GUARDIANSHIP AND ADMINISTRATION BOARD
LAUNCESTON

M G on the application of T G

GAB No. xxxx

REASONS FOR DECISION

Division Members:
Anita Smith, President
Ruth Hanson, Vice President
Catherine Wilding, Board Member

16 September 2004

Consent to medical treatment – application for hysterectomy for a child – appointment of a special representative – viability of alternative treatments, consequences of not treating – least restrictive alternative and best interests
Guardianship and Administration Act 1995 (Tas), ss 3, 6, 45, 46
Lack of compliance with *Guardianship and Administration Regulations* reg 9

The Application:

1. On 30 January 2004, the Guardianship and Administration Board ('the Board') received an application pursuant to section 44 of the *Guardianship and Administration Act* 1995 ('the Act') for consent to medical treatment for M G. The application, made by M's mother, T G, seeks consent for a hysterectomy. By reason of the fact that a hysterectomy is a medical treatment that will render M permanently infertile, the application is for consent to 'special treatment' within the meaning of section 3 of the Act.

2. The President of the Board convened a conference with Mr and Mrs G on 1 April 2004 to consider the process for the investigation and hearing of the application, including collection of reports, use of materials collected in a previous application and the appointment of a separate representative.

3. The Senior Investigation and Liaison Officer of the Board investigated the application. She obtained relevant journal articles and prepared her own report as well as obtaining the following reports:

   Family Planning Tasmania Inc
   X Medical Centre
   T and R G – Parents (3 reports)
   Obstetrician and Gynaecologist
   Consultant Psychiatrist
   Autism Consultancy Services
   Separate Representative, Legal Aid Commission

4. The Division members considered the above reports, procedural correspondence and some reports that were considered in an unsuccessful prior application for the same procedure in 2002. All information considered by the Division members was circulated to Mr and Mrs G and to the separate representative.

5. Division members visited M's home on the afternoon of Wednesday, 25 August 2004 to meet M in surroundings familiar to her. A hearing was convened on Thursday, 26 August 2004. The hearing was attended by Mr and Mrs G and a support person Ms B M, a barrister on behalf of the Separate Representative, a staff member from Family Planning, a staff member from M's school, the Obstetrician and Gynaecologist and the Consultant Psychiatrist.

The Legislation:

6. The definition of 'special treatment' in section 3 of the Act includes:

   > **"*(a)*** *any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out;*"

7. Section 6 of the Act requires the Division to observe the following principles:

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"*A function or power conferred, or duty imposed, by this Act is to be performed so that –*

> ***(a)*** *the means which is the least restrictive of a person's freedom of decision and action as is possible in the circumstances is adopted; and*
>
> ***(b)*** *the best interests of a person with a disability or in respect of whom an application is made under this Act are promoted; and*
>
> **(c)** *the wishes of a person with a disability or in respect of whom an application is made under this Act are, if possible, carried into effect.*"

1. Applications for consent to medical treatment are determined according to section 45 of the Act, which states:

> **"*(1)*** *On hearing an application for its consent to the carrying out of medical or dental treatment the Board may consent to the carrying out of the medical or dental treatment if it is satisfied that –*
>
> ***(a)*** *the medical or dental treatment is otherwise lawful; and*
>
> ***(b)*** *that person is incapable of giving consent; and*
>
> ***(c)*** *the medical or dental treatment would be in the best interests of that person.*
>
> ***(2)*** *For the purposes of determining whether any medical or dental treatment would be in the best interests of a person to whom this Part applies, matters to be taken into account by the Board include –*
>
> ***(a)*** *the wishes of that person, so far as they can be ascertained; and*
>
> ***(b)*** *the consequences to that person if the proposed treatment is not carried out; and*
>
> ***(c)*** *any alternative treatment available to that person; and*
>
> ***(d)*** *whether the proposed treatment can be postponed on the ground that better treatment may become available and whether that person is likely to become capable of consenting to the treatment; and*
>
> ***(e)*** *…*

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(f) any other matters prescribed by the regulations."

