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

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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 sub-set 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? It is ever appropriate to permit a teenager with transsexualism to undertake sex affirmation surgery?

Some of you may have read the Jodi Picoult novel *My Sister's Keeper,* which is about a couple that conceives a child to save the life of a daughter with leukaemia. This was recently turned into a movie which was released in June this year. 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 was based and the movie is currently being released in Australia.

In the book, unlike in real life, the younger child Anna by age thirteen has undergone countless surgeries, transfusions and shots so that her older sister Kate can fight leukaemia which has 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 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 those who have not read the book or even those who have it looks as if it will be an interesting and thought provoking film and clearly it is not far fetched. It is based at least on the true story that I commenced with and it is not that different from a case which found its way to the Family Court in 2007.[1]

That case concerned a baby who was 8 months old and who suffered from Infantile Osteopetrosis. Without a bone marrow transplant he was likely to die and the bone marrow transplant was his only potential cure. His cousin was just a little older than him, being one year old. The mother of the baby is the sister of the father of the one year old and two children were therefore cousins. Their parents were not only siblings but were very close by virtue of family ties and culture. The parents of the baby asked the court to make an order authorising the taking of bone marrow from the one year old so that it could specifically be transplanted into her cousin and 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, 'tissue' being defined to include an organ or part of a body. 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. In addition the 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.

Despite the prohibition in the state legislation, because this was an application made to the Family Court under the *Family Law Act 1975* (Cth), it was open to the trial judge to find that the Family Law Act overrode the state legislation.

Various questions arose for determination including the following:

[1] *Re: Inaya (Special Medical Procedure)* [2007] FamCA 658.

The Victorian Act would authorise the removal of tissue from the one year old but only in respect of her own treatment. Could it be argued that the use of the words "in the interest and health of the person" might include the future psychological health of the one year old child? That is, that 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 affects on her?

All concerned, that is both families and the independent children's lawyer, supported the making of the orders. 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 in as early as 1997 involving an application for a bone marrow transplant between a willing and knowledgeable child and an adult aunt, and another in 1999.

The judge found there was inconsistency between the state and federal legislation and therefore the federal legislation – the Family Law Act – applied.[2] There was psychological evidence about the family and its culture and the relationship between the two children and their families who 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. The trial judge found that it was in the best interests of the one year old to make the order for bone marrow harvesting.

I do not intend today to go into the issues about how the jurisdiction can be exercised, or to further explore all the kinds of cases that will conceivably arise in the foreseeable, but these cases underline what I want to take 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(2)*, which involved 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 inimicable 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.

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[2] 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.

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 position in Australia as pertaining to young people and medical treatment with that of the United Kingdom, which has had a Human Rights Act in force for ten 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.

International human rights in Australian law

Although Australia does not have a Bill of Rights and the Australian Constitution contains few express rights, that does not mean that human rights principles are alien to our municipal law.[3] We have ratified the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.

Successive Australian governments enacted specific legislation to give effect to its international obligations in the areas of racial discrimination, sex discrimination, disability discrimination and age discrimination.[4] The Human Rights and Equal Opportunity Commission (HREOC) administers these four Acts, as well as the *Human Rights and Equal Opportunity Act 1986* (Cth).

A particularly important human rights instrument affecting children is the *United Nations Convention on the Rights of the Child* (UNCROC), the most ratified of all the international human rights treaties. The Australian Government ratified UNCROC on 17 December 1990 and entered into force on 16 January 1991. 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.

However, as the High Court confirmed in the decision *Minister for Immigration and Ethnic Affairs v Teoh*, the fact that UNCROC has not been incorporated into Australian law does not mean that its ratification is of no significance. In their joint judgment, the (then) Chief Justice Mason and Justice Deane said: "Where a statute or subordinate legislation is

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[3] Those rights include s 40, the right to vote, s 116, the right to freedom of religion, and s 117, the right to freedom from disabilities or discrimination on the basis of State residence. There is however a large body of jurisprudence on implied rights and freedoms in the Australian Constitution, including *Australian Capital Television Pty Ltd v Commonwealth* (1992) 177 CLR 106 on the implied right of political freedom and *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.

[4] *Racial Discrimination Act 1975* (Cth), *Sex Discrimination Act 1984* (Cth), *Disability Discrimination Act 1992* (Cth), *Age Discrimination Act 2004* (Cth).

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."[5]

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 & B: : Family Law Reform Act 1995*.[6] 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. The Full Court opined that UNCROC is a Convention which has "received almost universal significance"[7] and, as such, one which must be given "special significance" for the purpose of interpreting domestic law. The fact that the Convention is expressed as a schedule to the HREOC Act was perceived by the Full Court to imbue it with even more significance in Australian law.

