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Imposing Identity: Why States Should Restrict Infant Intersex Surgery

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IMPOSING IDENTITY: WHY STATES SHOULD RESTRICT INFANT INTERSEX SURGERY

Laura Sundin*

ABSTRACT

Babies born with sex characteristics that do not “fit typical binary notions of male or female” are as common as babies born with red hair. These newborns may have one of many types of internal or external abnormalities, coined “intersex” conditions, such as having both an ovary and a testicle or having a large clitoris that resembles a penis. Despite their prevalence, the community of children with intersex conditions was stigmatized by prominent psychologists in the 1960s who theorized that to be “normal” the child must grow up with “unambiguous genitalia” and a binary gender identity.

This theory caused fear among the medical community. Pediatric surgeons even began referring to these children as “sexual freaks” who were “doomed to live in loneliness and frustration” unless surgically assigned a gender at birth. The societal mania of the 1960s led to current rigid patient care. Physicians commonly advise parents to subject their sexually variable newborns to medically unnecessary, irreversible surgery to conform “to a binary sex norm.” Last year alone, surgeons removed or reconstructed reproductive organs in approximately eight thousand newborns.

However, over eighty percent of the time when ambiguous genitals are evident, doctors choose to assign the baby as a female because it is an easier construct. This is shocking given research indicating that the adult later identifies as female less than fifty percent of the time. That adult is left with a lifetime of physical suffering—like “incontinence, scarring, [and] lack of sensation”—and emotional trauma from loss of bodily autonomy. Further, medical research shows these cosmetic surgeries are medically unnecessary—the child is not physically harmed by waiting to have gender assignment surgeries until the child can reasonably consent.

This Comment seeks to resolve the ethical dilemma of physicians’ freedom to impose their perception of normalcy over the nonconsenting patient’s best interests. It looks to recently proposed (yet rejected) California

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legislation calling for a temporary moratorium on intersex surgeries until the patient is six years old. The Comment suggests modifications to such legislation, based on medical practitioners' concerns about maintaining individualized patient care. Ultimately, the Comment advocates for legislation protecting against intersex surgeries without the patient's consent using legal arguments based on limiting parental authority; recent gender-identity related Supreme Court decisions; a comparison to female genital mutilation and nonconsensual sterilization; and a similarity to internationally denounced torture.

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I. INTRODUCTION

“*I*T’S a lot easier to see what’s irrational in another culture than it is to see it in our own.”¹

Becks is a fifteen-year-old with dark brown hair that falls well below her collarbone, traditionally feminine attributes like narrow shoulders and pronounced cheekbones, external genitalia that appear typically female,² and the label on her birth certificate that matches. Throughout her adolescence, Becks sketched comic book cartoons—the evidence of razor marks on her wrists visible to onlookers—and wondered aloud why she felt different from other girls in class.³ This outcasted, uncomfortable girl gained necessary clarity one fateful day. As previously scheduled, she was admitted on a Tuesday morning into Seattle Grace Hospital for surgery to remove a tumor that was resting on what the doctors assumed was her ovary.⁴ During the procedure, however, those doctors were surprised to discover that the ovary was, in fact, a testicle.⁵ Upon being told of the true ambiguous nature of her sexual organs, Becks understands that she can continue to associate as a female *or* instead embrace a male or gender-neutral identity.⁶ Powerfully, Becks takes scissors to her long hair, smiling because self-awareness is no longer as impossible as she once believed.⁷

This Seattle Grace Hospital patient is a realistic example of the 1.7% of the population⁸ who experts characterize as having an “intersex” condition—people “born with variations in their physical sex characteristics[] . . . [which] means an individual [is] born with . . . genitals, gonads, [or]

1. Natalie Angier, *New Debate Over Surgery on Genitals*, N.Y. TIMES, May 13, 1997, at C8 (quoting Cheryl Chase, founder of the Intersex Society of North America, a San Francisco-based support group for adults born with ambiguous genitalia, as she discusses the similarities of female genital mutilation in Africa to clitoral reduction surgery on babies with intersex conditions in America).