Fundamental Issues:

9. The procedure sought is 'otherwise lawful' for the purposes of section 45(1)(a) of the Act. In accordance with Regulation 9(e), the application was accompanied by a report by her General Practitioner, Dr T. The report confirmed that M has the mental capacity of a child of 14 months and that she will never be capable of consenting to treatment. This assessment of incapacity is consistent with all available opinions and sufficient to satisfy the requirements of section 36(2) and 45 (1)(b) of the Act.

10. Because of the severity of M's disability, there is no means by which the Division could ascertain M's wishes for the purposes of sections 45(2)(a) or 6(c) of the Act. For that reason, and because the application was brought by her mother and supported by her father, a qualified legal practitioner was appointed under section 10 of the Act to assist the Division by acting as M's separate representative in the hearing.

11. None of the factual evidence was disputed. The Division members were satisfied that each of the expert witnesses was appropriately qualified to give opinion evidence in their respective fields. The key issues to be determined are:

    (i) Any alternative treatments available (section 45(2)(c))
    (ii) The consequences to M if the proposed treatment is not carried out (section 45(2)(b)),
    (iii) Whether the proposed medical treatment is the 'least restrictive alternative' (section 6(a)) and

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(iv) Whether the proposed medical treatment is in M's best interests (sections 45(1)(c) and 6(b))

M's History and Circumstances:

12. M G is 14 years of age. After a normal birth and development up to the age of 2, M began to regress in cognitive and behavioural development in October 1992. She was diagnosed with Childhood Disintegrative Disorder (CDD) in September 1993. That condition presents in M with a profound degree of intellectual disability, symptoms of severe autism and tactile defensiveness. She lives with her parents, T and R G in their family home at X together with her older brother, K, and younger sister, L. She attends school at X which has an educational facility established specifically for children with autism.

13. M's parents impressed the Division as parents who care very deeply for all of their three children. They have made M's care a central focus in their lives, to the extent of moving from interstate several years ago to avail themselves of specialised educational services.

14. M attends school in normal school hours during each school term. Following school, at weekends and in school holidays, her parents have primary child care responsibilities with some help from carers who come to the home for a number of hours per day. This responsibility falls more to M's mother, as her father has full time employment some distance away. It is clear that they have very limited external support. Because of M's behaviour, incontinence and pattern of menstrual bleeding, they are also sleep deprived. M's siblings, as teenagers, are becoming acutely aware of the differences between their family and others, and show signs of resultant embarrassment and depression. All family members are at risk of, and at times have experienced, personal harm when M has tantrums.

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15. Because of the rigidity occasioned by M's form of disability and the lack of external supports, usual family activities (such as shared holidays) have long since faded to a distant memory. While, on one hand, the obsession for routine occasioned by M's autistic symptoms allows little variation of their routine, on the other hand day to day activities appear reasonably unpredictable for Mr and Mrs G because they are not able to assume that M will always cooperate with those daily routines. A consistent favourite activity for M is swimming.

M's Experience of Menstruation:

16. The application for hysterectomy states that the treatment will be in M's best interests because "M needs a long term solution, she is not reliable in taking medication." In the evidence, there are two issues that menstrual management presents for M. The first is her level of bleeding. The second is her behavioural responses to the range of menstrual issues such as pre-menstrual and menstrual mood swings, responses to possible pain of menstruation, responses to the sight of blood and the disruption that bleeding causes to her sleeping and waking routine. While there is evidence of some risk of pregnancy, this does not appear to be a dominant motivator for the application.

17. On 7 October 2001, Mrs G made her first application for sterilisation (which was dismissed on 7 August 2002). Between December 2001 and February 2002 M displayed unusually high levels of agitation, mood swings, violent temper outbursts and refusal to wear clothes. M commenced menstruation in May 2002. The unusual behaviours before and since are attributed to the changes brought by menarche. Five to six months later her menstrual cycle appeared to settle into 17 to 21 days with approximately 6 days bleeding, such bleeding was reported to be heavy.

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18. M frequently refuses or removes (in private or in public) sanitary products. This causes greater workload in laundering and, at times, acute embarrassment for carers, at school and within the family. The activities of washing M after bleeding and removal of sanitary pads exacerbate her tactile defensiveness. At times the sensitive management of that process can take hours. While M's inability to communicate makes detection of pain difficult, various reports indicate that there is significant pain associated with her menstruation.

