

Submission in response to ALRC Issues Paper 48 Review of the Family Law System

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Thank you for the opportunity to respond to the Issues Paper on the Family Law System. I write as a legal academic researching legal and medical regulation of sex and gender. I am a lecturer in the Law School at the University of New England, Armidale.

The focus of this submission is on the impact of the current family law system on people with intersex variations, and in particular on the welfare jurisdiction as it relates to special medical treatment. This submission will not consider any other issues raised in the Issues Paper.

Intersex Status

In March 2014 leading Intersex advocates and organisations in Australia and New Zealand developed a consensus statement setting out priorities and calls for human rights guarantees. That statement, The Darlington Statement, defines intersex as follows:

Intersex people are born with physical or biological sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that are more diverse than stereotypical definitions for male or female bodies. For some people these traits are apparent prenatally or at birth, while for others they emerge later in life, often at puberty.¹

The family law system largely impacts intersex people in the context of the welfare jurisdiction. To date there have been less than ten reported applications to the court for approval for special medical procedures to be performed on intersex children.² However, it is clear that many more medical interventions have been performed on Australian children with intersex variations than are represented by these cases. Although it is extremely difficult to obtain reliable data on how many intersex children are subjected to normalising treatment, it is clear that current clinical practices involve multiple treatments performed on many children. For example, an article in *The Age* in 2013 reported that the Royal Children's Hospital in Melbourne performs 10 to 15 genital reconstruction operations a year, often on children under the age of two.³ In addition to issues raised by some of these cases, it is of concern that significant medical interventions are performed on intersex children, often in infancy, without legal oversight and, arguably, on the basis of inappropriate consent processes.

¹ 'The Darlington Statement' (Joint Consensus Statement from intersex community retreat in Darlington, March 2017) < <https://oii.org.au/darlington-statement/> >

² These are *Re A (A Child)* (1993) 16 Fam LR 715; *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226; *Re Sally (Special Medical Procedure)* [2010] FamCA 237; *Re Sean and Russell (Special Medical Procedures)* [2010] FamCA 948; *Re Sarah* [2014] FamCA 208; *Re Dylan* [2014] FamCA 969; *Re Carla (Medical procedure)* [2016] FamCA 7; *Re: Kaitlin* [2017] FamCA 83.

³ Andrew Bock, 'It Takes More than Two', *The Age* (Melbourne), 20 June 2013, 18.

I wish to begin by emphasising that intersex is first and foremost a biological variation. It is not a gender identity. Intersex variations and intersex status are not related to or defined by gender identity. Although some intersex children may (like non-intersex children), be transgender, gender diverse or genderqueer, gender identity is not definitive of intersex status. The majority of intersex people are cis-gendered. The rainbow alliance as symbolised in the LGBTIQ acronym has led to some conflation between transgender and intersex experiences. The overlapping and intersectional nature of the LGBTIQ community is an extremely important point but must not mask the extent to which each of these communities is distinct and has separate needs. Increasingly, intersex is misconstrued as an issue of gender identity whereby third sex status is of central importance. This is not the case. As noted in the Darlington Statement, the word 'intersex' belongs to all people born with variations of sex characteristics irrespective of gender identity (including cis-gender) and 'attempts to classify intersex people as a third sex/gender do not respect our diversity or right to self-determination.'⁴

The Issues Paper

The issues paper identifies several questions that are relevant to intersex people.

Question 8 How can the accessibility of the family law system be improved for lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people?

In expanding on this question, the Issues Paper notes that 'Transgender and intersex children may also be engaged in the family law system in the exercise of the Family Court's welfare jurisdiction relating to approval for medical interventions related to their gender identity.' (90)

As noted above, this comment must be read with an understanding that intersex children may be gender diverse, but it would be misleading to assume that intersex children are necessarily transgender or gender diverse, because intersex is not a gender identity.

