546 citing *Gillick* [1986] AC 112, 185.
99 Ibid 567 citing *Mabon v Mabon* [2005] Fam 366, 373 (Thorpe LJ).
100 [2005] Fam 366.
101 *Axon* [2006] QB 539, 567 citing ibid 373 (emphasis added by Silber J).
102 Ibid.

consideration, how the law in Australia governing children's rights, including their right to consent to or to refuse medical treatment, could be redrawn if we enshrined international human rights norms in municipal law.

One of the things it would do is to lay bare, for social and jurisprudential benefit, the 'tension of rights' inherent in the *Family Law Act*. The Act is replete with what are often oppositional concepts: the paternalistic 'best interests' as the paramount consideration versus children's rights to have their views taken into account in accordance with their age and maturity; children's rights to the benefit of having a meaningful relationship with both parents versus their right to be protected from harm; the need to ensure that children's voices are heard in proceedings that affect them versus the need to protect children from the damaging effects of litigation, such that the Family Law Rules only permit a child to swear an affidavit or appear as a witness by court order.

To my mind, clashes between purported parental rights and the rights of children should be resolved with principle and transparency. This is where I think a Human Rights Act would make a major contribution. If you compare the pre-*Human Rights Act* cases in the United Kingdom with the reasoning in *Axon*, it is apparent that an articulated statutory rights framework, where areas of potential conflict are readily identifiable (if not so easily resolved), brings clarity and intellectual honesty to the issues in dispute. If children's immutable rights are in issue, we should say so, rather than attempting, as I think we have done, to quietly subsume human rights considerations under the rubric of 'best interests'. In so doing, I also think, the enactment of a Human Rights Act would encourage creativity and innovation in judicial approaches that move beyond the binary so as to transcend the discourse of 'rights in conflict'. For example, in seeking to reconcile welfare and rights-based considerations, Herring advocates for a 'relationship-based welfare approach', founded on the premise that a child's welfare is promoted when he or she lives in a fair and just relationship with each parent, preserving the rights of each, but with the child's welfare at the forefront of the family's concern.[103] Choudhry and Fenwick advance a 'parallel analysis' or 'ultimate balancing act' approach.[104]

Although the task of bringing a new human rights dimension to family law decision-making sounds rather daunting, especially for the judges who will have to do it, I do not believe it is as complex at it might at first appear. *Axon*, and the earlier case of *Roddy*[105] which involved an application by a 17 year old to lift a series of injunctions to enable her to tell her life story to the press, show that the common law is a valuable tool for investing international human rights with meaning in a domestic context. As Jane Fortin describes it, 'splicing' the *Gillick* competency test onto Convention rights by making *Gillick* competency a precondition to minors asserting their right to private life under article 8 is comparatively straightforward.[106]

103 Herring, above n 73.

104 Choudhry and Fenwick, above n 91, 481.

105 *Re Roddy (A Child) (Identification: Restriction on Publication)* [2004] 2 FLR 949 ('*Roddy*').

106 Fortin, 'Accommodating Children's Rights in a Post *Human Rights Act* Era', above n 94, 319.

Another important advantage that I see is that in making human rights considerations explicit in statute, parties, their lawyers and particularly Independent Children's Lawyers will be emboldened to direct their submissions towards how particular rights, such as a child's right to autonomy, should be taken into account in family law proceedings. Although it is true that this happens currently, in the sense that submissions are made and reports prepared that are directed towards the child's views and wishes, it is a relatively oblique, indirect method of incorporating consideration of children's human rights. In cases where submissions have been directed towards principles embodied in international human rights law, such as the first *Re Alex*[107] decision, in my view, they have facilitated a more structured and coherent expression of children's rights.

IX WHAT ABOUT SPECIFICALLY FOR INTERSEX AND TRANSGENDER YOUNG PEOPLE?