2. Typical female external genitalia include a vagina and clitoris. Jennifer Knudtson & Jessica E. McLaughlin, *Female External Genital Organs*, MERCK MANUAL: CONSUMER VERSION, <https://www.merckmanuals.com/home/women-s-health-issues/biology-of-the-female-reproductive-system/female-external-genital-organs> [<https://perma.cc/BRV6-NSZY>] (last modified Apr. 2019).

3. *See Grey’s Anatomy: Begin the Begin* (Season Two, Episode Thirteen) (ABC television broadcast Jan. 15, 2006).

4. *Id.*

5. *Id.*

6. *Id.*

7. *See id.*

8. This statistic was discovered by an expert and biologist in the field of sexual identity development, Anne Fausto-Sterling, as a result of a study she conducted in conjunction with Brown University. Melanie Blackless et al., *How Sexually Dimorphic Are We? Review and Synthesis*, 12 AM. J. HUM. BIOLOGY 151, 161 (2000) (“Adding the estimates of all known causes of nondimorphic sexual development suggests that approximately 1.7% of all live births do not conform to a Platonic ideal of absolute sex chromosome, gonadal, genital, and hormonal dimorphism.”). This statistic has been accepted widely by most experts but challenged by others. *See, e.g.*, Leonard Sax, *How Common is Intersex? A Response to Anne Fausto-Sterling*, 39 J. SEX RES. 174, 174 (2002); JULIE A. GREENBERG, INTERSEXUALITY AND THE LAW: WHY SEX MATTERS 2 (2012).

chromosome patterns[] that do not fit typical binary notions of male or female bodies.”⁹ This characterization is not rare; babies born with an intersex condition are as common as babies born with red hair.¹⁰ However, having an intersexual trait is highly misunderstood and stigmatized compared to that of having a specific hair color. As a result, not all individuals with intersex characteristics are given the opportunity that Becks was given—to claim a gender identity most fitting for them. Arguably, Becks *only* had this choice because doctors did not immediately recognize at birth that she possessed male sexual organs in addition to her female-typical vagina. Astonishingly, in approximately eight thousand newborns per year, doctors do instantly recognize reproductive abnormalities and surgically remove those which *they* believe will hinder the baby’s ability to fit societal notions of “normal.”¹¹ Often, doctors’ decisions on which sexual organs to remove or reconstruct are based on non-life threatening considerations, like reconciling the baby’s physical appearance and external genitals.¹²

The primary aim of this Comment is three-fold: (1) to educate readers on the current practice of performing operations on infants with intersex conditions without the patient’s own consent, and the (lack of) laws protecting against it; (2) to evaluate proposed state legislation denouncing such operations; and (3) to support a sweeping adoption of protective measures against such operations, based on a restriction of parental authority to make decisions that are not always in the child’s best interests, society’s evolving perceptions of intersex, the existence of laws banning genital mutilation and nonconsensual sterilization, and a comparison to internationally denounced torture.

To achieve the Comment’s aim, Part II proceeds by informing readers of the history of intersex surgeries still commonly performed on individuals at birth, with a focus on United States data. It will detail the various genital and gonadal conditions that constitute intersex, and it will present societal excuses for surgically correcting such conditions. It will also provide firsthand, traumatic accounts from adults who had such surgeries in infancy.

9. Medical Procedures: Treatment or Intervention: Sex Characteristics of a Minor, S.B. 201, 2019–2020 Leg., Reg. Sess. (Cal. 2019) (reproducing the text of S.B. 201 as introduced on January 31, 2019, and amended in the Senate on March 25, 2019, and again on January 6, 2020).

10. See Sax, *supra* note 8; Andrew L. Cunningham et al., *Red for Danger? The Effects of Red Hair in Surgical Practice*, 341 BRIT. MED. J. 1304, 1304 (2010) (“An estimated 1% to 2% of the general population worldwide has the phenotype for red hair.”).