So, therefore, although UNCROC 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 therefore be undertaken by reference to the UNCROC.

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 of survival and development

Article 3 of UNCROC states that the best interests of a child should be a primary consideration. That understanding is embodied in the Family Law

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[5] (1995) 183 CLR 273, 286-7.

[6] *B and B: Family Law Reform Act 1995* (1997) FLC ¶92-755

[7] Ibid p. 84,227.

Act. Section 60CA states that a child's best interests are the paramount consideration in deciding whether to make a particular parenting order in respect of a child. Decisions about children's medical treatment and particular whether the Court should authorise the performance of a special medical procedure on a child is a species of parenting order.

The Family Court and special medical procedure applications

But, you may ask, why is this so? Why does the Family Court needs 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, that is true. The Family Law Act presumptively vests parental responsibility in each parent, or parental responsibility can be allocated by court order. The exercise of that responsibility undoubtedly includes making decisions about children's medical treatment.

However, there are some procedures that by their very nature parents are deemed legally incapable of providing consent for 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 patrie, 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' doesn't have a fixed meaning. We know however from the High Court's decision in *Re: Marion*,[8] which concerned an application to sterilise a young woman with an intellectual disability, 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 is reversible are also relevant considerations. 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."[9]

[8] *Secretary, Department of Health and Community Services v. J.W.B. and S.M.B. (Marion's Case)* (1992) 175 CLR 218.

[9] Family Court of Australia, *A Question of Right Treatment: The Family Court and Special Procedures for Children, An introductory guide for use in Victoria*, 1998.

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 Family Law Act directs the Court to consider particular matters in considering whether or not to authorise that a special medical procedure be performed.[10] 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.[11]

Nevertheless, as the former Chief Justice Nicholson observed, the 'best interests' test is by its very nature paternalistic[12] and protective. Arguably, the 'best interests' test is at odds with a child's right to privacy, autonomy, self-determination and freedom of expression.

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*.[13] That case arose out of a challenge by Mrs Gillick, a mother of teenage girls, 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 aged under 16 without their parent's approval. The decision has been described as one "rightly seen by observers the world over as a landmark in children's jurisprudence."[14]

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 sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed."

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 "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."

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[10] *Family Law Act 1975* (Cth), s 60CC.
[11] Ibid s 60CC(3)(a) and
[12] *Re: Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC 93-175, para 154.
[13] [1985] 3 All ER 402.
[14] Michael Freeman, 'Rethinking *Gillick*' (2005) 13 *The International Journal of Children's Rights* 201.

That principle was approved by the High Court in *Re: Marion*. It is now well 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 aged **under 16 years.** That is there because, in the UK, under section 8 of the *Family Law Reform Act 1969* (UK), people aged 16 years and over are presumed to be capable of giving effect consent to any surgical, medical or dental treatment. That is not the case in Australia, which means that a court's assessment of a young person's '*Gillick* competence' can occur up until that persons turns 18.

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 (or what the UK authorities refer to as 'mature minors'). In that handful of cases that have come before the Family Court to date, there has not yet been a finding that the Court does not have jurisdiction to make orders about medical treatment because the young person concerned possesses sufficient maturity and insight to make the decision themselves. The Court does however seem to be moving in that direction and I hope to illustrate this by reference to those special medical procedure cases involving sex affirmation treatment.

The first of these is *Re: A*,[15] decided in 1993, a year after *Marion's* case. The mother of a 14 year old child born genitally female applied to the Court for an order authorising surgery to assist in the physical re-assignment of the child as male.[16] The child was born with a condition known as congenital adrenal hyperplasia, which caused the child's genitals to appear masculine. Genital surgery was performed on the child when young and he was placed on hormone therapy. However, the administration of female hormones was intermittent and the masculisation of the child's genitals continued. The child identified as male and sought surgery to affirm his chosen gender. The application was not opposed and the trial judge found it would be in the child's best interests for surgery to be performed. The trial judge found that the child understood the problem in general terms and expressed a desire

[15] *In the matter of the Welfare of a child A* (1993) FLC 92-402

[16] See discussion in Karen Gurney, 'Sex and the Surgeon's Knife: the Family Court's dilemma…informed consent and the spectre of iatrogenic harm to children with intersex characteristics' (2007) 33 American Journal of Law and Medicine 625.

that it be resolved. 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. It is not clear from the judgment on what basis the trial judge reached that conclusion.

There wasn't another application involving a sex and gender diverse child until 2004, in the case of *Re: Alex*. The child in this case was 13 at the time of the application, which was for the administration of hormones and, later, testosterone 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, had a strong, clear and consistently expressed with to undergo the treatment. The case was heard by the former Chief Justice Nicholson and he invited HREOC to intervene in the proceedings, which HREOC duly did. Nicholson CJ authorised the administration of hormonal treatment, 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". However, he went on to find that the evidence did not establish that Alex had the capacity to consent to the procedure himself. On the basis of the uncontroverted evidence 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. 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 to determine on a course of changing his or her sex. In my view that of course depends on the individual child.

