

Comment,
AMBIGUOUS GENITALS & SOCIETAL
DISDAIN: A CASE FOR A PROHIBITION OF
MEDICALLY UNNECESSARY, COSMETIC
GENITAL NORMALIZATION SURGERIES
ON INFANTS AND CHILDREN

Approximately five infants and children born with ambiguous genitalia are subjected to genital normalization surgery in the United States each day.¹ This practice originated from a disproven theory that sex and gender identity could be changed if an infant's genitals were reconstructed to appear male or female.² This form of treatment for individuals with intersex traits has proven to have disastrous physical and emotional consequences for the remainder of their lives. Even worse, this treatment unnecessarily infringes upon the fundamental rights of bodily integrity and procreation and the right to be free from discrimination on the basis of sex for these individuals. Since many of these surgeries are performed on infants and children, they have no ability to contribute to the decision. Despite the original theory having been disproven and widespread condemnation for the practice, genital normalization surgery is still the standard medical treatment for those born with ambiguous genitalia.³

Part I of this Comment will define intersexuality and the many forms the condition takes. Part II will describe genital normalization surgery, the consequences of surgery, and the methods used today. Part III will demonstrate the support for genital normalization surgery and Part IV will argue against the practice.

¹ Marcus de Maria Arana, S.F. Human Rights Comm'n, A Human Rights Investigation into the Medical "Normalization" of Intersex People 23 (2005), https://ihra.org.au/wp-content/uploads/2009/03/sfhrc_intersex_report.pdf.

² See generally *I Want to Be Like Nature Made Me*, HUMAN RIGHTS WATCH (July 25, 2017), <https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us> (last visited Feb. 28, 2020).

³ See Peter A. Lee et al., *Global Disorders of Sexual Development Update Since 2006: Perceptions, Approach and Care*, 85 HORMONE RES. PAEDIATRIS 158, 173-76 (2016).

Part V will define the rights of the parent and child with the duties of the physician. Part VI will describe proposals touted by opponents to eliminate the practice of genital normalization surgery. Part VII will explain ways in which to bring about legal reforms to the treatment of children with ambiguous genitalia.

I. Defining Disorders of Sexual Development and How the Condition Is Treated

Disorders of Sexual Development (“DSD”) or intersexuality is an “umbrella term” that describes a range of characteristics that lead to ambiguity about someone’s biological sex.⁴ The condition mixes fundamentally masculine anatomy with fundamentally feminine anatomy.⁵ The difficulty in identifying whether someone is intersexual is that there is no universal agreement on what characteristics are “fundamental” to the male or female sex.⁶ Someone’s sex is comprised of chromosomes, hormones, genital structures, and gonads.⁷ If any of these do not “match” as all male or all female, it can result in additional, secondary variations in the body.⁸ These include characteristics that aren’t typically considered sexual such as “muscle mass, hair distribution, breast development, hip-to-waist ratio, and stature.”⁹

The most obvious and well-known characteristic of an intersex person is having ambiguous genitalia that does not look like a “normal” male or female.¹⁰ However, other common variations include: a female infant with an abnormally large clitoris or without a vaginal opening; a male infant with an abnormally small penis or a scrotum that forms more similarly to a labia; a child with external anatomy of one sex and internal anatomy of the other; a child with chromosomal abnormalities such as XXX, XXY, XYY, or different chromosomal compositions in different

⁴ Pat Newcombe, *Blurred Lines—Intersexuality and the Law: An Annotated Bibliography*, 109 *LAW. LIBR. J.* 221, 222 (2017).

⁵ Alice Domurat Dreger, “*Ambiguous Sex—Or Ambivalent Medicine? Ethical Issues in the Treatment of Intersexuality*,” 28 *HASTINGS CTR. REP.* 24, 26 (1998) (hereinafter Dreger, *Ethical Issues*).

⁶ *Id.* at 26.

⁷ Newcombe, *supra* note 4, at 227.

⁸ *Id.*

⁹ *Id.*

¹⁰ *See id.*

tissues of the body; or a child with congenital conditions like androgen insensitivity syndrome or hypospadias.¹¹ With all these variations, many of which are not discovered until puberty or adulthood, it is difficult to identify when someone is intersex at birth, unless they are born with ambiguous genitalia.

It is unclear how many people are born with intersex traits. Older but still prevalent statistics indicate about 1 in every 2,000 children born each year have some form of intersex trait.¹² Critics argue that the statistic is inaccurate because it only considers one intersex trait, ambiguous external genitalia, in its calculation.¹³ Intersex rights activists argue that it is impossible to conduct a true census because of the variations intersex traits take and the delay in discovering the condition.¹⁴ However, activist groups like the Intersex Campaign for Equality estimate the birth rate is 1 in every 1,500 children, making the condition as common as having red hair.¹⁵

Identifying and naming the condition comes with additional difficulty. Originally, society deemed intersex people hermaphrodites or pseudo-hermaphrodites depending on the severity of their genital abnormality.¹⁶ Today, the most common name is intersex. Some advocacy groups do not support either term because they consider both terms as imprecise and inappropriate for labelling the person rather than the medical condition.¹⁷ Other advocacy groups denounce the medical term “disorders of sexual development” for stigmatizing people born with the condition as having a disorder.¹⁸ For these reasons, no consensus exists on what term is most appropriate to use.

Intersex rights groups are incorrectly conflated as being part of the transgender community. They are not. Transgenderism and the activism surrounding it have to do with someone’s self-

¹¹ *Id.* at 227-28; Dreger, *Ethical Issues*, *supra* note 5, at 26-27.

¹² Hida, *What Is Intersex?*, INTERSEX CAMPAIGN FOR EQUALITY (Apr. 6, 2013), <https://www.intersexequality.com/intersex/>.

¹³ *Id.*

¹⁴ See Samantha S. Uslan, Note, *What Parents Don’t Know: Informed Consent, Marriage, and Genital-Normalizing Surgery on Intersex Children*, 85 IND. L.J. 301, 301 (2010); See also Hida, *supra* note 12.

¹⁵ Hida, *supra* note 12.

¹⁶ Newcombe, *supra* note 4, at 222.

¹⁷ *Id.*

¹⁸ *Id.*

identity as a man or woman, and the subsequent right to live how he or she self-identifies.¹⁹ Intersexuality is being born as neither completely male or female and being raised to fit a particular mold.²⁰

This molding involves raising a child as a boy or girl, even when the physical characteristics of one's body do not match the assigned sex. Most children born with intersex traits do not require immediate surgery for their health and wellbeing.²¹ This is especially true for children born without ambiguous genitalia. For children born with abnormal genital appearance, the medical standard recommends that parents consent to genital normalization surgery on their child's behalf. This is a cosmetic surgery, or more often a series of surgeries, which make the child appear as normal as possible and align a child's genital appearance with the internal characteristics the child most possesses.²²

II. Primary Treatment Protocol: Genital Normalization Surgery

A. *Origins of Genital Normalization Surgery*

Before the late 1800s, only the most extreme sexual abnormalities were recorded.²³ During this time, sex was determined by a person's gonads. Since medical technology was primitive, gonadal examinations were not possible unless done during autopsy, so many abnormalities went unnoticed.²⁴ Therefore, there was no treatment for someone born with intersex traits.

This gonadal focus continued until the 1950s when sex determination shifted to the appearance of external genitalia.²⁵ During this time period, there was increased awareness and fear over sexual variation and homosexuality, leading to stigma, shame,

¹⁹ Robert Hupf, *2015 Special Issue: Advancing LGBQIA Rights in a Post-Obergefell World: Allyship to the Intersex Community on Cosmetic, Non-Consensual Genital "Normalizing" Surgery*, 22 WM. & MARY J. WOMEN & L. 73, 80 (2015).

²⁰ *Id.* at 78.

²¹ *Id.* at 80.

²² *Id.*

²³ Dreger, *Ethical Issues*, *supra* note 5, at 26.