19. In February 2002, M commenced taking an antipsychotic drug, Haloperidol. This led to an improvement in her mood but was also accompanied by weight gain. On 26 May 2002, her prescription was altered to another antipsychotic drug, Risperidone. This also led to weight gain and was stopped for that reason in September 2003.

20. When antipsychotics proved unsuccessful in managing behaviours, her parents reluctantly attempted hormonal control with Levlen ED, an oral contraceptive pill (OCP) between December 2003 and February 2004. Her parents reported a disastrous increase in aggression and no positive impact upon bleeding. On 13 February 2004, M re-commenced medication with Risperidone at a higher dosage. During the period of administration of Levlen ED, M exhibited biting and scratching herself and family members, damage to furniture and very loud screaming. She gained 6 kilograms in weight during the trial. In late February 2004 a second OCP, Primolut, was tried. Her agitation levels reportedly decreased, allowing a reduction in the level of Risperidone. The use of Primolut, however, was associated with higher levels of bleeding and was ceased on 25 March 2004.

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21. Based upon the evidence given by M's parents, the Obstetrician and Gynaecologist stated that M's pattern of bleeding does not suggest any abnormal pathology and does not put her at any particular risk, such as a risk of anaemia. The Division notes that the Autism Consultant communicated to the Board that M's heavy bleeding and frequency of periods were not "typical for a young woman in the beginning of establishing menses" and suggested an examination for fibroid tumours. Ms W is an 'autism consultant' based in Oregon. Her extensive qualifications are in education. It is appropriate that the Division prefers the opinion of an obstetrician and gynaecologist to that of an educationalist, thus concluding an absence of abnormal pathology in M's menstruation.

22. The Division does not accept any correlation between trials of OCP and M's weight gain. Weight gain, according to the Obstetrician and Gynaecologist, is an unlikely consequence of short-term applications of OCP. Evidence from the Consultant Psychiatrist confirmed the weight gain is a known side effect of the antipsychotic drugs, Haloperidol and Risperidone. The period during which M has gained weight coincides with her medication with those drugs.

23. Although her periods are within normal range, menstruation has no positive effect in M's life. She derives no concept of femininity from bleeding; it severely curtails her pursuit of her favourite activity, swimming. Her family are clearly distressed by her bleeding and overwrought with the prospect of long-term management of her periods, more so than her incontinence. While a different family may be capable of a different reaction to the bleeding, the Division also accepts that the social response of her parents, siblings, carers and teachers are important to her overall wellbeing.

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24. Mr and Mrs G prepared a synopsis of M's behaviour in connection with her menstruation from the communication books used to record M's day-to-day behaviours. It is clear that there are few days where M does not become upset or agitated at some stage. The pattern that emerges from the document is that around the time of her periods M's agitation and distress escalates. This is consistent with the Consultant Psychiatrist's discussion of pre-menstrual behaviour problems. She also has tantrums in response to bleeding and wearing sanitary pads. An example is as follows:

> "17 July – unhappy at having a walk in afternoon
> 20 July – hyped up at school
> 22 July - teary after dinner
> 23 July - major problems on school bus on way home from excursion. Had blood nose. Attacked staff – took 4 staff members to calm M down.
> 25 July – period started. Very edgey on walk to shops
> 26 27 July – unsettled at school. Edgey, removed to avoid tantrum. Hyped up later
> 28 July – distressed on outing with school needing time out. Attempts to attack staff on quite a number of occasions. Teary after dinner
> 30 July – tantrum on school bus in afternoon."

25. The Division accepts that it is in M's best interests that menstruation should be eliminated. Various methods of eliminating menstruation may or will have the effect of (i) reducing bleeding, (ii) reducing pain associated with menstruation and (iii) control mood swings and behavioural issues associated with hormonal fluctuations including premenstrual responses. The questions remain: whether a hysterectomy is the most appropriate method of eliminating menstruation and whether it would it address each of those problems?

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Treatments that have the Effect of Eliminating Menstruation or its Negative Effects:

26. This is not a case where training or education will have any effect upon M's ability to cope with menstruation. Both the Consultant Psychiatrist and Family Planning Inc confirmed that attempts at education have failed, the latter organisation stating:

> "In my report of 2002, I suggest trying an education program to see if M can be assisted to manage her menstruation. This has been shown to fail and staff and family report that M has not been able to learn anything from menstrual management education."