Paragraph 90 of the Issues Paper goes on to say that 'concerns exist about the opportunity for children to participate in this process' of the court's welfare jurisdiction. This is supported by reference to a comment by Morgan Carpenter, director of IHRA (formerly OII) writing on a recent case called *Re Carla*. Carpenter's critique of *Re Carla* is not primarily focussed on the absence of the child's meaningful participation in the court proceedings. Rather, Carpenter comments adversely on the failure of the process to protect the child's best interests and human rights in respect of her bodily integrity, autonomy, her right to health and her right to a life free from harmful practices.⁵ Framing this as a concern about access to participation in formal legal proceedings is too narrow.

Intersex minors are not given proper access to the protective functions of the welfare jurisdiction of the family court. Surgical and medical interventions to 'normalise' children born with intersex variations are in practice not identified as special medical procedures unless they will have the effect of sterilising the child. Accordingly, many, even most decisions about medical treatment of intersex children are assumed not to require court authorisation. Hormone therapy, genital normalisation surgeries and sterilization

⁴ 'The Darlington Statement' (Joint Consensus Statement from intersex community retreat in Darlington, March 2017) <<https://oii.org.au/darlington-statement/>>

⁵ Morgan Carpenter, *The Family Court Case Re: Carla (Medical Procedure)* [2016] FamCA 7 (8 December 2016) OII Australia—Intersex Australia <<https://oii.org.au/31036/re-carla-family-court/>>.

procedures are imposed on infants and very young children with intersex variations on a regular basis in Australia. These interventions are performed without judicial or administrative oversight and on the basis of parental consent alone. This is the key problem of lack of access to the family law system for intersex people.

Question 14 What changes to the provisions in Part VII of the Family Law Act could be made to produce the best outcomes for children?

The Issues Paper identifies the court's welfare jurisdiction as a focus of concern, and in paragraph 136 identifies many of the key issues where intersex children have engaged with the family law system.

In addition to concerns raised by cases such as *Re Carla*⁶ as identified in various human rights critiques, there is a broader problem of invisibility and occlusion of intersex rights and interests. Because the approach of some medical practitioners is that intersex is in itself a defect in urgent need of 'fixing', many of the medical interventions are directed at 'curing' intersex by erasing physiological sex and gender ambiguity. These interventions are performed in the interests of 'normalising' intersex bodies. In this paradigm, intersex is an illness or deformity, and normalising treatments are the cure. Because these treatments are constructed as therapeutic, they have escaped the attention of the court. By failing to challenge and, in some instances by actively contributing to this mis-construction, the family law system has failed to protect intersex children.

Two cases decided in the Family Court in 2017 highlight the lack of understanding of the human rights issues and bioethical problems that are relevant to the medicalisation of intersex minors. Both of these cases display a poor grasp of the contentious nature of the approach adopted by some members of the medical community. As has been noted in many reports and articles, there is a lack of consensus within the medical community on the best approach to treating intersex children, and in particular to the timing of medical normalisation of intersex children.⁷

Re Carla,⁸ concerned a five year old child with 17-βHD-3. The application was for a gonadectomy 'so that Carla can continue to live a healthy life as a female in the way that she identifies and is being raised.'⁹ Carla's diagnosis occurred when she was still in nappies, and her parents made a decision to raise her as a girl 'with the understanding that her gender identity would be assessed when it was developmentally

⁶ *Re Carla (Medical Procedures)* [2016] FamCA (20 January 2016).

⁷ See, for example, Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia* (2013).; Milton Diamond, 'Clinical implication of the organizational and activational effects of hormones', *Hormones and Behavior*, Vol. 55, 2009, p. 627; Jean D. Wilson, Marco A. Rivarola, Berenice B. Mendonca, Garry L. Warne, Nathalie Josso, Stenvert L.S. Drop, and Melvin M. Grumbach, 'Advice on the Management of Ambiguous Genitalia to a Young Endocrinologist From Experienced Clinicians', *Semin Reprod Med.*, Vol. 30, No. 5, 2012, pp 339–350. ; Peter A. Lee et al, 'Global Disorders of Sex Development Update Since 2006; Perceptions, Approach and Care' (2016) 85 *Hormone Research in Paediatrics* 158.