²⁴ *Id.*

²⁵ Newcombe, *supra* note 4, at 222.

and secrecy for those who were born with atypical genitalia.²⁶ As the medical field advanced and surgical techniques were created, there was an opportunity to “correct” the existing genitalia of infants to be more socially and cosmetically acceptable.²⁷ In addition, the work of Dr. John Money advanced the theory that humans develop sexual identity based entirely on learned behavior. By molding the ambiguous genitals of an infant at birth and subsequently raising the child as the sex assigned to him or her, the child could grow to avoid feelings of confusion over sex or gender identity despite any differences in chromosomal or hormonal make up.²⁸

Dr. Money advanced this theory with his now-famous “John/Joan” case. His test subject, David Reimer, was accidentally castrated during circumcision. Under Dr. Money’s direction, doctors removed David’s testicles, and his remaining genital structures were reconstructed to appear female despite David having male hormonal levels and male chromosomes.²⁹ David’s parents were instructed to raise David as a girl alongside his twin brother. Despite David growing to question his sex and gender identity, Dr. Money published this study touting it as a successful sex assignment.³⁰ Later, when David was fourteen, he threatened suicide if he could not live as a man.³¹ It was then that his parents disclosed all that had happened to him as an infant.³² As an adult, David committed suicide.³³

Despite the tragic ending to the case, and despite it not being a case of congenital intersexuality, the “John/Joan” case was used to convince physicians that sex-assignment surgery on infants would successfully lead to their integration into the male or female sex.³⁴ Genital normalization surgery became the standard medical care for infants born with ambiguous genitalia.

²⁶ *Id.* at 223.

²⁷ Hupf, *supra* note 19, at 80.

²⁸ *Id.*; Newcombe, *supra* note 4, at 222-23; Uslan, *supra* note 14, at 302.

²⁹ Hupf, *supra* note 19, at 81.

³⁰ Uslan, *supra* note 14, at 302.

³¹ *Id.* at 302-03.

³² *Id.* at 303.

³³ *Id.* at 303.

³⁴ Dreger, *Ethical Issues*, *supra* note 5, at 25.

“Traditionally, the choice has been which gender to assign the baby, not *whether* to perform genital normalization surgery.”³⁵

B. *Methods of Genital-Normalization Surgeries*

1. *Decision of What Sex to Assign the Infant*

In the beginning, sex assignment was based upon the child’s chromosomes and the presence and size of the phallus.³⁶ If the child had a Y chromosome, he was genetically male; therefore, he was raised as a male if the length of the present phallus could be stretched to greater than 2.5 centimeters, or one inch.³⁷ Surgeries, hormones, and other treatments would be used to make the phallus appear “believable.”³⁸ Teams of doctors would then be used to maintain that believability after genital normalization surgery as the child matured throughout childhood and adolescence.³⁹ Treatment would also include surgeries on analogous body parts like breasts during adolescence.⁴⁰ Throughout the infant’s adolescence and adulthood a “cocktail” of hormones would be used to prevent the body from reverting to the natural sex.⁴¹

If the size of the phallus was less than 2.5 centimeters, the child would have feminizing genital normalizing surgery, regardless of chromosomes or a phallus.⁴² Surgeons would reconstruct the phallus to look like a clitoris, build a vulva and vaginal opening, and remove any testes or other male tissues.⁴³ Before any reforms took place, this technique was done even if it meant ster-

³⁵ Emily Greenhouse, *New Era for Intersex Rights*, NEW YORKER (Dec. 30, 2013), <https://www.newyorker.com/news/news-desk/a-new-era-for-intersex-rights> (emphasis in original).

³⁶ See Dreger, *Ethical Issues*, *supra* note 5, at 27; Uslan, *supra* note 14, at 305.

³⁷ Alice Domurat Dreger, *A History of Intersexuality: From the Age of Gonads to the Age of Consent*, 9 J. CLINICAL ETHICS 345, 349 (1998) (hereinafter Dreger, *History of Intersexuality*).

³⁸ *Id.*

³⁹ Dreger, *Ethical Issues*, *supra* note 5, at 27.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² Dreger, *History of Intersexuality*, *supra* note 37, at 349.

⁴³ Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* 181, 182 (1998) (hereinafter Dreger, *Hermaphrodites and the Medical Invention of Sex*); Uslan, *supra* note 14, at 306.

ilizing the infant, because “adequate” penis size and sexual function were treated as more important for boys than potential fertility and parenthood.⁴⁴

For girls, the emphasis was placed on preserving fertility, even if it meant a loss of sensation, sexual function, or bodily control and incontinence.⁴⁵ Surgeons considered larger clitorises to be “cosmetically offensive.”⁴⁶ Therefore, a baby’s clitoris was surgically reduced so it would not be visible when standing and so the organ would look more “feminine and delicate,” even when it meant permanently desensitizing the organ.⁴⁷ This practice was designed when gender roles were more stereotyped than they are today and this practice was used to force infants into a gender binary society where women were meant to be mothers and men were meant to be sexual beings.⁴⁸

2. *Post-Operative Consequences*

The consequences of surgery can be severe. Genital normalizing surgeries can result in complete or partial scarring, loss of sexual function, inability to experience sexual pleasure, and sterility.⁴⁹ In some cases, these surgeries are so destructive to the function of the genitals that it is difficult to call these surgeries “genital normalizing.” The experience of surgery can leave infants and children open to complications such as frequent urinary tract infections, incontinence, and increased need for invasive medical examinations.⁵⁰ Post-operative care requires follow up physician examinations throughout childhood, both to ensure proper healing and to ensure the growth of the child aligns with the adequate and believable maturation of the genitals.⁵¹ These

⁴⁴ Dreger, *Hermaphrodites and the Medical Invention of Sex*, *supra* note 43, at 182.

⁴⁵ *See id.*

⁴⁶ Dreger, *Ethical Issues*, *supra* note 5, at 28.

⁴⁷ *Id.*

⁴⁸ Uslan, *supra* note 14, at 306.

⁴⁹ *See id.* at 307.

⁵⁰ *See* Alison Davidian, *Beyond the Locker Room: Changing Narratives on Early Surgery for Intersex Children*, 26 WIS. J. L. GENDER & SOC’Y 1, 11 (2011).

⁵¹ *See* Dreger, *History of Intersexuality*, *supra* note 37, at 349 (“they can make it look like what they think a penis should look like . . . doctors will examine the child at regular intervals and work – using surgical and endocrino-

examinations have been emotionally traumatizing for children who say these exams are intrusive and communicate to them that they are not normal compared to other children.⁵²

3. *Disclosure About the Condition to Families*

According to Dr. Money's theory, genital normalizing surgery would only be successful in eliminating sexual identity confusion if the parents, family, and community raised the child to be the assigned sex. Any confusion the relatives would have about the condition might be conveyed to the child and result in psychological distress and identity dysphoria.⁵³ As one expert put it, "talking truthfully with intersexuals and their families will undo all the 'positive' effects of the technological efforts aimed at covering up doubts."⁵⁴ In the beginning, this meant doctors did not provide full and complete information to parents about their child's condition.⁵⁵ Doctors would explain that there was not an issue with the infant's sex; the trouble was in the doctor's ability to determine the sex.⁵⁶ After additional testing, the doctor would be able to learn the "correct sex" and help "finish" the sexual development.⁵⁷ This deceptive explanation implied to parents that more gestational time would have resulted in unambiguous sex organs.⁵⁸ It also implied that doctors and surgeons were not changing anything fundamental about the child, when in reality they were reconstructing the appearance of a normal sexual anatomy for a child that did not align with other charac-

logical technologies – to make him look like a 'true boy.');" Uslan, *supra* note 14, at 307-08.

⁵² Dreger, *Ethical Issues*, *supra* note 5, at 30; Dreger, *History of Intersexuality*, *supra* note 37, at 353; Porter Gale & Laleh Soomekh, XXXY, Stan. U. Dep't of Comm. (2000); Uslan, *supra* note 14, at 307-08, <https://www.youtube.com/watch?v=KHSxBLfrgxg>.

⁵³ See Dreger, *Ethical Issues*, *supra* note 5, at 27.

⁵⁴ *Id.* at 31.

⁵⁵ Hazel Glenn Beh & Milton Diamond, *An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?*, 7 MICH. J. GENDER & L. 1, 48 (2000).

⁵⁶ Dreger, *Ethical Issues*, *supra* note 5, at 28 (quoting Suzanne J Kessler, *The Medical Construction of Gender: Case Management of Intersexed Infants*, SIGNS 16 (1990)).

⁵⁷ Dreger, *Ethical Issues*, *supra* note 5, at 27-28.