11. This statistic equates to doctors assigning a gender of their choice to two out of every 1,000 live births. Blackless et al., *supra* note 8; See Kimberly Mascott Zieselman, *I Was an Intersex Child Who Had Surgery. Don’t Put Other Kids Through This.*, USA TODAY (Aug. 10, 2017, 6:56 AM), <https://www.usatoday.com/story/opinion/2017/08/09/intersex-children-no-surgery-without-consent-zieselman-column/539853001/> [https://perma.cc/Q799-VVTM] (presenting a firsthand anecdote by the author who appeared externally female but was born with male-typical testes, which were removed in childhood on the advice of doctors and by the consent of *her parents* so that she could grow up as a “normal” girl).

12. See Zieselman, *supra* note 11.

Part III describes the absence of American laws banning medically unnecessary, genital-altering surgeries on babies.¹³ The Comment will detail groundbreaking California legislation that, if it had passed, would have been the first to disallow such surgeries without the patient's consent.

Part IV responds to the medical community's protests to surgical moratoriums in general. Part V will present arguments supporting passage of federal legislation with the same protective sentiment as that of the California bill. Part VI will explore multi-disciplinary modifications, and it will ultimately advocate for federal adoption of a legally mandated postponement of elective gender-assignment surgeries with such modifications.

II. BACKGROUND

A. RELEVANT TERMINOLOGY

Until recently, people referred to the community of individuals with intersex conditions exclusively as “hermaphrodites.”¹⁴ The term was popularized in the 1950s, but since the beginning of this century the term has been realized as misleading and frightening.¹⁵ It is considered by medical professionals, academics, and intersex advocates as offensive because the term suggests to people that someone has “two full sets of genitals and sex organs,” including both a penis and vagina, which “only exists in mythology.”¹⁶ The condition of hermaphroditism was finally replaced with the less misleading descriptor “intersex.” However, the longevity of “hermaphrodite” makes apparent that even the most socially conscious community can be slow to recognize that harshness fosters misconception; the most “progressive” sitcom of our generation, which “commit[s] to . . . gender identity diversity,” was *still* using the problematic term just fifteen years ago.¹⁷

13. “[American] laws do not specifically protect children against . . . [intersex] operations [without personal consent], but several areas of law prohibit conduct that could be interpreted to include” such operations. INTERACT & HUM. RTS. WATCH, “I WANT TO BE LIKE NATURE MADE ME”: MEDICALLY UNNECESSARY SURGERIES ON INTERSEX CHILDREN IN THE US 145 (2017), https://www.hrw.org/sites/default/files/report_pdf/lgbtintersex_0717_web_0.pdf [<https://perma.cc/SJD5-B3MH>].

14. See, e.g., Dana Hughes, *IAAF Won't Confirm or Deny Semenya 'Hermaphrodite' Reports*, ABC NEWS (Sept. 11, 2009, 10:45 AM), <https://abcnews.go.com/Health/International/iaaf-silent-caster-semenya-hermaphrodite-rumors/story?id=8548265> [<https://perma.cc/PST3-L3EQ>].

15. See Hazel Glenn Beh & Milton Diamond, *David Reimer's Legacy: Limiting Parental Discretion*, 12 CARDOZO J.L. & GENDER 5, 13, 25 (2005) (discussing the history of intersex terminology).

16. Alice D. Dreger et al., *Changing the Nomenclature/Taxonomy for Intersex: A Scientific and Clinical Rationale*, 18 J. PEDIATRIC ENDOCRINOLOGY & METABOLISM 729, 732 (2005).