Re: Alex 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, 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, and 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[17] (particularly the chapter 'Adult decision-making, *Gillick* and parents') and international human rights instruments.

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 Act1998* (UK) was enacted "to give further effect to rights and freedoms guaranteed under the European Convention on Human Rights". The articles of the European Convention on Human Rights and Fundamental Freedoms form a schedule to the Human Rights Act and are protected rights under the Human Rights Act. 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. The Human Rights Act also provides, in section 3, that where possible, all legislation is to be interpreted in accord with Convention rights.[18] As far as children and medical treatment is concerned, the preponderance of the litigation has involved Article 8. Article 8 states:

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

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[17] 2nd edition, LexisNexis Law in Context Series, London, 2003.

[18] See discussion in Jonathan Herring, 'The Human Rights Act and the Welfare Principle in Family Law – Conflicting or Complementary' [1999] CFLQ 223.

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 were criticised as a 'retreat' from *Gillick*. Interestingly, both cases, *Re: R* and *Re: W*, were heard and determined without any reference to European Convention rights, Strasbourg jurisprudence or UNCROC.

Re: R (a Minor (Wardship: Medical Treatment))[19] 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 anti-psychotic 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 Lord Justice Staughton 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, Lord Donaldson was not so restrained. His Honour distinguished between what he said Lord Scarman discussed in *Gillick* – the parental right to determine whether or not a child will have medical treatment – and the right to consent to such treatment. Consent was described by Lord Donaldson as key which unlocks a door, with *Gillick* competent children and their parents or legal guardians possessing joint and several rights to 'unlock the door'. In essence, Lord Donaldson is saying that parents have 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.

Lord Donaldson did not pursue the 'keyholder' theme in the second case, *Re: W*, referring instead the analogy of a 'flackjacket.'[20] *Re: W* involved a 16 year old girl (who was thus competent to consent to medical treatment by virtue of section 8 of the Family Law Reform Act 1969) 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 section 8 of the Family Law Reform

[19] [1992] Fam 11

[20] See discussion of the 'flackjacket' metaphor see John Eekelaar, 'White Coats or Flack Jackets? Children and the Courts – Again' (1993) 109 LQR 182.

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 of a minor of sufficient age and understanding to make an 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. The consent cannot be overridden by a person exercising parental responsibility but can by a court. Lord Donaldson substituted the 'flackjacket' 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 'flackjacket' protecting doctors from the "claims of the litigious" 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 'flackjacket'. 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 Witnesses was compelled to undergo blood transfusions she described as being "like rape",[21] a heart transplant was ordered to be performed against her wishes on a 15 year old girl who was found to be clearly *Gillick* competent,[22] and where a hospital was granted leave to administer blood products to an almost 17 year old male who was a committed Jehovah's Witness.[23] There was no reference to the European Convention on Human Rights and Freedoms or UNCROC in these decisions.

Academic Michael Freeman concluded his analysis of these cases with the following statement: "The law clearly now discriminates and does so on the 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."

Post Human Rights Act litigation – *Axon* and the reinvigoration of *Gillick*

[21] *Re S* [1994] 2 FLR 1065.
[22] *Re M* [1999] 2 FLR 1097.
[23] *Re P* [2004] 2 FLR 1117.

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.[24] In fact, some academic commentators asserted that the Act would damage children's rights by strengthening the rights of parents over their children. This concern was informed by the European Court of Human Rights' decision in *Nielsen v Denmark*,[25] where by a nine to seven majority the Court held that holding a child in a closed psychiatric ward for 5 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 1998* (UK), reflect a belief in liberty and autonomy. 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 *Re: Axon*,[26] the first post Human Rights Act reassessment of *Gillick*.[27]

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 Convention rights to privacy of 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. Ms 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

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[24] Rachel Taylor, 'Reversing the Trend from *Gillick? R (Axon) v Secretary of State for Health* [2007] CFLQ 81, p. 5. See also Sonia Harris-Short, 'Family law and the Human Rights Act 1998: judicial restraint or revolution'? [2005] CFLQ 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 J. Legal Stud. 435.

[25] 11 Eur. H.R. Rep 175 (1989)

[26] *R (on the application of Sue Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin).