⁵⁸ Beh & Diamond, *supra* note 55, at 48.

teristics in the body. This left parents to make medical decisions on their child's behalf without material information.

C. *Modern Treatment Protocol*

1. *New Research on Intersexuality and the Effects of Genital Normalization Surgery*

More studies have been done since Dr. Money's "John/Joan" case that do not support his theory that sexual identity is infinitely pliable.⁵⁹ Brain function and hormonal influences have more impact on gender identity than the appearance of one's genitals.⁶⁰ Some data indicate that the strongest factor in the success of a child's integration into a particular sex is parental attitude. Well-educated and honest parents made for more confident and adjusted children.⁶¹

From medical advancements, more intersex traits are discoverable at birth, and information gathered has shown that most intersex traits pose no immediate health risk, meaning treatment to "correct" these traits can safely be postponed until the child is old enough to be involved in the decision.⁶² The only life-threatening intersex condition is congenital adrenal hyperplasia.⁶³ It is an electrolyte imbalance that results in masculinization of genetically female fetuses.⁶⁴ It can lead to infertility and death if untreated.⁶⁵ Additional research has discovered that the testes of intersex people with androgen insensitivity syndrome have a high rate of becoming cancerous during the person's life.⁶⁶ It is beneficial to diagnose the condition early so the testes can be monitored or removed.⁶⁷ However, these conditions cannot be helped

⁵⁹ See Dreger, *Ethical Issues*, *supra* note 5, at 25.

⁶⁰ JULIE A. GREENBERG, INTERSEXUALITY AND THE LAW: WHY SEX MATTERS 15, 19 (2012).

⁶¹ Dreger, *Ethical Issues*, *supra* note 5, at 29-30 (in a study conducted of 30 people assigned the male sex at birth).

⁶² Joshua C. Albritton, Comment, *Intersexed and Injured: How M.C. v. Aaronson Breaks Federal Ground in Protecting Intersex Children from Unnecessary Genital-Normalization Surgeries*, 24 TUL. J.L. & SEXUALITY 163, 169-70 (2015).

⁶³ See Dreger, *Ethical Issues*, *supra* note 5, at 30.

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

in any way by a cosmetic surgery aimed at “normalizing” the appearance of a child’s genitals. Ambiguous genitalia are simply an indicator of a potential health risk, and not an indication of a medical emergency.

Recent studies also implicate the long-term, negative consequences of genital normalizing surgery on the lives of individuals. These consequences include sterility, loss of or diminished ability to experience sexual pleasure, chronic pain and discomfort, incontinence, lifetime mental and emotional suffering, and impairment of the parent-child and child-doctor relationships.⁶⁸ The growing consensus is that there is no persuasive evidence to support a conclusion that the presumed benefits of normalization surgery outweigh the potential costs.⁶⁹

2. *Medical and Legal Perspective on Genital Normalization Surgery*

The American Academy of Pediatrics continued to claim that intersex characteristics were a “social emergency that required early surgical intervention” until 2006.⁷⁰ This changed when the 2006 Consensus Statement on Intersex Disorders by U.S. and Europeans medical specialists and intersex advocates was published. It advocated for a reserved approach before proceeding to genital surgery.⁷¹ The Consensus Statement also advocated for more open dialogue between physicians and the parents and children.⁷² It recognized the impact surgeries can have on the children’s quality of life and recognized the lack of long-term data on the surgery’s effectiveness.⁷³ The Consensus Statement most notably advocated for the child’s involvement in the decision about whether to have surgery and stated that sur-

⁶⁸ Beh & Diamond, *supra* note 55, at 55; Julie A. Greenberg, *Health Care Issues Affecting People with an Intersex Condition or DSD: Sex or Disability Discrimination?*, 45 *LOY. L.A. L. REV.* 849, 864 (2012) (hereinafter Greenberg, *Health Care Issues*).

⁶⁹ Greenberg, *Health Care Issues*, *supra* note 68, at 864.

⁷⁰ Davidian, *supra* note 50, at 9.

⁷¹ Peter A. Lee, Christopher P. Houk, S. Faisal Ahmed & Ieuan A. Hughes, *Consensus Statement on Management of Intersex Disorders*, 118 *PEDIATRICS* e488, e491 (2006).

⁷² *Id.*

⁷³ *Id.*

geries should focus on maintaining the function of the genitals, including fertility, rather than on cosmetic appearances.⁷⁴

After the Consensus Statement was published, the American Academy of Pediatrics implemented a new policy of a long-term strategy involving several professionals from various occupations working with the family and listed a variety of factors physicians should consider before determining which sex to assign a child. These include the child's chromosomes, genital appearance, surgical options, the potential need for lifelong hormone replacement therapy, potential for fertility, views of the family, and the family's related cultural practice.⁷⁵ This reform still leaves the medical standard as "which gender to assign the baby, not *whether* to perform genital normalization surgery."⁷⁶

In 2016, the American Medical Association moved for a resolution that genital normalizing surgeries should only be performed in the rare case that the intersex traits present a life-threatening anomaly.⁷⁷ The resolution also advocated for the children to participate in the decision making process for surgery once they have grown into their sexual and gender identities.⁷⁸ The National Institute of Health has called genital surgery on infants a "crisis of clinical management."⁷⁹

The strongest condemnation of genital normalization surgery has come from the United Nations. In 2013, the U.N. Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment submitted a report on torture and abuse under the guise of health care.⁸⁰ The report said that genital normalizing surgeries add to the suffering of sexual minorities rather than diminish it, uses science to stigmatize and shame abnormal individuals into social submission, and is tanta-

⁷⁴ *Id.*

⁷⁵ See Newcombe, *supra* note 4, at 224-25.

⁷⁶ Greenhouse, *supra* note 35 (emphasis in original).

⁷⁷ See *I Want to Be Like Nature Made Me*, HUMAN RIGHTS CAMPAIGN (July 25, 2017), <https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us>.

⁷⁸ *Id.*

⁷⁹ *interACT FAQ*, INTERACT, <https://interactadvocates.org/faq/> (last visited Jan. 31, 2020).

⁸⁰ Hupf, *supra* note 19, at 84.

mount to torture.⁸¹ The report called for states to repeal any law allowing unnecessary genital normalizing surgeries.⁸² In 2017, the U.N. Commission on Human Rights' Free & Equal Campaign went a step further to call for a prohibition of unnecessary surgeries and discrimination based on intersex traits.⁸³

Malta is the only country to ban genital normalizing surgery. The Gender Identity, Gender Expression, and Sex Characteristic Act bans unnecessary genital normalizing surgeries, prohibits discrimination based on sex characteristics or atypical sexual characteristics, and provides for a gender-neutral X category.⁸⁴

3. *Today's Approach*

Despite the research on the effects of genital normalizing surgery, the medical boards' recommendations, and the international condemnation of the practice, these findings are not binding on practicing physicians. Little data indicates these recommendations have been adopted by practicing physicians.⁸⁵ It is difficult to change the minds of physicians that genital normalization surgery, the gold-standard of care for these children for the past seventy years, is in fact harming children more than helping them. Physicians continue to operate under the binary male-female sex system, and they want to assign an ambiguous child into one of those two categories.⁸⁶ Subjecting the child to normalizing surgery is still considered the best way to avoid psychological damage, despite the additional emotional and physical damage it can cause.⁸⁷

Still, no medical consensus exists among practicing physicians regarding the appropriate age, procedure, surgical technique, or reasonably acceptable outcome of genital normalizing

⁸¹ Alice Dreger, *Ending Forced 'Genital-Normalizing' Surgeries*, ATLANTIC (Feb. 25, 2013), <https://www.theatlantic.com/health/archive/2013/02/ending-forced-genital-normalizing-surgeries/273300/>.

⁸² Hupf, *supra* note 19, at 84.

⁸³ Free & Equal Campaign, *Fact Sheet Intersex*, UNITED NATIONS COMMISSION ON HUMAN RIGHTS, <https://www.unfe.org/wp-content/uploads/2017/05/UNFE-Intersex.pdf> (May 2017).

⁸⁴ Hupf, *supra* note 19, at 102-03.

⁸⁵ See *interACT FAQ*, *supra* note 79; Newcombe, *supra* note 4, at 225-26.

⁸⁶ See Albritton, *supra* note 62, at 171.