⁸ *Re Carla (Medical Procedures)* [2016] FamCA (20 January 2016).

⁹ *Ibid.* [3]

appropriate to do so.¹⁰ When Carla was 4 years old, her treating paediatric psychiatrist formed the opinion that she had developed a fixed female gender identity. Rates of gender change are higher in children with 17 β -HSD-3 than for most other intersex variations. The development of gender identity is difficult to predict in early childhood, as gender identity changes usually occur much later:

Gender role changes were reported in 56–63% of cases with 5 α -RD-2 and 39–64% of cases with 17 β -HSD-3 who were raised as girls. The changes were usually made in adolescence and early adulthood. In these two syndromes, the degree of external genital masculinization at birth does not seem to be related to gender role changes in a systematic way.¹¹

The fact that children in this cohort experience significantly high rates of gender change at or after adolescence is described by Warne and Hewitt as ‘well known’.¹² On that basis, it is arguable that this opinion on Carla’s fixed gender identity was extremely premature, rendering the proposed medical interventions more risky in terms of making a wrong decision with grave consequences.

The basis for the expert witness’s opinion in *Re Carla*¹³ is mired in highly stereotypical gender performance filtered through the eyes of Carla’s parents:

- a) Her parents were able to describe a clear, consistent development of a female gender identity;
- b) Her parents supplied photos and other evidence that demonstrated that Carla identifies as a female;
- c) She spoke in an age appropriate manner, and described a range of interests/toys and colours, all of which were stereotypically female, for example, having pink curtains, a Barbie bedspread and campervan, necklaces, lip gloss and ‘fairy stations’;
- d) She happily wore a floral skirt and shirt with glittery sandals and Minnie Mouse underwear and had her long blond hair tied in braids; and
- e) Her parents told Dr S that Carla never tries to stand while urinating, never wants to be called by or referred to in the male pronoun, prefers female toys, clothes and activities over male toys, clothes and activities, all of which are typically seen in natal boys and natal girls who identify as boys.¹⁴

As Richards notes, ‘Whilst each of these preferences may, indeed, be consistent with female gender identity, it must be remembered that as the clothes, toys, and bedroom fittings were all purchased by others who viewed Carla as a girl, Carla’s individual preferences were yet to emerge with any independence.’¹⁵ The extent to which these items reflect stereotypical ‘girl preferences’ suggests that Carla’s parents were already deeply invested in Carla’s female gender identity.

In describing past medical interventions, Forrest J describes a clitoral recession and labioplasty as being performed to ‘feminise Carla’s external appearance.’ He characterises this as having ‘enhanced the appearance of her female genitalia’. This characterisation of genital surgery, which in other circumstances would qualify as female genital mutilation, reveals a deep and unexamined level of

¹⁰ Ibid. [13]

¹¹ PT. 2005;34(4):399–410. Cohen-Kettenis, ‘Gender Change in 46,XY Persons with 5 α -Reductase-2 Deficiency and 17 β -Hydroxysteroid Dehydrogenase-3 Deficiency.’ (2005) 34(4) *Archives of Sexual Behavior* 399.399

¹² J K Hewitt and Garry Warne, ‘Management of disorders of sex development’ (2009) 3(1) *Pediatric Health* 51.

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¹⁴ *Re Carla (Medical Procedures)* [2016] FamCA (20 January 2016). [15]

¹⁵ Bernadette Richards and Thaddeus Mason Pope, ‘Stretching the Boundaries of Parental Responsibility and New Legal Guidelines for Determination of Brain Death’ (2017) 14(3) *Journal of Bioethical Inquiry* 323. 324

gender essentialism. It expresses hostility towards the unaltered bodies of people with variations of sex characteristics. The language trivialises the impact of the genital surgeries.