17. See Ani Bundel, ‘Grey’s Anatomy’ Subverts the Patriarchy Every Thursday Night. *And Viewers Are Loving It.*, NBC NEWS THINK: OPINION, ANALYSIS, ESSAYS (Feb. 9, 2018, 2:39 PM), <https://www.nbcnews.com/think/opinion/grey-s-anatomy-subverts-patriarchy-every-thursday-night-viewers-are-nca846451> [<https://perma.cc/6ZL2-LR46>]; see *Grey’s Anatomy: Begin the Begin*, *supra* note 3 (airing in 2006, the episode referred to the intersex character Becks only by the term “hermaphrodite”).

Notably, in 2006, experts from the Lawson Wilkins Pediatric Endocrine Society coined the newest term, “Disorders of Sex Development” (DSD), which is sometimes used in academic articles and media as a synonym for intersex.¹⁸ However, the term DSD is met with pushback for implying a disability, and it is the least familiar term for describing the same ambiguous, atypical sexual conditions.¹⁹ Therefore, this Comment solely uses the term “intersex” to refer to ambiguous genital, gonadal, and chromosomal conditions. Some individuals with such conditions also choose to identify *as* intersex; however, this Comment does not assume that an intersex identity is fitting for all within this community. This Comment advocates for the opportunity to choose one’s own identity.

B. INTERSEX CONDITIONS

Numerous variations of atypical sexual organs are characterized as intersex. Broadly speaking, intersex variations are divided into four categories.²⁰ A person in the first category is deemed “46, XX intersex” and has the XX chromosomes of a genetically typical woman yet has the external genitals of a typical male or has undeveloped internal female anatomy.²¹ Specifically, an otherwise-typical female patient with ovaries has a “larger than average clitoris” or the labia fused, both abnormalities resulting in what looks like a penis.²² Alternatively, the patient could have an “absent, misshapen, or small” uterus or “no cervix.”²³ One of the most common genetically inherited conditions that causes “46, XX intersex” is congenital adrenal hyperplasia (CAH), where one of the two adrenal glands produces too much androgen, a male sex hormone.²⁴ CAH causes “masculine-typical characteristics” to appear.²⁵ When a mother takes male hormones such as testosterone or has a male hormone-producing ovarian tumor during pregnancy, male characteristics in an otherwise assumed-female baby may appear.²⁶

The second category—coined “46, XY intersex”—is a person with male-typical XY chromosomes but “external genitals [that] are incompletely formed, ambiguous, or clearly female.”²⁷ Here, the patient may have been “born without a penis,” with a penis that is significantly smaller than normal, or with “testes [that] are small (about half [the] typi-

18. *Intersex*, LGBT MENTAL HEALTH SYLLABUS (2007), https://www.aglp.org/gap/7_intersex/ [<https://perma.cc/38ZS-5TDQ>].

19. *See id.*

20. *Intersex*, MEDLINEPLUS, <https://medlineplus.gov/ency/article/001669.htm> [<https://perma.cc/38ZS-5TDQ>] (last updated June 2, 2020).

21. *Id.*

22. GREENBERG, *supra* note 8, at 1. The labia are the “folds of skin of the external female genitals.” *Intersex*, MEDLINEPLUS, *supra* note 20.

23. *Frequently Asked Questions*, INTERSEX SOCIETY N. AM., <https://isna.org/faq/> [<https://perma.cc/JXV8-UJRF>].

24. *Id.*

25. *Id.*

26. *Intersex*, *supra* note 20.

27. *Id.*

cal size) and quite firm.”²⁸ 46, XY intersex is most commonly caused by Androgen Insensitivity Syndrome (AIS) (also called “testicular feminization”), a genetic defect in which a biologically male person is “resistant to male hormones” and as a result, physically female characteristics appear.²⁹ Depending on the severity of AIS, it can result in the child looking like a girl, undescended testes, or an undeveloped penis, among other symptoms.³⁰

A person in the third category has either XX or XY chromosomes but has a combination of male and female gonads (sex glands), rather than just ovaries or just testes.³¹ The patient here, deemed “true gonadal intersex,” may have one ovary *and* one testes, or one of the gonads may contain *both* types of tissue (called an “ovotestes”).³² The cause of true gonadal intersex is unknown, but it “has been linked to exposure to common agricultural pesticides.”³³