⁸⁷ See Newcombe, *supra* note 4, at 225.

surgery.⁸⁸ However, there is evidence that many doctors reject the theory that it is best to mislead families into believing the child has ambiguities because of a lack of gestational completion.⁸⁹ Additionally, doctors more commonly recommend age-appropriate honesty with the child and counseling for the child and family.⁹⁰ Still, only a few doctors in practice recommend postponing surgery until the child is old enough to take part in the decision.⁹¹ Families still choose genital normalization surgery for their children out of concern that the child will be considered abnormal if the doctors do not take immediate action.⁹²

III. Proponents of Genital Normalization Surgery

Supporters of these surgeries have many claims as to why genital normalization surgery is in the best interest of the child. Some claim that early sex assignment alleviates uncertainty for parents and helps them to raise the child conforming to societal norms.⁹³ They say these surgeries spare the child from psychological pain and sexual identity confusion.⁹⁴ Additionally, the surgeries are used to protect the parent-child relationship. Proponents believe genital normalization surgery “erases” the child’s deformities which may provide comfort to the parents who might otherwise not be able to sufficiently bond with the child out of the parents’ own discomfort.⁹⁵ Finally, another principal concern supporters have is that by a child not having surgery, other children may grow to tease and socially ostracize the child for behaving queerly.⁹⁶ They support the idea that doctors tell children “less than the whole truth” in order to maximize the

⁸⁸ Cristian González Cabrera, *The Role of International Human Rights Law in Mediating Between the Rights of Parents and Their Children Born with Intersex Traits in The United States*, 24 WM. & MARY J. WOMEN & L. 459, 464-65 (2018); Newcombe, *supra* note 4, at 226.

⁸⁹ *interACT FAQ*, *supra* note 79.

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² Newcombe, *supra* note 4, at 225.

⁹³ Johanna Viau-Colindres et al., *Bringing Back the Term “Intersex”*, 140 J. PEDIATRICS e20170505 (Nov. 2017).

⁹⁴ See Uslan, *supra* note 14, at 305.

⁹⁵ Beh & Diamond, *supra* note 55, at 44-45; Newcombe, *supra* note 4, at 223.

⁹⁶ See Uslan, *supra* note 14, at 305.

ultimate conformity with the assigned sex and gender and the child's overall psychological wellbeing.⁹⁷

Proponents for this default course of treatment behave under the "monster ethics" theory. This theory, originally developed in the nineteen hundreds and often applied to cases of conjoined twins, argue that some conditions "are so grotesque, so pathetic, any medical procedure aimed at normalizing them would be morally justified."⁹⁸ When applied to the ethics of separating conjoined twins, the theory justifies sacrificing one twin to allow the other to live a normal life.⁹⁹

This theory, however, is too drastic to justifiably apply to infants and children with ambiguous genitalia. Not appearing clearly male or female is not "grotesque" or "pathetic." Society has evolved beyond clear definitions of male and female, and society recognizes non-binary individuals. This theory also fails to prioritize the child's needs over others' discomfort.

IV. Opposition to Genital Normalization Surgery

Activists began challenging genital normalization surgery beginning in the late 1990s.¹⁰⁰ They argue genital normalization surgery on infants should be prohibited in favor of waiting until the children have developed an identity of their own and can give informed consent on their own behalves for a procedure. In support of this point, they argue the current medical standard unfairly shames and stigmatizes children and parents; the risks of the surgeries significantly outweigh the benefits; and the original theory that inspired the surgeries, Dr. Money's theory that sex and gender identity are entirely malleable, has been disproven.¹⁰¹ Activists' opposition to genital normalization surgeries on infants can be organized into four categories: the burden and risk of treatment; the need to protect the decisional capacity of the minor; the effectiveness of the treatment; and the discriminatory application of treatment.

⁹⁷ Uslan, *supra* note 14, at 305 (quoting Julie Greenberg, *Legal Aspects of Gender Assignment*, 13 *ENDOCRINOLOGIST* 227, 279 (2003)).

⁹⁸ Dreger, *Ethical Issues*, *supra* note 5, at 33.

⁹⁹ *Id.*

¹⁰⁰ Newcombe, *supra* note 4, at 223.

¹⁰¹ Hupf, *supra* note 19, at 82.

A. *Burden and Risk of Treatment*

People who have been subjected to genital normalization surgery tell stories of immense trauma. It is a painful series of procedures in the most intimate of places.¹⁰² There are countless stories from people who feel permanently scarred and traumatized by the procedure.¹⁰³ To make matters worse, although the surgery is cosmetic and can ultimately be “re-done” if the person grows to reject the sex-assignment, the desensitization, scarring, and sterilization are irreversible.¹⁰⁴

People who have had genital normalizing surgery describe it as sexual abuse.¹⁰⁵ Children are subjected to numerous inspections of their genitals upon every doctor visit and by their parents. This continues throughout childhood, adolescence, and early adulthood.¹⁰⁶ Additionally, for children assigned to the female sex, vaginoplasties are the most egregious of genital normalization surgeries. To create a vaginal opening where there was not one at birth, doctors resect a segment of intestine or colon from the infant.¹⁰⁷ They then create a hole in the genitals of the infant and use the resected intestine to line the walls of the opening.¹⁰⁸ As one person who had the procedure recounts, it is “not easy to keep an artificial hole open and uninfected.”¹⁰⁹ Post-operative care requires maintenance of the opening every few hours and daily dilation of the artificial cavity to prevent it from healing and closing.¹¹⁰ This procedure, and ones like it, may result in stenosis, increased risk of infections, loss of feeling, and psychological trauma¹¹¹ that outweigh the supposed benefit of strong sex and gender identity.

¹⁰² See generally Albritton, *supra* note 62, at 166.

¹⁰³ See Newcombe, *supra* note 4, at 223.

¹⁰⁴ *Id.*

¹⁰⁵ Dreger, *History of Intersexuality*, *supra* note 37, at 353; Uslan, *supra* note 14, at 307-08.

¹⁰⁶ Dreger, *Ethical Issues*, *supra* note 5, at 30.

¹⁰⁷ See *id.* at 32; Gale & Soomekh, *supra* note 52; Uslan, *supra* note 14, at 307-08.

¹⁰⁸ Gale & Soomekh, *supra* note 52; Uslan, *supra* note 14, at 307-08.

¹⁰⁹ Gale & Soomekh, *supra* note 52. See Dreger, *Ethical Issues*, *supra* note 5, at 29.

¹¹⁰ Uslan, *supra* note 14, at 307-08.

¹¹¹ See Dreger, *Ethical Issues*, *supra* note 5, at 32.

In addition to the trauma experienced after surgery, there is a significant risk the assigned sex will not align with the child's developed gender identity.¹¹² It is "impossible to predict with certainty how an intersex infant's gender identity will develop"¹¹³ yet doctors assign a child to a particular sex by irreversible means. Recent research indicates that biological factors influence how gender identity develops, yet some children are assigned a sex and gender in contradiction to their biological sex due to "inadequate" phallus or clitoris appearance.¹¹⁴ Gender dysphoria is a common symptom of any disorder of sexual development, with rates of approximately 50% for those subjected to sex assignment surgery.¹¹⁵

The psychological trauma associated with this treatment can be most egregious to children. Failure of the parents and doctors to talk openly and honestly about the condition contributes to the shame and confusion experienced by children.¹¹⁶ Struggling with mental health and access to treatment increase the chances the child will be prone to failing in school, engaging in self-destructive behavior, or running away.¹¹⁷ As teenagers and adults, people with intersex traits realize that their "sexual feeling, ability to feel like they can couple with another human being, is literally destroyed by some doctor's idea of how genitals are supposed to look."¹¹⁸ As adults, people with intersex traits usually learn of their condition and past medical treatment through requesting their medical records. This discovery reveals the lies they were told by their parents and doctors throughout their life and leads to immense emotional trauma and distrust in the parent-child and the doctor-patient relationships.¹¹⁹

¹¹² See Albritton, *supra* note 62, at 171.

¹¹³ Complaint at ¶ 13, *Zzyym v. Kerry*, 220 F. Supp. 3d 1106 (D. Colo. 2016).

¹¹⁴ *Id.* at ¶ 12.

¹¹⁵ Viau-Colindres et al., *supra* note 93, Abbreviation.