Moreover, the fact that these genital surgeries have already been performed indicates that the parents and medical team were not content to wait until Carla had formed a fixed gender identity before commencing interventions that explicitly and irreversibly shaped her body towards a 'feminine' appearance. This indicates that the applicants and the expert witnesses had become irrevocably invested in Carla being assigned and physically shaped as a female well before these proceedings had commenced. As Richards comments, 'this application was seeking advice and approval for an already identified path' and 'there was a core assumption that Carla's identification as a female was correct and there was no further evidence of the early decision to "review that ... as she grew."' ¹⁶

The issue of Carla's potential fertility is constructed as fanciful and highly dependent on advanced technological intervention. Justice Forrest explains that 'whilst it is conceivable that in the future, technology might be developed that would enable Carla to have a child that is genetically her own through stem cell manipulation, the prospects of the development of such technology are unknown at this stage' ¹⁷ It becomes clear, however, that such technological developments will only be required if the testes are removed and cryopreserved. It is later explained that if the gonadectomy is not performed, 'she might still be infertile or sub-fertile given that they are intra-abdominally located.' ¹⁸ Forrest J invokes a highly conventional heteronormative image of reproduction:

However, if the surgical procedure is not undertaken and the gonads are left in situ, the issue of Carla's future potential fertility raises other significant social and emotional complexities given that Carla identifies as a female and, according to the expert evidence, is likely to continue to, whilst any fertility she could potentially attain is based on male gametes. ¹⁹

As Tamar-Mattis puts it, '[m]any doctors also do not see sterilizing surgeries as sterilization if the child would not have been fertile in the mode expected for the assigned gender.' ²⁰ Justice Forrest fears that the use of male gametes by a person who identifies as female would generate such significant social and emotional complexities as to make the prospects too difficult to contemplate. He concludes that 'there is no certainty of future fertility if the surgery does not take place.' While this is true, there is certainty of infertility if the surgery does take place. Carla's fertility is not given the weight it would be given were if she was not intersex.

The judgment in *Re Carla* embarks on a process of weighing up the risks of intervention versus non-intervention, but the analysis is not balanced or informed. Future medical interventions such as vaginal surgery are mentioned but identified as a future possibility rather than a risk. An expert witness is cited as concluding that the psychological risks of undergoing the procedure outweigh the risks of not proceeding. However, the judgment fails to identify any of the possible psychological risks of proceeding

¹⁶ Ibid.

¹⁷ *Re Carla (Medical Procedures)* [2016] FamCA (20 January 2016). [27]

¹⁸ Ibid. [29]

¹⁹ Ibid. [28]

²⁰ Anne Tamar-Mattis, 'Report to the Inter-American Commission on Human Rights: Medical Treatment of People with Intersex Conditions as a Human Rights Violation' (Advocates for Informed Choice, 2013). 5

with the gonadectomy, including the significant risk (39-64%)²¹ that Carla's gender identity will change during adolescence. The risks of non-intervention are exaggerated and inflated, while the risks of intervention are consistently ignored or minimised.

For example, Forrest J comments that

... "in theory" male puberty could be suppressed hormonally in Carla to prevent any virilisation until Carla was older and could give informed consent to treatment. However, this would require at least three monthly injections of depot Lucrein intramuscularly, three monthly medical reviews and any female pubertal development would thereby be necessarily delayed until her testes were removed and pubertal suppression could be ceased. This would mean that Carla's pubertal development would be significantly delayed compared to her peers with likely detrimental social and psychological effects on her in addition to detrimental physical effects including in respect of her bone health.²²

Puberty suppressant hormone therapy is constructed as tedious, invasive and risky. By contrast, the administration of puberty inducing hormones is pictured as a happy and life-affirming opportunity to bond with her peers:

It is then proposed that in the future, as Carla approaches the age of 12, that exogenous oestrogen be administered to her in increasing doses over approximately two years to induce female pubertal development. This could occur at a time comparable to her female peers and is most likely to be positive for her social and psychological well-being.²³