27. The range of options for control or alleviation of the symptoms of menstruation considered in this case were:

    (a) Endometrial Ablation
    (b) Analgesics such as Naproxen
    (c) Oral Contraceptive Pills (OCP)
    (d) Mirena Device
    (e) Hysterectomy

28. <u>(a) Endometrial Ablation:</u> The Obstetrician and Gynaecologist explained to the Division that new procedures are now available in Y that improve the delivery of endometrial ablations. However the Division concluded that the delivery and outcome of an endometrial ablation render it a 'special treatment' in any event and no party has seriously pursued this option. Such a procedure would not eliminate the need for continued use of contraceptives and is therefore impractical for present purposes.

29. <u>(b) Analgesics such as Naproxen:</u> Although there can never be direct confirmation of this, M's behaviour around menstruation may be a reaction to

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menstrual pain. Evidence from Dr J in the 2002 application confirmed that the application of analgesics such as Naproxen could reduce pain in menstruation. The Consultant Psychiatrist and the Obstetrician and Gynaecologist confirmed this evidence in the present hearing. Dr J in 2002 also stated that use of Naproxen reduces the extent of bleeding.

30. Mr and Mrs G appear to have an experiential resistance to the administration of some drugs to M and thus have not attempted administration of analgesics. Such resistance appears to be grounded in their belief that the onset of CDD was directly attributable to the vaccines administered to M as an infant. There are contradictions in their resistance to administration of drugs in that it does not extend to the use of antipsychotics. There is no scientific proof of any link between vaccines and CDD. Whether that attribution is rational or is a grief reaction it has the effect that there is little or no likelihood that the use of Naproxen or any other analgesics will be attempted by her parents to alleviate M's symptoms associated with menstruation.

31. (c) OCP: The experiment with OCP as described above also caused Mr and Mrs G to be extremely cautious with the use of OCP's and hormonal treatments. Both trials of OCP were concluded swiftly. It might be said that a scientific analysis would require longer trials with each OCP before the conclusion that they would not have eventually had the desired effect. However, taking into account the stress and difficulties that the family tolerated during the trials, it is understandable that they should remove the apparent cause of the aggression at the early stages rather than continue to be at risk of assaults and witnesses to M's distress. It is also understandable that they now hold serious reservations about attempting any of the multifarious range of OCP's or injectable contraceptives available on the market.

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32. <u>(d) The Mirena device:</u> The level of reservation about OCP's extends to the option preferred by a number of the witnesses, the use of a device known as Mirena, a levonorgestrel-releasing intrauterine system. The Obstetrician and Gynaecologist, Family Planning Inc. and the separate representative all preferred a trial with a Mirena device over a hysterectomy at this stage.

33. The Mirena device is placed in the uterus and releases small continuous quantities of progestogen for up to five years. The Obstetrician and Gynaecologist reports:

> "This can be inserted under a short general anaesthetic as a Day Procedure case and M would be able to go home soon after its insertion. This on average reduces menstrual flow by 95% and most women who have had it in 4-6 months become amenorrhoeic. There is usually a significant reduction in menstrual loss from the time it is inserted although a significant percentage do experience some spotting for a few months following its insertion."

34. Many insertions of the Mirena device can be performed without anaesthetic, however M would require a short anaesthetic because of her uncontrollable behaviour and potential distress. The separate representative pointed out that the insertion occurs with no wound to heal, no dressings and, therefore, reduced distress to M. The Obstetrician and Gynaecologist also stated that inserting a Mirena device is less traumatic than surgery and the safest option.

35. Conversely, the Consultant Psychiatrist said:

> "Unfortunately Mirena contains leronorgestrel. This is a compound similar to that which was in the contraceptive pills that M has tried, with such adverse effects on her behaviour. … I would say it is certainly a possibility that adverse behavioural effect could occur due to the progestogen effect in M."

36. Consistent with their views about OCP's and analgesic preparations, Mr and Mrs G submitted that the "… Mirena would be continuing 'invasions', spreading

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foreign substances around her body for years to come." and have concerns that it will cause pain anxiety and temper outbursts in a manner similar to the OCP.

