Adolescence is a time of dramatic change, where children are growing rapidly and are searching for their identities. ‘Becoming’ rather than ‘being’ is an apt description of this period of life. Emotions run high; change is ongoing. Experimentation and risk-taking are common occurrences. Adolescents have a heightened awareness of their body image and a preoccupation with the physical changes to their bodies. They have an increased interest in sexuality and an important element of adolescent development is gender identity. While this has relatively rarely been seen as aspects of the right to health, issues of sexual health and well-being have played a significant role in defining the rights of the child.

The entitlement of a child to decision-making power has been clarified in the context of medical treatment. The standard approach to establishing where the parents’ responsibility ends, and where the child’s right to control over his/her own bodies begins, is to establish whether the child is ‘Gillick competent’. (Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112). When the child is aware of the nature and the consequences of a course of action, it is the child’s decision which counts. This landmark ruling was made by the English House of Lords, which found that a 15 year old had the capacity to seek contraceptive advice, and to decide to take the contraceptive pill, without the need for parental consent. The test is functional rather than status-based. It is not determined by the specific age or stage of a child, but by the competency of the particular individual at the time of asserting the right. As such, the Gillick test fits with the dynamic developmental model of children’s rights (Jones & Marks, 1994), and with those who consider that rights emerge with the child (Campbell, 1992; Freeman, 1983; Eekelaar, 1986).

The Australian case of Marion (Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 – known as Marion’s Case) could be seen as diluting ‘parental rights’ or as assuring that appropriate decision-making takes place where the child is not Gillick competent. The case involved a 13 year old girl with a significant intellectual disability. The parents sought court authorization to sterilize their daughter. The High Court found that Marion was not Gillick competent, and suggested that
where what was at stake was a non-therapeutic invasive procedure, no child would be likely to meet the standard. However, these are not matters which the parents can simply decide on behalf of the child. The High Court made it clear that in decisions of this nature, a court must grant permission to carry out any medical treatment. Because of Marion’s subjective position, it was unnecessary to consider how to ensure that, consistent with Article 12 of the Convention on the Rights of the Child; the view of the child was appropriately taken into account.

This article focuses on two recent Australian decisions where a court was called upon to authorize invasive medical procedures (Re A (1993) 16 Fam LR 715; Re Alex [2004] FamCA 297). Both cases concern young people who were extremely distressed about their gender identity, and had applied for permission to undergo sexual reassignment. These cases provide contrasting pictures in terms of the decision-making process and therefore with the extent to which the outcomes are well-grounded. Both cases raise issues regarding the rights of the child, the child’s right to consent and the role of the courts in medical treatment applications. Because there are no binding rules or guidelines for the courts to apply in special medical treatment decisions, there is a great difference in the way the respective courts make their judgments. The cases demonstrate that a firmer basis in values and process is required. The wide discretion available to judges needs to be reined in, and specific criteria for decision-making needs to be established. The risk to the denial of the child’s right to health is too great to be subjected to the whims and predisposition of unguided judges.

1. The Gender Re-Assignment Cases

a) Re A (1993) 16 Fam LR 715

‘A’ was born with ambiguous genitalia and an inter-sexed condition known as congenital adrenal hyperplasia. This disorder is the result of the over-production of androgens (male sex hormones) in the adrenal glands of the foetus, which in a female foetus causes masculinization of the genitalia. In A’s case, although the child was born with normal female fertility, the degree of masculinization at birth meant that she had a clitoris exactly like a male penis, and the labia were fused together in such a way that they gave the external appearance of an empty scrotum.¹ As a result there was some initial confusion as to the child’s gender. The birth certificate recorded the birth of a boy, with a male name, but the child was, until the time of the hearing, known by a female name.

A sufficient number of children are inter-sexed for American texts to list this as a common childhood ailment (Ford, 2000). In cases such as A’s, where chil-