An individual within the final category—deemed “complex or undetermined intersex”—has chromosome configurations other than typical XX or XY.³⁴ The patient’s intersex character is not obvious because “there is [not a] discrepancy between internal and external genitalia.”³⁵ Here, conditions include the person having XO chromosomes or having “either an [extra] X or a[n] [extra] Y” chromosome, resulting in abnormal hormone levels.³⁶

Some categorical abnormalities—like atypical chromosomal configurations—are subtler than others and are usually not discovered until adolescence or even adulthood. However, experts suggest that as many as two in every thousand babies are born with an abnormal variation that is so obvious that surgeons feel compelled to correct it immediately upon birth.³⁷

C. PERFORMANCE OF CORRECTIVE SURGERIES

A surgery performed to correct or to “normalize” sex anatomy is commonly referred to as an “intersex surgery,”³⁸ a “genital surgery,”³⁹ a

28. *Frequently Asked Questions*, *supra* note 23; see Greenberg, *supra* note 8, at 1.

29. *Androgen Insensitivity Syndrome*, MEDLINEPLUS, <https://medlineplus.gov/ency/article/001180.htm> [<https://perma.cc/EH3H-LDQR>].

30. *Id.*

31. *Intersex*, *supra* note 20.

32. *Frequently Asked Questions*, *supra* note 23.

33. *Intersex*, *supra* note 20.

34. *Id.* GREENBERG, *supra* note 8, at 1.

35. *Intersex*, *supra* note 20.

36. *Id.*

37. Blackless et al., *supra* note 8.

38. See *Frequently Asked Questions*, *supra* note 23 (clarifying that the Intersex Society of North America does not recommend such surgeries for children with intersex conditions).

39. See *US: Harmful Surgery on Intersex Children*, HUM. RTS. WATCH (July 25, 2017, 1:01 AM), <https://www.hrw.org/news/2017/07/25/us-harmful-surgery-intersex-children> [<https://perma.cc/BQG9-KY62>].

“gender-normalizing”⁴⁰ surgery, or a “gender assignment”⁴¹ surgery. The types of surgeries performed on minors with intersex traits are masculinizing and feminizing. Masculinizing surgical procedures are those performed to make one’s sexual anatomy more like that of a typical XY-male, while feminizing surgical procedures are performed on one to be reared as a typical XX-female.⁴²

The various types of feminizing surgeries include: a clitoridectomy, a labiaplasty, a vaginoplasty, and a gonadectomy (of the testes).⁴³ A clitoridectomy is a procedure in which the pediatric surgeon “reduce[s] or remove[s] infant clitorises deemed abnormally large.”⁴⁴ Such surgery is surprisingly common in the United States; it is performed on “2,000 babies a year.”⁴⁵ For example, Ms. Coventry, whose “clitoris measured just over half an inch long, two or three times the average size,” but posed no medical risk and merely looked “boyish,” was operated on at the age of six at the request of her parents who were concerned of how a large clitoris “would affect [her] growing up.”⁴⁶ In her own words, without her consent, the doctors “just snipped it right off,” which has led to an adulthood lacking in sexual stimulation.⁴⁷ This nonconsensual genital mutilation is condemned in Part V of this Comment. A labiaplasty involves doctors reshaping or creating tissue surrounding the vagina when it is misshaped or missing.⁴⁸ A vaginoplasty is performed “to create or deepen a vagina.”⁴⁹ A feminizing gonadectomy involves removal of testes from a baby that is assigned as female.⁵⁰

The less commonly performed masculinizing surgeries include: an orchiopexy, a hysterectomy, a penile enlargement surgery, and a gonadectomy (of the ovaries).⁵¹ An orchiopexy is an operation per-

40. See Julie Compton, *You Can’t Undo Surgery’: More Parents of Intersex Babies Are Rejecting Operations*, NBC NEWS (Oct. 24, 2018, 3:30 AM), <https://www.nbcnews.com/feature/nbc-out/you-can-t-undo-surgery-more-parents-intersex-babies-are-n923271> [https://perma.cc/2SJ6-UZK2].