37. Mr and Mrs G also pointed to the deficit of long term studies of the effects of the Mirena device, believing that M would be a 'guinea pig' until such time as long term (35 to 40 years) have concluded. They disliked the fact that such a procedure must be repeated every 5 years and the inconvenience and distress that might cause for M. They stated:

> "Each hospital visit with the Mirena would be horrendous for M, as she can only understand that people are interfering with her in a way she does not want."

38. The Mirena device is not experimental, it is an approved contraceptive treatment. There are risks of rejection of the device, and should M contract a pelvic inflammatory disease, the consequences of that disease are worse with the Mirena device but abate after its removal. The Consultant Psychiatrist commented that adverse effects of the Mirena device:

> "… include Menorrhagea and that the adverse reactions include the behavioural effects of headache, depressive moods and fatigue which may be expressed in M by increased agitation and possibly aggression."

39. The Obstetrician and Gynaecologist's evidence at the hearing was that because the Mirena device is inserted locally, it contains smaller doses of hormones. OCP's necessarily have higher doses because they are required to withstand the digestive processes before entering the blood stream and circulating to the uterus. With a Mirena device, very little of the hormone is absorbed in circulation resulting in lower incidence of side effects associated with OCP. For this reason, the Mirena device is used for women who, like M, cannot tolerate the side effects of the OCP.

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40. The Division gave careful consideration to issues raised by Mr and Mrs G about the impact of M's tactile defensiveness upon her ability to tolerate the insertion of a Mirena device.

41. Tactile defensiveness manifests as an inability to adequately screen out extraneous tactile stimulation causing the sufferer to perceive tactile sensations as extreme and uncomfortable. M's brain may register subtle sensations as extreme irritation or even pain and she may respond in an abnormally reactive way. Her parents speculated that this hypersensitivity might mean that she will be able to 'feel' the device after insertion. The Obstetrician and Gynaecologist gave evidence that the only source of pain would be possible cramping in the first day or two after insertion. There is no evidence that allows the Division to conclude that M would be able to detect or feel the device once inserted.

42. When asked whether the attempts at use of OCP had lead to any increased or lasting trauma for M, the Consultant Psychiatrist stated that she was not aware of any. She was also not aware that a trial with the Mirena device would lead to any long term trauma for M, should it prove to be unsuccessful, apart from the potential for possible aggressive behaviours to undermine M's relationship with her carers.

43. The Obstetrician and Gynaecologist considered that, equal to a hysterectomy, the insertion of the Mirena device will have a positive effect upon pre-menstrual symptoms.

44. In the hearing the Obstetrician and Gynaecologist confirmed that should a Mirena device be tried and found to be unsuccessful for M, the reversal procedure is as

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simple as the insertion. Once removed, the device ceases to have effect immediately.

45. The Division concluded that a trial with a Mirena device is likely to have markedly better results than the trials with OCP. The Division also noted that, short of appointing an independent guardian (which was only briefly touched upon at the hearing and no person has given consent to appointment for the purposes of section 46(2)), it has no means to order treatment with a Mirena device or to demand a trial with that device should the parents not wish to observe that recommendation.

46. (e) Hysterectomy: The Consultant Psychiatrist, the family's General Practitioner and the applicants see the long term nature of hysterectomy having the greatest benefit for M. A hysterectomy is the surgical removal of the uterus. Because the ovaries are not included in a hysterectomy, ovulation and hormonal production remain the same, but do not result in menstrual bleeding or menstrual pain. Removal of ovaries is not sought nor is it a realistic option, due to the acceleration of the onset of menopause, risks of osteoporosis and other complications.

47. The Consultant Psychiatrist and the Obstetrician and Gynaecologist agreed that, when a person experiences pre-menstrual syndrome, stopping periods by hysterectomy will alleviate pre-menstrual behavioural problems. However the Obstetrician and Gynaecologist was of the opinion that:

> "… if there's no definite pre-menstrual syndrome then I would have thought doing a hysterectomy would have little effect on her behaviour."

In the previous application a paediatric and adolescent gynaecologist expressed the following opinion:

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> "Thus undertaking a hysterectomy (ie preventing all further bleeding) with conservation of the ovaries may not solve all problems, as the hormone levels will continue to do their usual ups and downs."