¹¹⁶ Dreger, *Ethical Issues*, *supra* note 5, at 31.

¹¹⁷ DOUGLAS E. ABRAMS ET AL., *CHILDREN AND THE LAW: DOCTRINE, POLICY, AND PRACTICE* 702 (6th ed. 2017).

¹¹⁸ Gale & Soomekh, *supra* note 52 (quoting Howard Devore, Ph.D. in clinical psychology and a person with intersex traits).

¹¹⁹ Dreger, *Ethical Issues*, *supra* note 5, at 31-32.

B. *Protecting the Decisional Capacity of the Minor*

The decision regarding sex assignment surgery is an incredibly personal decision and will affect every aspect of the child's life. Yet, the decision is not being made by the person forced to live with its consequences. Parents are entrusted with decision making rights for their child, but when there is no medical need to operate, the child's decisional capacity should be protected by the parents and surgery should be delayed.¹²⁰ This preserves the child's right to an open future by constraining the parents from "consenting on the child's behalf to that which may impair the enjoyment of autonomy at maturity."¹²¹ The destruction of reproductive capacity, erotic sensation, and the unique opportunity for sex options should not be destroyed by anyone other than the person whose body it is.

A person's sex still has major implications for someone's standing in society. For example, someone assigned to the female sex will be oppressed by the gender wage gap, higher rates of physical and sexual violence, difficulty in attaining reproductive health care and justice, and discrimination against being ordained in certain religious sects.¹²² Someone assigned to the male sex will likely not be oppressed by these things. Until 2015, the doctor's decision in the child's infancy could have affected their right to marry in the United States and still affects the child's experience of discrimination.¹²³ All these considerations are important when determining what sex to assign an infant when that infant has no say in the matter.

C. *The Effectiveness of Treatment*

The onus should be on physicians to provide treatment that will improve the quality of life, rather than provide treatment out of a fear of future social harm.¹²⁴ It is illogical to attempt to treat a psychosocial problem with surgery or medical treatment.¹²⁵ Advocates argue that subjecting children to genital normalizing surgery out of fear of social ostracization is like attempting to

¹²⁰ Beh & Diamond, *supra* note 55, at 41-42.

¹²¹ *Id.*

¹²² See Albritton, *supra* note 62, at 174.

¹²³ *Obergefell v. Hodges*, 574 U.S. 1118 (2015).

¹²⁴ Beh & Diamond, *supra* note 55, at 42.

¹²⁵ Dreger, *Ethical Issues*, *supra* note 5, at 30.

lighten the skin of a child of color because of the racism that child will one day face in society.¹²⁶ Genital normalization surgery is even more illogical than skin lightening because genitals are more easily concealed and private to an individual than skin color. Even if these cosmetic surgeries are effective, studies of the consequences on sexual sensation, orgasms, fertility, and related psychological effects are unavailable.¹²⁷

Physicians have a duty to follow-up with patients after surgery during their infancy and childhood.¹²⁸ Appropriate follow-up for these surgeries requires years of monitoring the progression of the child's genitals throughout adolescence to ensure they are maturing properly.¹²⁹ Many of these patients are lost over time. They do not make and keep follow-up doctor appointments with the same doctors over the course of their infancy, childhood, adolescence, and adulthood, leading to inadequate long-term data to show whether these surgeries are effective.¹³⁰ From the first-hand accounts of those subjected to the surgeries, it would appear there are serious gaps in data that should be filled before subjecting someone to genital normalizing surgery without their own informed consent.

D. *Discriminatory Application of Treatment*

Despite the recommendation in 2006 from the Consensus Statement and the American Academy of Pediatrics, the ultimate goal of practicing physicians appears to have remained the same: to maintain the females' reproductive potential to the detriment of their sexual function and enjoyment and to maintain

¹²⁶ *Id.*

¹²⁷ See *id.* at 32 (citing Kurt Newman et al., *The Surgical Management of Infants and Children with Ambiguous Genitalia*, 215 ANNALS OF SURGERY 651 (1992)).

¹²⁸ Dreger, *Ethical Issues*, *supra* note 5, at 32 (quoting *Is Early Vaginal Reconstruction Wrong for Some Intersex Girls?*, UROLOGY TIMES, Feb. 1997, at 10-12).

¹²⁹ Dreger, *Ethical Issues*, *supra* note 5, at 30.

¹³⁰ See *id.* at 32 (quoting *Is Early Vaginal Reconstruction Wrong for Some Intersex Girls?*, *supra* note 128; Uslan, *supra* note 14, at 307).

the males' sexual function to the detriment of their reproductive potential.¹³¹

The decision to assign a child to the male or female sex has been applied discriminatorily to unfairly prejudice male and female children. First, sex assignment operates within a binary framework, refusing to accept children born outside of the male-female system. It operates under a "heterosexual matrix" by assigning children a sex based upon traditional sex roles.¹³² Children assigned to the male sex must have an adequate penis size to facilitate vaginal penetrative sex. It must be capable of becoming erect and expelling urine and semen when appropriate; have a urethral opening at the tip of the penis; and be "believably shaped and colored."¹³³

Conversely, to assign a child to the female sex, the child must be able to have a vaginal opening that will accept an average-sized penis.¹³⁴ The vaginal opening, when constructed by surgeons, need not be self-lubricating, sensitive, or be able to contract as a naturally occurring vagina would.¹³⁵ "A functional vagina can be constructed in virtually everyone [while] a functional penis is a much more difficult goal."¹³⁶ Even within heterosexuality, this focus on vaginal penetration reduces sex from a vast array of sexual practices and pleasures to only one sexual activity and unnecessarily forecloses children the experience of sexual gratification and procreation.¹³⁷

Intersex activists object to these gender role presumptions dictating a "right" and "wrong" way to be male or female. Society has evolved beyond traditional gender roles, and children born outside the boundaries of the two sexes should not be reconstructed to fit into, thereby reinforcing, these roles. The arbi-

¹³¹ Dreger, *Ethical Issues*, *supra* note 5, at 29. (citing Justine M. Reilly & C.R.J. Woodhouse, *Small Penis and the Male Sexual Role*, 142 J. UROLOGY 569 (1989)); See Uslan, *supra* note 14, at 306, 307.

¹³² Dreger, *Ethical Issues*, *supra* note 5, at 29 (quoting Ellen Hyun-Ju Lee, Senior Thesis, *Producing Sex: An Interdisciplinary Perspective on Sex Assignment Decisions for Intersexuals*, BROWN UNIVERSITY (1994)).

¹³³ *Id.*

¹³⁴ Dreger, *Hermaphrodites and the Medical Invention of Sex*, *supra* note 43, at 182.

¹³⁵ Dreger, *Ethical Issues*, *supra* note 5, at 29.

¹³⁶ *Id.*

¹³⁷ *Id.* (citing Lee, *supra* note 132).

trary nature in which acceptable and unacceptable variations of anatomical differences is decided has been implemented in a discriminatory way, unnecessarily foreclosing fundamental rights for children before they reach majority.¹³⁸

V. Balancing the Rights of Parents and Children with the Duties of Physicians

A. Parental Rights to Consent to Children's Treatment

Parents have a liberty interest under the Fourteenth Amendment to direct their child's upbringing.¹³⁹ There is a presumption in law that "parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions . . . [and] that natural bonds of affection lead parents to act in the best interest of their children."¹⁴⁰ This presumption protects the parents' right to consent to medical procedures on their children's behalves.¹⁴¹ But, this right is limited.¹⁴² Some conflicts of interest between the parents and child challenge the presumption that parents will act in the best interest of the child.

When parents wish to foreclose or restrict a fundamental right of their child, the state may intervene, acting in *parens patriae*, to protect the child's interests.¹⁴³ For example, a state is permitted to intervene and require judicial oversight when parents wish to sterilize their child because sterilization is irreversible and involves a fundamental right of the child.¹⁴⁴ In some states, judicial oversight is required in this circumstance, even when the physician and parents are in agreement.¹⁴⁵ Additionally, the Supreme Court held that when parents want to institu-

¹³⁸ Dreger, *Ethical Issues*, *supra* note 5, at 29.

¹³⁹ See Albritton, *supra* note 62, at 175 (citing *Pierce v. Soc'y of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923)).