As for transgender and intersex children specifically, the implications are potentially profound. Let me give you an example. The Grand Chamber of the European Court of Human Rights, in the decisions of *Goodwin v United Kingdom*[108] and *I v United Kingdom*,[109] overturned earlier decisions to find that failure of states to legally recognise gender reassignment breached article 8 of the *European Convention on Human Rights*. In particular, it was found that requiring post-operative transsexuals to live in an 'intermediate zone' as neither one gender nor the other interfered with article 8 rights to personal development and physical and moral security in the full sense enjoyed by others in society.[110]

In what to me is a fascinating example of convergence between international and domestic law, the Grand Chamber quoted at length from the Family Court of Australia's decision in *Re Kevin (Validity of Marriage of Transsexual)*,[111] in which Chisholm J found that:

> it is wrong to say that a person's sex depends on any single factor, such as chromosomes or genital sex; or some limited range of factors, such as the state of the person's gonads, chromosomes or genitals (whether at birth or at some other time).[112]

This decision fortified the Grand Chamber's conclusion that:

> It is not apparent to the Court that the chromosomal element, amongst all the others, must inevitably take on decisive significance for the purposes of legal attribution of gender identity for transsexuals.[113]

107 (2004) 31 Fam LR 503.
108 (2002) 35 EHRR 447.
109 (2003) 36 EHRR 53.
110 Richard Clayton and Hugh Tomlinson, *The Law of Human Rights* (2nd ed, 2009) 1106-7.
111 (2001) 28 Fam LR 158 ('*Re Kevin*').
112 Ibid 229.
113 *Goodwin v United Kingdom* (2002) 35 EHRR 447.

As a result of both Strasbourg decisions, the United Kingdom Government was obliged under international law to bring the law of the United Kingdom into line. The result was the *Gender Recognition Act 2004* (UK), which enabled a person with gender dysphoria who had lived in the acquired gender for two years to be issued with a gender recognition certificate. This had the effect of the person's acquired or affirmed gender becoming their recognised gender for all official purposes. The position in the UK compares highly favourably with that in Victoria, as I discussed in *Re Alex (No 2)*.[114] In Victoria, a person must undertake 'sex affirmation surgery' before being issued with a document acknowledging the person's name and affirmed sex.[115] The issuing of documents recognising Alex's gender as male has been a live issue in both cases, *Re Alex* and *Re Alex (No 2)*, and HREOC has identified official and identity documents as a human rights issue for sex and gender diverse people.[116] This example demonstrates the power inherent in international human rights law, when given appropriate status, to transform substantive and procedural rights in domestic law. Which leads me to my final question – whether and in what ways might *Re Alex* have been decided differently if a Human Rights Act had been in force in Australia.

That is the subject for a paper all on its own so I will just touch on a few key areas in conclusion. I was fortunate to be provided with a paper by Rachael Wallbank, a family lawyer with a particular interest in sexuality and sex formation, which compares *Re Kevin* and *Re Alex* decisions. Her paper has informed my thinking in this area.[117] First, the way in which Alex's 'condition', for want of a better term, was diagnosed and the 'treatment' proposed may have been different. The evidence of Alex's treatment team was that he was suffering from 'gender dysphoria' or 'gender identity disorder' – conditions which are identified and described in the *Diagnostic and Statistical Manual of Mental Disorders*.[118] Wallbank describes this 'diagnosis' as:

> derived from the outdated medical presumption that the assertion by an individual of a sexual identity contrary to the sex indicated by their genitalia, gonads and chromosomes … must indicate disorder and/or illness.[119]

Perhaps the type of thinking that informed the European Court of Human Rights in *Goodwin v United Kingdom*, which recognised and respected diversity in human sexual formation as protected by article 8, could affect the way in which transsexualism is conceived of in special medical procedure applications. That would build on the tendency in *Re Alex* and a similar case, *Re Brodie (Special*

114 [2009] (Unreported, Family Court of Australia, Bryant CJ, 6 May 2009).

115 *Births, Deaths and Marriages Registration Act 1996* (Vic) s 30E.

116 Australian Human Rights and Equal Opportunity Commission, *Sex and Gender Diversity*, Issues Paper (2008).

117 Rachael Wallbank, '*Re Kevin* in Perspective' (2004) 9 *Deakin Law Review* 461.

118 See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* DSM-IV-TR (2000).

119 Wallbank, above n 117, 473. See also Gurney, above n 54.

Medical Procedure),[120] to resist pathologising transsexualism by characterising it as a 'disease'.