The Consultant Psychiatrist expressed this slightly differently:

> "Pre-menstrual discomfort which presumably contributes to her increased behavioural disturbance pre-menstrually will resolve. Her ovaries will be preserved and so her level of behavioural disturbance that increased with menarche will remain but the increased aggressiveness which occurred with attempts to use hormonal control will not occur."

48. The Division concludes that a hysterectomy will control pre-menstrual behaviour to some extent but will not alleviate all hormonal behavioural responses.

49. A hysterectomy is not reversible.

50. A hysterectomy is a valid and appropriate procedure when indicated. After hysterectomy and in the absence of any complications, there would be no bleeding, no need for follow up examinations or treatment. As reported by Mr and Mrs G: "Once the surgery is completed, the issue of menstruation disappears and it never has to affect M again." The option of hysterectomy being a one-off long-term solution is very important for Mr and Mrs G.

51. The Consultant Psychiatrist took a holistic view of M's circumstances and thus stated:

> "…it's very important that the parents be maintained at a level that they can continue to manage M. They care for her in a loving, responsible and humane fashion. M would suffer in a very significant adverse manner should her parents capacity to care for her be reduced. It is already evident that mother has shown a direct adverse effect on

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> her mental health as a result of M's increased aggression. For all of the above reasons I would recommend that M have a hysterectomy to permanently prevent menstruation. M's frequent heavy menstruation will cease. The stress of trying to teach her to manage it (which has not developed over two years to any significant extent) will be removed. The extra stress caused to her by other people managing her menstruation will be removed. … Increased stress on mother which directly affects M's future security and comfort, will be resolved."

52. Because M is a young woman and has not had children, a hysterectomy would be performed by means of an abdominal incision. In some cases, the procedure can be undertaken vaginally, involving less incision and less post operative pain but this option is unavailable for M generally being most appropriate for women who have borne children. An abdominal incision would necessitate 4 to 5 days admission to hospital. Significant post-operative pain would require regular narcotic injections and an intravenous drip. M would most likely require extensive post-operative sedation. This post operative period is anticipated by the Obstetrician and Gynaecologist to be a difficult situation for M, her family and ward staff. The Consultant Psychiatrist addressed post-operative distress but concluded that the reasons for hysterectomy (stated above) outweighed the disadvantages of the short-term distress.

53. A hysterectomy brings with it many risks including pulmonary embolus, which can be fatal, and the risk of pro-lapse. The Obstetrician and Gynaecologist stated at the hearing that there is also a risk of the onset of menopause being brought forward some years earlier than normal due to the removal of the uterus.

54. The Obstetrician and Gynaecologist reported that she would be unwilling to perform a hysterectomy unless there has been an unsuccessful trial of a Mirena device. In the hearing she confirmed that this was a matter of professional responsibility for her and would be the case regardless of the Division providing consent for the procedure. The Obstetrician and Gynaecologist's opinion resulted

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from a request by the family's regular general practitioner. Parts of the application name Dr K, who has subsequently retired, and Dr D, about whom the Division has no other recent information, as practitioners who would perform the procedure. Accordingly, should the Division give consent to treatment without a trial of the Mirena device, in the immediate term we would not have details of the registered practitioner who would carry out the treatment, nor the date, time and place of proposed treatment, and other matters provided for in Regulation 9.

55. Section 11(2)(a) of the Act states that the Board "must, in hearing any matter, act according to equity and good conscience without regard to technicalities and legal forms." A deficit in the written application is not a fatal flaw. However, to accord equity and good conscience, the Division would have to be satisfied that a nominated practitioner was suitable and sensitive to the M's particular needs before giving consent to the procedure. Thus, in the absence of a suitable nominated practitioner, a hysterectomy is not a viable option at this time as consent would be speculative.

The consequences to M if the treatment is not carried out:

56. Physically M is not at any risk from continued menstruation, there are no abnormal pathologies and no obvious anaemia. Not performing a hysterectomy eliminates the risks of post-operative complications and will have no effect upon the commencement of menopause.

57. M's parents have invested a significant amount of time and energy in seeking the consent of the Board for sterilisation of their daughter during two applications. Following the first application, at which the Mirena device and other alternatives were discussed, they proceeded with two trials of OCP, which they termed as

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disastrous. It is reasonable to assume that if they did not proceed with a trial of the Mirena device following the last hearing, they may not on this occasion either, especially given their belief that M will be at risk because of the lack of long-term studies of its effects.