What is not mentioned is that Carla will thereafter be required to undergo hormone therapy for the rest of her life, as is the usual treatment protocol for this intersex variation. The emphasis on peers gives weight to the sense of urgency that has been laboriously constructed throughout the judgment. Justice Forrest argues that

The medical evidence recommends that the procedure be performed prior to Carla commencing puberty and supports the position that there is no reason to delay the procedure especially given that there are physical and psychological risks associated with such a delay and particularly given that it will be less psychologically traumatic for Carla if it is performed before she is able to understand the nature of the procedure.²⁴

This extraordinary statement exemplifies a lack of respect for the child's autonomy and self-determination which is all too common in cases concerning children with variations of sex characteristics. It defies existing evidence as to the traumatic impact on intersex people of a paternalistic and secretive medical protocol that has dominated clinical dynamics for decades.²⁵

²¹ Cohen-Kettenis, above n 10

²² *Re Carla (Medical Procedures)* [2016] FamCA (20 January 2016).

²³ *Ibid.* [18]

²⁴ *Ibid.* [30]

²⁵

Of concern in the *Re Carla*²⁶ decision is the failure to adopt the recommendations of the Senate Committee *Report on Involuntary or Coerced Sterilisation of Intersex People in Australia*.²⁷ This is evident even in the language used by Forrest J. For example, Forrest J uses the term 'sexual development disorder' which is an unconventional term which is not used by any stakeholders in the debate. Whilst criticising the adopted terminology may seem trivial and hair-splitting, terminology has consistently been a focus of conflict and contestation among stakeholders.²⁸ The Senate Committee Report dedicated several pages to a close and careful survey of the controversies around the terminology²⁹ and concluded that 'the evidence before this committee is clear that the default term should be 'intersex'.³⁰

*Re Kaitlin*³¹ was also heard in 2017. Kaitlin (the pseudonym adopted by the Family Court) was born in 2000 with variations of sex characteristics diagnosed as 'hypopituitarism' meaning that her body does not naturally produce many hormones, including testosterone. Kaitlin was 'born male' but identified as female from a 'very early age'. Despite this, she was prescribed testosterone at age 12 or 13 in order to commence puberty. It is not clear why male hormones were considered to be appropriate. In any case, Kaitlin did not comply with the treatment.

The case was brought to permit Kaitlin to commence hormone therapy to trigger female puberty. Justice Tree notes that;

for all of her life, Kaitlin has taken hormones as part of a therapeutic regime to treat her pituitary disorder, the effects of which hormones were irreversible. Moreover, because her body was unable to produce, amongst many other hormones, testosterone, in order to undergo puberty at all she was required to take either testosterone or estrogen. Precisely why court authorisation for the administration of estrogen is then said to be required by *Re Jamie* is difficult to explain. True it is that the effects of its administration will be irreversible over time, but not in any conceptually different way to the irreversible effects of the administration of testosterone.³²

Instead of reflecting on the fact that an intersex child was prescribed hormone treatment without court authorisation, Tree J goes on to reflect what Kaitlin's situation meant for transgender minors, concluding that 'this case well illustrates that the irreversibility of therapeutic treatment does not provide a sound, logical basis for requiring court authorisation for stage two treatment for Gender Dysphoria.'³³

Rather than commenting on the fact that an intersex child has been given inappropriate medical treatment resulting in iatrogenic gender dysphoria, Tree J is instead concerned with the implications for other minors. No adverse comment is made about the fact that hormone therapy was prescribed for an intersex child without court approval, even though approval was at that time required for the same treatment for transgender minors. If we examine cases where the Family Court still required such

²⁶ *Re Carla (Medical Procedures)* [2016] FamCA (20 January 2016).

²⁷ Committee, Parliament of Australia, (2013).

²⁸ *Ibid.* [2.5]

²⁹ *Ibid.* [2.5]-[2.19]

³⁰ *Ibid.* [2.20]

³¹ *Re: Kaitlin* [2017] FamCA 83.