If a young person's gender expression is accorded status as an enforceable human right, that begs the question whether the Family Court's permission would even be required to perform medical procedures on a young person who strongly wishes to give physical effect to their expressed gender. Again, this is an issue raised in Rachael Wallbank's paper.[121] Where surgical intervention is contemplated (as it was *not* in the *Re Alex* case) a reading of *Gillick*, even 'spliced on' to article 8 and UNCROC rights, suggests that seeking a court's permission will be a necessary pre-condition to performing sex affirmation surgery. However, whether a court's consent is required prior to the administration of hormonal therapies, particularly those that are reversible, may require a rethink.

Articles 2 and 3 of the *European Convention on Human Rights* and article 24 of UNCROC protect a right to health. UNCROC states that children have the right to the highest attainable standard of health. I anticipate these rights could be engaged in mounting an argument against a requirement to obtain a court's permission to undertake non-surgical treatment of young people with transsexualism. The time and cost associated with any court process and the possibility of a judge ordering that a particular form of treatment be delayed until an age or developmental goal is reached may mean that secondary sexual characteristics are developed that require surgery at a later stage. This was the situation in *Re Alex (No 2)*: there had been some breast development prior to the treatment plan being authorised by the Court, the presence of which caused Alex great distress and resulted in a further application to perform a double mastectomy. It could be argued that an obligation to obtain the Court's consent denies children with transsexualism access to timely treatment and increases the prospect of surgical intervention, and thus is inimicable to a child's right to health. Interestingly, as far as gender affirmation surgery is concerned, the European Court of Human Rights has found that a state's failure to facilitate gender reassignment surgery may in some circumstances constitute a breach of article 8 of the *European Convention on Human Rights*.[122]

Finally, whether through interpreting human rights principles through the lens of *Gillick*, as Silber J did in *Axon*, or any other way of mediating family law and human rights, it is difficult to conceive of the Family Court finding that it had a residual discretion to make orders refusing medical treatment for a *Gillick* competent child capable of providing a valid consent to it. Nicholson CJ in *Re Alex* doubted the correctness of HREOC's submission that 'if this Court finds that the child has achieved "a sufficient understanding and intelligence" to enable the child "to understand fully what is proposed", then this Court has no further role in this matter'.[123] Were those submissions underpinned by an Australian Human Rights Act, in my view, they would have been compelling. As the UK

120 [2008] FamCA 334 (Unreported, Carter J, 15 May 2008).

121 Wellbank, above n 117.

122 *Van Kück v Germany* (2003) 37 EHRR 51; *L v Lithuania* (2008) 46 EHRR 22.

123 *Re Alex* (2004) 31 Fam LR 503, 532.

case law suggests, however, the position is not so clear with respect to the right to refuse medical treatment. Nevertheless, as Thorpe LJ said in *Mabon v Mabon* – a statement that I think deserves repetition – 'we must, in the case of articulate teenagers, accept that the right to freedom of expression and participation outweighs the paternalistic judgment of welfare'.[124]

X CONCLUSION

UK jurisprudence has already shown a fissure between a child's right to consent to medical treatment and a child's right to refuse medical treatment so that clearly *Gillick* competent minors are having their strongly held wishes overborne with respect to refusing medical treatment. It would be surprising if the Family Court were not called upon to adjudicate a dispute of this type in the foreseeable future. To the extent that UNCROC is embodied in the *Family Law Act*, and particularly as far as a child's best interests are concerned, the determination of cases has been made with a child-rights focus. However, the way those rights are articulated and given effect to and the priority they are accorded as against the rights of other parties will unarguably be different if cases are conducted within an explicit rights framework. The post-*Human Rights Act* litigation in the United Kingdom shows that, as least as far as consent to medical treatment is concerned, a statutory rights-based instrument makes manifest that which can often be obscured by an open-ended 'best interests' inquiry. In so doing, a Human Rights Act has enormous potential to give real and enduring effect to young people's right to make their own decisions about their own bodies.

124 [2005] Fam 366, 373.