58. At the hearing the Division directed questions to Mr and Mrs G about experimenting with the use of analgesics, such as Naproxen, and it was clear that they would not use such substances for Mrs G or her other daughter L, let alone for M with their fears for her sensitivity.

59. It is reasonable to assume that if the Board does not give consent to a hysterectomy, M will proceed to menstruate for 6 days every 17 to 21 days and experience emotional, behavioural and physical distress. She will continue to require antipsychotic preparations to control her behavioural disturbance, the proven side effects of which are weight gain and its concomitant risks. Additionally her social support systems will continue to be undermined by the burdens that menstrual management will have upon her family, particularly her mother. While M’s menstrual cycle may vary over time, it is also possible that this will continue for 35 to 40 years.

Is the proposed treatment the ‘least restrictive alternative’?

60. Menstruation clearly undermines M’s freedom of decision and action. Presently, it undermines her relationships with her direct carers, creates stress and occasionally havoc within her home and prevents her from pursuing favourite activities such as swimming. The least restrictive alternative for M will be one that promotes her ability to remain living with her parents and siblings and potentially enhances those relationships.

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61. Effectively, consideration of the alternative treatments and M's best interests, can be isolated to a comparison between the insertion of a Mirena device and performing a hysterectomy.

62. The proposed hysterectomy will cause short-term post-operative restriction (i.e. sedation, management of the wound), which is significant. The level of anaesthetic required for the procedure presents risks. Once healed, the procedure is finalised and there are no ongoing gynaecological issues, however hormonal fluctuations of mood and behaviour will remain due to the presence of the ovaries. A hysterectomy can only be guaranteed to eliminate one source of stress in the G household, bleeding. At the hearing, Mr G stated that elimination of bleeding would still be a "pretty major change" and while it is in their view the best option, Mr and Mrs G simultaneously stated "there's no good option."

63. Insertion of the Mirena device which will also eliminate bleeding presents as a less restrictive option for M because it is (i) totally reversible, (ii) does not involve removal of an organ, (iii) requires shorter term anaesthetics and post operative restriction, (iv) has no impact upon menopause and most importantly (v) is reasonably likely to have the combined effect of contraception, amenorrhea and regulation of the hormonal cycles.

64. Insertion of the Mirena device presents as restrictive from the perspective that its effectiveness is limited to 5 years and therefore may require repetition.

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Best interests:

65. The majority of the High Court in *Secretary, Department of Health and Community Services* v *J.M.B. and S.M.B (Marion's Case)* [1992] HCA 15; (1992) 175 CLR 218 said

> "The function of a court when asked to authorise sterilisation is to decide whether, in the circumstances of the case, that is in the best interests of the child. We have already said that it is not possible to formulate a rule which will identify cases where sterilisation is in his or her best interests. But it should be emphasised that the issue is not at large. Sterilisation is a step of last resort. And that, in itself, identifies the issue as one within narrow confines.
>
> In the context of medical management, "step of last resort" is a convenient way of saying that alternative and less invasive procedures have all failed or that it is certain that no other procedure or treatment will work. The objective to be secured by sterilisation is the welfare of the disabled child. Within that context, it is apparent that sterilisation can only be authorised in the case of a child so disabled that other procedures or treatments are or have proved inadequate, in the sense that they have failed or will not alleviate the situation so that the child can lead a life in keeping with his or her needs and capacities.
>
> It is true that the phrase "best interests of the child" is imprecise, but no more so than the "welfare of the child" and many other concepts with which courts must grapple. As we have shown, it is confined by the notion of "step of last resort", so that, for example, in the case of a young woman, regard will necessarily be had to the various measures now available for menstrual management and the prevention of pregnancy. (*Case names and references omitted*) And, if authorisation is given, it will not be on account of the convenience of sterilisation as a contraceptive measure, but because it is necessary to enable her to lead a life in keeping with her needs and capacities. With the range of expertise available to them, judges will develop guidelines to give further content to the phrase "best interests of the child" in responding to the situations with which they will have to deal."