³² *Ibid.* [19]

³³ *Ibid.* [20]

approval, there is much concern expressed about the risks of the treatment. Such risks were, until *Re Kelvin*,³⁴ the rationale for retaining the requirement of court authorisation.³⁵

*Re Carla*³⁶ and *Re Kaitlin*³⁷ are typical of the judicial attitude to medical treatment of intersex minors. The courts are entirely deferential to the medical perspective presented in the evidence, even though it frequently does not represent a consensus position within the medical community. Previous invasive, irreversible and non-therapeutic medical interventions such as genital surgeries and hormone treatments are noted without adverse comment on the lack of court authorisation. Much of the reasoning lacks critical rigour and is tainted by gender stereotyping. The discussions reveal little concern about the extensive medical interventions that have been performed and/or are planned for the minor. The prospect of life-long medical intervention is rarely commented on. Intersex minors are not afforded the same level of protection deemed necessary for non-intersex minors.

The ALRC has invited comment regarding potential amendments to Part VII of the Family Law Act. In respect to the welfare jurisdiction, and its exercise in relation to intersex children, The Senate Committee has recommended oversight of medical decision making by the Family Court and/or a civil or administrative tribunal.³⁸ The Committee's report further recommends that guidelines for the treatment of common intersex conditions based on medical management, ethical, human rights and legal principles be drafted by the special medical procedures advisory committee, and be subject to annual review. This seems a preferable approach to legislative amendment. It is important that, in seeking to protect the human rights of intersex children, their rights to effective therapeutic medical treatment must be preserved and protected. Questions of need, therapy and ethics are complex and contested. It is important that these questions be ventilated and explored comprehensively.

Bock, Andrew 'It Takes More than Two', *The Age* (Melbourne), 20 June 2013, 18

Cohen-Kettenis, PT. 2005;34(4):399–410., 'Gender Change in 46,XY Persons with 5 α -Reductase-2 Deficiency and 17 β -Hydroxysteroid Dehydrogenase-3 Deficiency.' (2005) 34(4) *Archives of Sexual Behavior* 399

Committee, Senate Community Affairs References, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia* (2013)

³⁴ *Re Kelvin* (2017) EA30 of 2017 FamCAFC 258.

³⁵ *Re Jamie* (2013) 278 FLR 155. 192

³⁶ *Re Carla (Medical Procedures)* [2016] FamCA (20 January 2016).

³⁷ *Re: Kaitlin* [2017] FamCA 83.

³⁸ Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia* (2013) Recommendation 6

Hewitt, J K and Garry Warne, 'Management of disorders of sex development' (2009) 3(1) *Pediatric Health* 51

Lee, Peter A. et al, 'Global Disorders of Sex Development Update Since 2006; Perceptions, Approach and Care' (2016) 85 *Hormone Research in Paediatrics* 158

Re A (A Child) (1993) 16 Fam LR 715

Re Carla (Medical procedure) [2016] FamCA 7

Re Carla (Medical Procedures) [2016] FamCA (20 January 2016)

Re Dylan [2014] FamCA 969

Re Jamie (2013) 278 FLR 155

Re Kelvin (2017) EA30 of 2017 FamCAFC 258

Re Lesley (Special Medical Procedure) [2008] FamCA 1226

Re Sally (Special Medical Procedure) [2010] FamCA 237

Re Sarah [2014] FamCA 208

Re Sean and Russell (Special Medical Procedures) [2010] FamCA 948

Re: Kaitlin [2017] FamCA 83

Richards, Bernadette and Thaddeus Mason Pope, 'Stretching the Boundaries of Parental Responsibility and New Legal Guidelines for Determination of Brain Death' (2017) 14(3) *Journal of Bioethical Inquiry* 323

Tamar-Mattis, Anne, 'Report to the Inter-American Commission on Human Rights: Medical Treatment of People with Intersex Conditions as a Human Rights Violation' (Advocates for Informed Choice, 2013)