[27] For a discussion of *Axon* see (for example) Jo Bridgeman, 'Young People and Sexual Health: Whose Rights? Whose Responsibilities?' (2006) 14 Med R Rev 418; Anada Hall, 'Children's Rights, Parents' Wishes and the State: the Medical Treatment of Children' [2006] Fam Law 317; Rachel Taylor, 'Reversing the Retreat from *Gillick*? *R (Axon) v Secretary of State for Health* [2007] 1CFLQ 81.

contention, Mrs Axon cited the decision of the European Court of Human Rights in *Neilson*, to which I earlier referred.

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. Silber J rejected this argument. He distinguished *Neilson* (which Mrs Axon cited in support of her application) 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:

> *[A]ny 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.*[28]

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."

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. Silber J quoted with approval from Lord Justice Thorpe's decision in *Mabon*,[29] which concerned the right of children to instruct their own counsel in private family law proceedings, where his Honour said: "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

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[28] *R (on the application of Sue Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin) paras 129 and 130.

[29] [2005] EWCA Civ 634.

right to freedom of expression and participation outweighs the paternalistic judgment of welfare."

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."

Application to Australia – what might a Human Rights Act mean here for kids and medical consent?

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

One of the things it would do is 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 right 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, is 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.[30] Choudhry and Fenwick advance a 'parallel analysis' or 'ultimate balancing act' approach.[31]

Although the task of bringing a new human rights dimension to family law decision making sound rather daunting, especially for the judges who will have to do it, I don't believe it's as complex at it might at first appear. *Axon*, and the earlier case of *Roddy*,[32] 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".[33]

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* decision, in my view they have facilitated a more structured and coherent expression of children's rights.

What about specifically for intersex and transgender kids?

As for transgender and intersex children specifically, the implications are profound. Let me give you an example.

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[30] Jonathan Herring, 'The Human Rights Act and the Welfare Principle in Family Law – Conflicting or Complementary?' [1999] CFLQ 223.

[31] 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 J. Legal Stud. 435, p. 481.

[32] *Re Roddy (a child) (identification: restriction on publication)* [2004] 2 LFR 949

[33] Jane Fortin, 'Accommodating Children's Rights in a Post Human Rights Era' (2006) 69(3) MLR 299, p. 319.

The Grand Chamber of the European Court of Human Rights, in the decisions of *Goodwin v United Kingdom*[34] and *I v United Kingdom*,[35] overturned earlier decisions to find that failure of states to legally recognise gender reassignment breached Article 8 of the European Convention. 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.[36]

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*,[37] in which Justice Chisholm 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)."

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." As a result of both Strasbourg decisions, the UK 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 enables a person with gender dysphoria who has lived in the acquired gender for two years to be issued with a gender recognition certificate. This has 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 (2).* In this state, a person must undertake "sex affirmation surgery" before being issued with a document acknowledging the person's name and affirmed sex.[38] The issuing of documents recognising Alex's gender as male was a live issue in both the *Re: Alex* cases and HREOC has identified official and identity documents as a human rights issue for sex and gender diverse people.[39]

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[34] (2002) 35 EHRR 447
[35] (2003) 36 EHRR 53
[36] Richard Clayton and Hugh Tomlinson, *The Law of Human Rights*, Oxford University Press, Oxford, 2009, pp. 1106-7.
[37] *In Re Kevin (Validity of Marriage of Transsexual)* (2001) FLC 93-087.
[38] *Births, Deaths and Marriages Registration Act 1996* (Vic), s 30E.
[39] Human Rights and Equal Opportunity Commission, *Sex and Gender Diversity Issues Paper*, May 2008.

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 of 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 Rachel Wallbank, a family lawyer with a particular interest in sexuality and sex formation, which compares the *Re: Kevin* and *Re: Alex* decisions. Her paper has informed my thinking in this area.[40]

First, the way in which Alex's 'condition', for want of a better term, was diagnosed and the proposed 'treatment' 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. 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."[41] Perhaps the type of thinking that informed the European Court of Human Rights in *Goodwin*, 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,*[42] 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 Rachel Wallbank's paper. 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

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[40] Rachel Wallbank, 'Re Kevin in perspective' (2004) 9 Deakin LR 22.

[41] Ibid, p. 472. See also 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 Am J L & Med 625.

[42] *Re: Brodie (Special Medical Procedure)* [2008] FamCA 334

prior to the administration of hormonal therapies, particularly those that are reversible, may require a re-think.

Articles 2 and 3 of the European Convention 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 (2)*. In that case 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 come circumstances constitute a breach of Article 8 of the European Convention.[43]

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. Chief Justice Nicholson 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". Were those submissions underpinned by an Australian Human Rights Act, my view they would be irresistible. As the UK case law suggests however, the position is not so clear with respect to the right to refuse medical treatment. Nevertheless, as Lord Justice Thorpe said in *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."

[43] *Van Kuck v Germany* (2003) 37 UHRR 1, *L v Lithuania* (2008) 46 EHRR 23.

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 was 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 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.