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66. The Division notes the judgment of Justice Warnick in the 1995 Family Court case, *In the Matter of Katie* (1996) FLL 92-659 which states:

> "It is not that every possible management technique, whether accompanied by undesirable features or risks to health, must be tried before authorisation can be given."

67. For that reason, the Division has not required proof that the entire range of contraceptives (Implanon, Depo Provera) was tried and proven to fail. However, should an option present as equal to or better than hysterectomy the Division cannot overlook that alternative.

68. Many of the reasons advanced for a hysterectomy relate to the needs of her parents and siblings. The Division acknowledges that the best interests of M's family are intricately bound up with M's best interests. To paraphrase Justice Warnick in *In the Matter of Katie* "The procedure would benefit the parents in that it would meet what [the Division assesses] to be their genuine beliefs that hysterectomy is best for [M]. It would constitute an emotional burden on the parents for the procedure to be unauthorised, so long as the parents remained of the belief that alternatives did not carry the same benefits for [M]."

69. It is important to note that while there are many similarities between the case considered by Justice Warnick and the present one, that case does not discuss the option of the Mirena device, and it is likely that the relatively new device was not available for consideration by the Family Court in 1996.

70. The G family are clearly stressed, overwrought, under-supported and looking for some solution that meets both M's needs and their belief system. Their willingness to experiment with a range of treatment options for M, is compromised by M's hypersensitivity to certain substances. They are also reluctant to trial M on medications that are not proven in longitudinal studies.

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71. That reluctance results in a refusal to consider use of a Mirena device and analgesics for period pain. In the absence of consideration of the Mirena device, the only practicable option for producing amenorrhea is a hysterectomy.

72. Considering M's needs separate to those of her family, the issue of her pre-menstrual and menstrual behavioural disturbance and pain is as important as control of bleeding. While granting consent for a hysterectomy may appease major concerns of the parents about bleeding, methods for control of behaviour after a hysterectomy will be limited to the use of the antipsychotics which are already having negative effects upon M's health because of weight gain.

73. The Division takes into account the fact that M is very young and has been menstruating for 27 months. If left untreated, she would continue to menstruate for 35 to 40 years. In 27 months, only 2 attempts at hormonal control have been made, lasting only 4 months in total. Use of simple non-prescription pain relief has not been attempted.

74. The Division also takes into account the fact that, if it gave consent, no registered practitioner has been identified to undertake the procedure, neither has a time and place of operation. If the Division gave consent, it would do so without being able to satisfy itself that the registered practitioner was appropriately qualified to undertake the procedure in M's best interests and with appropriate levels of post-operative care.

75. The Division has contemplated the judgment in *Briginshaw v Briginshaw* (1938) 60 CLR 336. We conclude from it that we must be satisfied upon convincing evidence that the procedure is justified. Applications for sterilisation are amongst the most weighty that the Board must consider within its jurisdiction. It is

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appropriate that we take into account the gravity of the consequences flowing from a finding for or against giving consent.

76. The Division also adopts the ratio of the High Court in *Marion's case* that we must be certain that no other procedure or treatment will work. Given the narrow range and brevity of previous attempts and the lack of pain management, the Division is not in a position to say that no other treatment will work. Adopting both tests, we cannot say that the procedure is justified while the Mirena device remains untested.

77. The Division was deeply moved by the conundrum that faces Mr and Mrs G and their family. We gave consideration to granting conditional consent, subject to receiving a report of any trial and subsequent failure of the Mirena device and the nomination of a suitable registered practitioner who would perform the procedure.

78. The Act appears to provide the Division with only two options; to grant or refuse consent to special treatment with section 46 allowing further or continuing treatment occurring with the consent of an appointed guardian. Section 46 does not apply to these circumstances. Accordingly, unlike Parts 4 and 7 of the Act that allow orders to be made with conditions, section 45 only allows a grant or refusal of consent and no conditional consent is possible.

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THE BOARD ORDERS

1. The application is dismissed.

2. In accordance with section 13(2) of the Act, the Division considers that it is in the public interest that this statement of reasons, altered so as to remove any particulars that may lead to the identification of any witness or party to the proceedings, may be published. Accordingly, the Board will produce an approved de-identified version of this statement of reasons for publication.

Anita Smith	Ruth Hanson	Catherine Wilding
PRESIDENT	VICE PRESIDENT	BOARD MEMBER

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