¹⁴⁰ *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

¹⁴¹ See Albritton, *supra* note 62, at 169-70.

¹⁴² See *Bellotti v. Baird*, 443 U.S. 622 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976); *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Parham*, 442 U.S. 584.

¹⁴³ See *Bellotti*, 443 U.S. 622; *Danforth*, 428 U.S. 584; *Prince*, 321 U.S. 158; *Parham*, 442 U.S. 584.

¹⁴⁴ See, e.g., Albritton, *supra* note 62, at 175.

¹⁴⁵ *Uslan*, *supra* note 14, at 310.

tionalize their child, an independent evaluation must be done before the child's liberty interest can be infringed.¹⁴⁶ This evaluation includes interviewing the child.¹⁴⁷ Finally, parents are not allowed an "absolute, and possibly arbitrary, veto" to their minor child's wish to have an abortion.¹⁴⁸ If states do require parental consent before a minor may obtain an abortion, an alternative procedure to obtain authorization must be available to the minor.¹⁴⁹ These instances show that parents do not have absolute authority to infringe upon their child's fundamental rights.

B. *Child's Rights*

Children are persons under the U.S. Constitution and are entitled to a protection of their rights.¹⁵⁰ Three rights most infringed by genital normalization surgeries on infants and children are the right to bodily integrity, the right to procreation, and the right to be free from sex discrimination.

1. *Right to Bodily Integrity*

People have a fundamental right to be secure in their being.¹⁵¹ The Supreme Court held "no right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others."¹⁵² The right to bodily integrity has continued to evolve through the courts, emanating from the right to privacy and the doctrine of informed consent.¹⁵³ People have the right to decide what to do with their own body without undue influence.¹⁵⁴ This includes the right to deny medical treatment.¹⁵⁵ Forced medical treatment, such as genital normalization surgery, is the utmost intrusion into one's bodily autonomy because the right is unnecessarily infringed and

¹⁴⁶ *Parham*, 442 U.S. at 604.

¹⁴⁷ *Id.*

¹⁴⁸ *Danforth*, 428 U.S. 584.

¹⁴⁹ *Bellotti*, 443 U.S. at 643.

¹⁵⁰ *In re Gault*, 387 U.S. 1 (1967).

¹⁵¹ Albritton, *supra* note 62, at 172.

¹⁵² *See Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

¹⁵³ *See Albritton*, *supra* note 62, at 173.

¹⁵⁴ *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 846 (1992).

¹⁵⁵ *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 269 (1990).

foreclosed to the child before the child can reach majority and exercise it.¹⁵⁶

2. *Right to Procreation*

Procreation is an exercise of the right of bodily autonomy and is “one of the basic civil rights of man.”¹⁵⁷ No other fundamental right is more necessary to the survival of the human race.¹⁵⁸ The right to control and plan for this right is vested in all persons.¹⁵⁹ If there is a substantial risk or goal of sterilization, these genital normalizing procedures unnecessarily foreclose the child’s right to an open future involving such a fundamental right before the child is ever capable of exercising it.¹⁶⁰

3. *Right to Be Free from Sex Discrimination*

Under the original title of the Affordable Care Act, discrimination on the basis of sex is prohibited in health programs or activities that receive funding from the U.S. Department of Health and Human Services (“HHS”) and in any program or activity administered by HHS.¹⁶¹ The Department of Health and Human Services, Office for Civil Rights issued its final ruling interpreting the Affordable Care Act in 2016, saying “the prohibition on sex discrimination extends to discrimination on the basis of intersex traits or atypical sex characteristics.”¹⁶² Unlike other protections under this title, such as protections from discrimination on the basis of gender identity, this anti-discrimination policy has not been enjoined or repealed since its enactment in 2010.¹⁶³

¹⁵⁶ See, e.g., *id.* at 271.

¹⁵⁷ *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

¹⁵⁸ *Id.*

¹⁵⁹ See *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965); Albritton, *supra* note 62, at 173.

¹⁶⁰ See Albritton, *supra* note 62, at 174, 175; Joel Feinberg, *The Child’s Right to an Open Future*, in *WHOSE CHILD?*, 124, 125-26 (William Aiken & Hugh LaFollette eds., 1980); Joseph Millum, *The Foundation of the Child’s Right to an Open Future*, 45 *J. SOC. PHILOSOPHY* 522 (2014).

¹⁶¹ 42 U.S.C. § 18116 (2019).

¹⁶² *Nondiscrimination in Health Programs and Activities; Final Rule*, 81 *Fed. Reg.* 31375 (May 18, 2016).

¹⁶³ *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (Apr. 25, 2018), <https://www>

For a state actor to discriminate on the basis of sex, the state actor must show its action is substantially related to achieving an important government interest.¹⁶⁴ There must be an exceedingly persuasive justification for the discrimination for it to be lawful.¹⁶⁵ A government employee is a state actor. A doctor of a public hospital or social service office that has custody of a child subjected to genital normalization surgery has been scrutinized under this role as a state actor.¹⁶⁶ No case has ever been filed on behalf of a child with ambiguous genitalia challenging the practice of genital normalization surgery as discrimination based on sex.¹⁶⁷

C. *Physician's Fiduciary Duty*

Physicians have a fiduciary duty to obtain informed consent from parents to treat children in non-emergency situations.¹⁶⁸ The informed consent doctrine dictates a physician must disclose all material information about a medical procedure and its alternatives before informed consent can be obtained.¹⁶⁹ Material information includes the reason behind the need for treatment, the risks associated with the treatment, reasonable risks and expectations post-treatment, and the risks associated with not obtaining treatment.¹⁷⁰

The exception to the informed consent doctrine is in cases of medical emergency. If there is a genuine state of emergency where it is impracticable to obtain informed consent before treatment because the life of the patient is at risk, obtaining informed consent can be foregone.¹⁷¹ However, if there is no serious threat to the life of the patient, and informed consent is not ob-

.hhs.gov/civil-rights/for-individuals/section-1557/index.html (last visited Jan. 31, 2020).

¹⁶⁴ *Craig v. Boren*, 429 U.S. 190, 197 (1976).

¹⁶⁵ *United States v. Virginia*, 518 U.S. 515, 524 (1996).

¹⁶⁶ *M.C. v. Amrhein*, 598 F. App'x 143 (4th Cir. 2015).

¹⁶⁷ Only one case has ever been filed on behalf of a child with ambiguous genitalia. The case, *M.C. v. Amrhein*, is discussed more in Part VII.A.3.

¹⁶⁸ Albritton, *supra* note 62, at 170.

¹⁶⁹ Newcombe, *supra* note 4, at 230.

¹⁷⁰ *See Id.*; Albritton, *supra* note 62, at 170.

¹⁷¹ Albritton, *supra* note 62, at 172; *Chambers v. Nottebaum*, 96 So.2d 716, 718 (Fla. Dist. Ct. App. 1957).

tained before treatment, physicians can be liable for medical battery.¹⁷²

State actors are protected by the qualified immunity doctrine. The doctrine protects state actors from civil damages associated with the discretionary functions of their work.¹⁷³ For the doctrine to apply, the state actors must not have had fair warning from the law and precedent at the time of their action that their conduct would violate a clearly established constitutional right.¹⁷⁴

VI. Legal Remedies Desired by Opponents of Genital Normalization Surgeries

A. Moratorium on Medically Unnecessary Genital Normalization Surgery Done Without the Child's Informed Consent

The United States and state governments should ban medically unnecessary genital normalizing surgeries that are conducted without the child's informed consent. Intersex conditions do not risk biopsychosocial consequences; therefore, surgery should not be performed until the child can take part in the decision.¹⁷⁵ This decision need not wait until the child reaches the age of majority. The mature minors doctrine dictates that when a minor demonstrates sufficient capacity, the child may make medical decisions for him or herself.¹⁷⁶ Research shows it is particularly beneficial for children to be informed about their condition and participate in medical-decision making.¹⁷⁷ Particularly, children involved in their own healthcare decisions are shown to have better health care outcomes and more self-esteem.¹⁷⁸ De-

¹⁷² *Mohr v. Williams*, 108 N.W. 818, 818 (Minn. 1906); Albritton, *supra* note 62, at 171-72.

¹⁷³ *Morse v. Frederick*, 551 U.S. 393, 414 (2007); *Amrhein*, 598 F. App'x 143.

