

Children with differences of sexual development would almost invariably reach a stage of being competent independently to make decisions and choices relating to whether they need or wish to undergo genital or gonadal surgery. They would make competent or capacitous decisions (depending on their age at the time) in just the same way as they would when faced with any other intervention. The decision would be based upon a disclosure of the benefits, risks and complications entailed; and of the alternatives (including the alternative to do nothing at all) open to them.

But until this competence or capacity is reached, those with parental responsibility have a central role in decision making, although the scope of PR diminishes as the child approaches the stage where he or she can make decisions independently. Thus whilst the valid consent of the competent child or young person with capacity is sufficient to make genital or gonadal surgery lawful, the position of the dependent child is less clear cut, irrespective of any consent provided by those with parental responsibility.

In the phase when a child with a difference of sexual development is dependent on others for medical decisions to be made, the common law provides guidance as to how his or her best interests will be determined. When confronted with decisions as to whether life sustaining treatment should be withdrawn, early cases settled on the concept of 'intolerability as the talisman for recognising that cessation of treatment was lawful. But it was quickly recognised that creating a decision threshold on the basis of an overall 'impression' of the clinical situation risked over-simplification of usually complex facts. In its place, the balancing exercise was adopted, where the multifarious contributors to a child's welfare could be identified. Once collected, the influence of these elements to the decision in question, whether supporting or opposing action, can be weighed against each other. It is the sum of their individual weights, rather than the number of separate elements, that need to be accounted for.

This is because the child's welfare is the paramount consideration, and it will not necessarily follow that the child's best interests are consistent with a parental assertion that surgery is indicated. In many cases, the parents view may perfectly coincide with their child's interests, but not necessarily so. For example, those with parental responsibility may hold an entrenched view that female genital surgery is consistent with cultural inclusion, but this is proscribed by law in England, considered antithetical to the child's welfare. Cultural circumcision of the incompetent boy requires the consent of both parents, a proportionate step to make it more likely that the motive for surgery is cultural inclusivity rather than based on less substantial grounds. In the same way, parental certainty that the external genital appearance will be anathema to the social or cultural acceptance of a child with a difference of sexual development may have weight in terms of the impairing the ability of the mother and father to embrace the child into their family. But whilst this burden may be tangible and weigh in favour of intervention, so the pending wishes of the future competent child may weigh equally (or with greater weight) against intervention, favouring preservation of their congenital anatomy.

As in all cases where a child's welfare must be determined, a near-literal 'balancing act' must be performed. It must be acknowledged that the balance sheet is more usually employed in cases where the question at issue is whether life-sustaining treatment should be continued. But application of this principle in accumulating the benefits and disbenefits of surgery in the child with DSD in front of you; and finding

where the balance settles; and then cross referencing this result with a similar exercise to balance benefits and disbenefits of non intervention should result in a near-objective assessment of where the child's best interests lie.

It can be seen how widely the net to catch elements which may constitute best interests must be cast, encompassing all aspects bearing upon a child's welfare. In this way, the relevant weight of disparate contributions to the balancing act such as perceived urgency of the need for intervention versus the entirely speculative view of what the putative capacitous young person will see as their natural phenotype may be impossible to assess. But many other contributors to welfare will be more easily identified, and the balancing act has now proven its worth in countless cases in the Family court.

Placing relevant elements into the balance pan allows their individual scrutiny; aspirations to make a child 'more normal', or to adjust 'atypical' to 'typical' are plainly vague. But when considered in the context of the specific child in front of you with their unique set of facts, anticipating the realistic benefits and risks which could accrue from resolving/ameliorating anatomical discordance can make decision making more straightforward. Involvement of the family (and where possible the child) allow the non-medical aspects of the patient's welfare to be identified, and accounted for within the balancing exercise.

An obvious example is the parents approach to virilised genitalia in a genetic girl. Quite plainly, even looking (as we are instructed in Wyatt) through the eyes of the child into their putative era of sexual awareness, we can have no certainty as to what the child's attitude will be. Nonetheless, the acceptance of the uncertainty is helpful, since if completion of the balance sheet reveals biological or sociological certainties of tangible harm associated with a particular therapeutic option, it is likely that this should exceed the weight of future uncertainty.

What Resolution 2191 7.1.1- 2 of the PACE fails to consider is the possibility that this balancing exercise will reveal that surgery is in the child's best interests. This is another example of using a talisman (this time, the prohibition without informed consent or child participation) without considering the wider welfare of the patient.