¹⁷⁴ *Morse*, 551 U.S. at 429; *Amrhein*, 598 F. App'x 143.

¹⁷⁵ Beh & Diamond, *supra* note 55, at 58 (citing Laurence McCullough, medical ethicist).

¹⁷⁶ ABRAMS ET AL., *supra* note 117, at 707.

¹⁷⁷ *Id.* at 704 n.6 (citing Ursula Kilkelly & Mary Donnelly, *Participation in Healthcare: The Views and Experiences of Children and Young People*, 19 INT'L J. CHILDREN'S RTS. 107 (2011)).

¹⁷⁸ *Id.*

laying treatment also allows the child to grow and develop an identity of his, her, or their own, at no medical danger to the child.¹⁷⁹ Delay of the decision to conduct surgery eliminates the risk of improper sex assignment and subsequent emotional turmoil. Operating without the child's consent under this prohibition would result in medical battery.¹⁸⁰

B. *Alternative Proposals*

There are two alternative proposals to a moratorium of surgery done without the informed consent of the child. The proposals are for the government to either recognize a third sex or for the government to not require sex designations on formal documents and identifications.

1. *Recognition of a Third Sex*

The binary male-female system used by most state governments refuses to recognize intersex individuals as they were born.¹⁸¹ They are not naturally all female or all male, and are thus forced to attest to a lie on government identification that requires conformity to the "M" or "F" checkbox. It is this requirement to check one box that creates the pressure on parents and doctors to force the child into one of those boxes by surgical means.¹⁸² If the state were to recognize individuals with intersex traits as a third sex, parents and doctors would not be forced to make the "right" decision regarding sex assignment because children would be legally recognized as they were born.¹⁸³ A third sex would promote the visibility of intersex traits and help destigmatize people with the condition.¹⁸⁴

In U.S. federal court, there is a pending case challenging the federal government's denial of a passport to an individual with intersex traits for refusing to falsely attest to being a male or fe-

¹⁷⁹ Albritton, *supra* note 62, at 176.

¹⁸⁰ *Id.*

¹⁸¹ Uslan, *supra* note 14, at 304.

¹⁸² See Hupf, *supra* note 19, at 88.

¹⁸³ *Id.* at 87.

¹⁸⁴ *Id.*

male on the application.¹⁸⁵ The U.S. District Court for the District of Colorado found the binary policy to be arbitrary and capricious and remanded the issue back to the Department of State to reconsider issuing the passport with “X” indicating a third sex.¹⁸⁶ On subsequent re-denial of the passport application and the applicant’s appeal, the Court held the State Department had exceeded its authority by imposing an arbitrary and capricious binary policy.¹⁸⁷ The court enjoined the Department to consider the passport application without relying on the sex marker.¹⁸⁸ The Department appealed the District Court’s decision and moved for a stay of judgment pending appeal. The motion was denied by the district court on the basis that the merits of the Department’s appeal were weak.¹⁸⁹ Its appeal of the decision was heard by the U.S. Court of Appeals for the Tenth Circuit on January 22, 2020 and the appellate court’s decision is pending.¹⁹⁰

2. *No Sex Designation Requirements*

Another alternative to a moratorium on genital normalizing surgery done without the consent of the child is for the government to not require sex designation on identifying documents. Society is more “gender-blurring” than ever before and a person’s sex designation on identifying documents is not as descriptive as it once was.¹⁹¹ Like the proposal of a third sex, eliminating the required sex designation would alleviate the pres-

¹⁸⁵ *Accord Zzyym v. Pompeo*, No. 15-cv-02362-RBJ, 2019 U.S. Dist. LEXIS 27647 (D. Colo. Feb. 21, 2019); *Zzyym v. Pompeo*, 341 F. Supp. 3d 1248 (D. Colo. 2018); *Zzyym v. Kerry*, 220 F. Supp. 3d 1106 (D. Colo. 2016).

¹⁸⁶ *Zzyym* Complaint at 1109.

¹⁸⁷ *Zzyym*, 341 F. Supp. 3d 1248.

¹⁸⁸ All parties agreed during the proceedings that the only ground for denial of the passport application was the incomplete sex marker section of the application.

¹⁸⁹ *Zzyym v. Pompeo*, No. 15-cv-02362-RBJ, 2019 U.S. Dist. LEXIS 27647. (The court held that the defendant’s likelihood of success on the merits of the appeal did not weigh in the defendant’s favor, influencing the court’s decision to deny the stay of judgment.)

¹⁹⁰ *Lambda Legal Urges Tenth Circuit to Uphold Ruling in Favor of Intersex Vet Seeking Accurate Passport*, LAMBDA LEGAL (Jan. 22, 2020), https://www.lambdalegal.org/news/co_20200122_lambda-legal-tenth-circuit-rule-intersex-veteran-passport.

¹⁹¹ See Newcombe, *supra* note 4, at 224.

sure on parents and doctors to pick the “right” sex assignment for the child.¹⁹²

3. *Criticism Within the Intersex Activist Community*

Disagreement exists within the intersex activist community as to whether these alternative proposals help or harm the overall movement. Overall, individuals in the community seek to fit into society as they are, not destroy the recognitions that come with having a sex designation on a birth certificate, driver’s license, or passport.¹⁹³ Some activists fear promoting these alternatives will distract attention from the main goal and confuse people on what the priority is: preventing medically unnecessary, cosmetic surgeries on infants.¹⁹⁴

VII. How to Bring About Legal Reforms

Reform can be imposed through three ways: litigation, lobbying legislators, and lobbying medical ethics boards.

A. *Litigation*

1. *Challenge the Methods of Physicians as Medical Malpractice*

As discussed, there historically have been significant issues in the disclosure of information to parents regarding their child’s condition. Although parents are now more often advised to be open with their children about the condition, there continues to be an aura of urgency surrounding genital normalization and the question remains of “which gender to assign the baby, not *whether* to perform genital normalization surgery.”¹⁹⁵ The creation of a spurious emergency misleads parents into consenting to procedures that can be postponed until the child can contribute to the decision.¹⁹⁶ This deceitful treatment prevents informed consent from ever being given.¹⁹⁷

¹⁹² Hupf, *supra* note 19, at 87.

¹⁹³ *Id.* at 89.

¹⁹⁴ *Id.* at 89, 90.

¹⁹⁵ Greenhouse, *supra* note 35 (emphasis in original).

¹⁹⁶ See Albritton, *supra* note 62, at 170.

¹⁹⁷ *Id.*

Another principal issue with physician disclosure is the failure to impart accurate and complete information about the condition and procedure. Physicians have a desire to not admit the limitations of their knowledge and ability regarding a condition and treatment.¹⁹⁸ There is a significant lack of data regarding the long-term effects of genital normalization surgery and in the medical community, it is still unconfirmed that the harms of surgery outweigh the supposed benefits.¹⁹⁹ However, this uncertainty must be conveyed before informed consent can be given.²⁰⁰ Repercussions of these surgeries are serious: sterilization, scarring, loss of sexual function, loss of sensation, incontinence, improper sex assignment, and emotional and psychological trauma.²⁰¹ If the uncertainty of the procedure and the risks are not adequately conveyed in ways people can understand, along with the choice to wait for the child to grow and make the decision, any consent given on the child's behalf is not valid under the current legal model.

2. Challenge the Methods of Physicians as Sex Discrimination

If discrimination based on sex is done by a state actor, such as a doctor in a public hospital, different treatment based on sex must be for an exceedingly persuasive reason and the means must bear a substantial relationship to an important government interest.²⁰² Doctors unnecessarily and illegitimately treat XX chromosome and XY chromosome children differently.²⁰³ This different treatment is based on generalizations about a particular class and reinforce the traditional gender roles in a binary, heterosexual framework. This is unconstitutional.²⁰⁴ The focus on satisfactory intercourse or reproductive capability infringes on the child's right to be free from sex discrimination in health care under 42 U.S.C. § 18116, § 1557 of the Affordable Care Act, but also on the child's fundamental right to bodily integrity and pro-

¹⁹⁸ Beh & Diamond, *supra* note 55, at 47.

¹⁹⁹ See Uslan, *supra* note 14, at 307.

²⁰⁰ See Beh & Diamond, *supra* note 55, at 47.

²⁰¹ Albritton, *supra* note 62, at 170-71.

²⁰² *Nguyen v. INS*, 533 U.S. 53, 61 (2001); *Virginia*, 518 U.S. at 524.

²⁰³ See, e.g., *id.*

²⁰⁴ See, e.g., *id.*

creation. These rights are held equally by chromosomal males and females and should not be infringed in exchange for cosmetically appealing genitalia.

3. *Challenge the Presumption of Parental Authority to Consent to Genital Normalization Surgery*

Parents lack the right to consent on their child's behalf for medically unnecessary, cosmetic genital normalizing surgery. It exceeds parental authority by unfairly favoring the interest of a parent to have a "normal" child compared to the fundamental rights of the child entrusted to the parents to protect until the age of majority.²⁰⁵ These surgeries unnecessarily foreclose the "child's right to an open future"²⁰⁶ to exercise certain fundamental rights in the future because of parental conduct.²⁰⁷ Therefore, surgery should be done only when the child agrees. The rights at issue here—procreation, bodily integrity, and the right to be free from discrimination—are at risk of permanent infringement if genital normalization surgery is performed. When fundamental rights such as these are at risk by the choices of the parent, the state may act in *parens patriae* to protect the rights of the child.²⁰⁸

The legality of parental authority to provide informed consent on their child's behalf has not been litigated regarding this specific issue. Likely, this is due to parents being entrusted with the rights of their child to protect and control until the child reaches the age of majority or emancipates. Unless a physician and parents strongly disagree on treatment, it is unlikely the government will get involved to decide what course of treatment is in the best interest of the child.²⁰⁹

The most glaring issue in challenging the parental authority presumption is the issue of standing in litigation. The state must step in to enforce the need for informed consent from the child. If a doctor operates on a child without the child's informed consent, presumably at the direction of the parents, no one but the

²⁰⁵ See Feinberg, *supra* note 160, at 125-26; Uslan, *supra* note 14, at 310.

²⁰⁶ Hazel Glenn Beh & Milton Diamond, *David Reimer's Legacy: Limiting Parental Discretion*, 12 *CARDOZO J.L. & GENDER* 5, 5 (2005).

²⁰⁷ See Feinberg, *supra* note 160, at 125-26; Uslan, *supra* note 14, at 310-11.

²⁰⁸ See *Parham*, 442 U.S. 584; *Prince*, 321 U.S. 158.

²⁰⁹ Greenberg, *supra* note 97, at 283.

state or a next friend would file suit on the child's behalf.²¹⁰ Having someone like a health care professional independently judge the need for surgery on the child's behalf, like the procedural safeguards afforded the child in *Parham v. J.R.*, will be insufficient. The medical community continues to believe that surgery is in the best interest of the child, despite the research, condemnation, and testimonials stating otherwise. Parents are influenced by the pseudo-emergency created by the medical community and have a conflict of interest in their own desire for a "normal" child. The most appropriate independent evaluation would be the courts which would be able to balance the rights of the child with the rights of the parents.²¹¹ Otherwise, the child's long-term fundamental rights may be infringed.²¹²

Only one lawsuit has ever been filed on behalf of a child against the practice of genital normalization surgery.²¹³ The case resulted in a narrow holding, and decided whether the social services department that had custody of the child with intersex traits, M.C., and the doctors at a public hospital could claim qualified immunity. The court held that a reasonable social service worker or doctor in 2006 would not have had fair warning from the existing precedent at the time that performing sex assignment surgery on an infant violated a clearly established constitutional right.²¹⁴ Therefore, the doctors and social workers could claim qualified immunity. In a suit against the hospital, M.C.'s adoptive parents settled with the hospital for \$440,000 in exchange for a statement that the hospital denied all claims of negligence or liability.²¹⁵

The doctrine of qualified immunity presents a challenge for any individual seeking damages from a government official for violating an individual with intersex traits' rights. No litigation

²¹⁰ Albritton, *supra* note 62, at 176.

²¹¹ Uslan, *supra* note 14, at 322.

²¹² Greenberg, *supra* note 97, at 282.

²¹³ *M.C. v. Amrhein*, 598 F. App'x 143.

²¹⁴ *Id.*

²¹⁵ *M.C. v. Aaronson*, SOUTHERN POVERTY LAW CENTER, <https://www.splcenter.org/seeking-justice/case-docket/mc-v-aaronson>; Azeen Ghorayshi, *A Landmark Lawsuit About an Intersex Baby's Genital Surgery Just Settled for \$440,000*, BUZZFEED NEWS (July 27, 2014), <https://www.buzzfeednews.com/article/azeenghorayshi/intersex-surgery-lawsuit-settles#.babBVxog7>. (last visited Jan. 31, 2020).

will create a precedent that future litigation can rely on to collect damages if the official will be shielded for not violating a “clearly established” right.²¹⁶ Therefore, it will be necessary to seek legislative protection to clearly establish the rights of people with intersex traits.

B. Lobbying

1. Lobby Federal Legislators

At the federal level, Congress should expand the prohibition in 18 U.S.C.S. § 116. Currently, the section provides a prohibition on female genital mutilation except when necessary to the health of the person on whom it is performed.²¹⁷ Although the statute was originally implemented to condemn African-originating customs, it is quite similar to the U.S. approach to treating children with ambiguous genitalia. The United States uses genital normalization surgery to enforce genital conformity and proper sex roles for people with intersex conditions and the practice should be equally as condemned as female genital mutilation, which occurs for similar purposes.²¹⁸ It seems it was important enough to Congress to protect the well-being of girls from this cultural tradition, and it is time Congress protect people with intersex traits subjected to medical treatment that has substantially similar results to female genital mutilation.

2. Lobby State Legislators

Many genital normalization surgeries carry a substantial risk of sterilization or sterilization is a secondary consequence of the chosen sex assignment.²¹⁹ States are permitted to require judicial oversight for parents who want to sterilize their children.²²⁰ In some states, judicial oversight is required, even when the doctors and parents are in agreement, creating a presumption against sterilization.²²¹ It would follow that judicial oversight should be implemented when parents want to subject their child to genital

²¹⁶ *M.C.*, 598 F. App’x at 145.

²¹⁷ 18 U.S.C.S. § 116 (LexisNexis 2019).

²¹⁸ Dreger, *Ethical Issues*, *supra* note 5, at 33.

²¹⁹ *See* Albritton, *supra* note 62, at 175.

²²⁰ *Id.*

²²¹ Beh & Diamond, *supra* note 55, at 39; Uslan, *supra* note 14, at 310.

normalization surgeries that aim to or substantially risk sterilization.

One example of successful state lobbying is in California. California Senate Bill 201 was introduced by State Senator Wiener in January 2019 and amended in March 2019 to require informed consent of a person with intersex traits before surgery.²²² The bill also requires certain material disclosures to patients such as the need for long-term follow-up care, short and long term risks, and the risk of no treatment at all.²²³ While promising to the future rights of the intersex community, the bill did not get past committee.

3. Lobby Medical Ethics Boards

Finally, another remedy would be to lobby medical ethics boards. Medical ethics boards provide ethical guidance to practitioners by drafting general recommendations in balancing the interests of individuals as well as case-specific recommendations when conflicts or inquiries arise.²²⁴ However, like the recommendations of the American Academy of Pediatrics and 2006 Consensus Statement, the recommendations of ethics boards are not binding on physicians and take many years to be implemented into practice on any significant scale.²²⁵

VIII. Conclusion

Genital normalizing surgery creates more trauma than its use claims to prevent. Subjecting infants and children to these surgeries before they can take part in the decision unnecessarily forecloses their opportunity to later exercise their fundamental rights of bodily integrity, procreation, and the right to be free from discrimination on the basis of sex. Reforms should be made

²²² S.B. 201 (Cal. 2019).

²²³ CA S.B. 201.

²²⁴ *Ethics Committees in Health Care Institutions*, AMERICAN MEDICAL ASSOCIATION, <https://www.ama-assn.org/delivering-care/ethics/ethics-committees-health-care-institutions>.

²²⁵ Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER L. & JUST. 59, 78 (2006); Uslan, *supra* note 14, at 308.

through litigation and lobbying which aim to prevent parents and physicians from subjecting children to genital normalization surgeries without the child's consent.

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