41. *Intersex*, LGBT MENTAL HEALTH SYLLABUS, *supra* note 18.

42. See William G. Reiner, *Gender Identity and Sex-of-rearing in Children with Disorders of Sexual Differentiation*, 18 J. PEDIATRIC ENDOCRINOLOGY & METABOLISM 549 (2005).

43. Angier, *supra* note 1 (clitoridectomy); *Feminizing Genitoplasty*, CLEVELAND CLINIC, <https://my.clevelandclinic.org/health/treatments/16202-feminizing-genitoplasty> [https://perma.cc/L35V-ZDPL] (labiaplasty); Rodrigo Uprimny, *ISNA’s Amicus Brief on Intersex Genital Surgery*, INTERSEX SOC’Y N. AM. (Feb. 7, 1998), <https://isna.org/node/97> [https://perma.cc/6AVS-Y6Y7] (vaginoplasty); *Frequently Asked Questions*, *supra* note 23 (gonadectomy).

44. Angier, *supra* note 1.

45. *Id.*

46. *Id.*

47. *See id.*

48. *Feminizing Genitoplasty*, *supra* note 43.

49. Uprimny, *supra* note 43.

50. *Frequently Asked Questions*, *supra* note 23.

51. *Orchiopexy*, CLEVELAND CLINIC, <https://my.clevelandclinic.org/health/treatments/17297-orchiopexy> [https://perma.cc/4KBF-H6GN]; *Hysterectomy*, WEBMD, <https://www.webmd.com/women/guide/hysterectomy#1> [https://perma.cc/H55W-ATFB]; Tim Jewell, *Penis Enlargement Surgery: How Much Does It Cost and Is It Worth the Risk?*, HEALTHLINE, <https://www.healthline.com/health/mens-health/penis-enlargement-surgery->

formed to treat a child with undescended testes by moving the undescended testicle from the stomach “into the scrotum and permanently fix it there.”⁵² A hysterectomy removes part or all of a uterus (a female reproductive organ used to house a fetus prior to birth) and can also include removing the cervix.⁵³ Penile enlargement surgery inserts silicone under the patient’s penis skin to make the penis longer and wider.⁵⁴ Gonadectomies are more commonly performed when doctors have assigned the female gender and remove present testes.⁵⁵ However, if a male gender is instead assigned, the surgery removes the baby’s ovaries.⁵⁶

The statistics are staggering: essentially, 12% of people with intersex conditions are assigned a gender by immediate, post-birth feminizing or masculinizing surgery; this means that unlike Becks, twenty-one babies per day are unable to consent to their own identity.⁵⁷ A doctor’s performance of such a “normalizing” surgery can, and too often does, result in the doctor surgically assigning a gender that is different from the gender the person chooses to identify with in adulthood.⁵⁸ The consequences felt by victims of such surgeries include physical suffering like “incontinence, scarring, [and] lack of sensation,”⁵⁹ and emotional trauma like “post-traumatic stress disorder, problems with intimacy and severe depression.”⁶⁰

In general, surgeons and other medical practitioners are undecided on how to best protect their young intersex patients; this is due in large part to the scarce amount of data that exists in directing physicians’ actions.⁶¹ The United States does not mandate reports on surgical procedures and their outcomes, so the “most reliable sources” are incomplete, voluntary reports by physicians and patients.⁶² These voluntary studies “are used by practitioners in advising parents” of children with intersex conditions.⁶³ However, the relevant studies do not even address whether the patient was given the option to opt out of surgery nor do they include the patients’ opinions on their lives “had they not been operated on.”⁶⁴ Additionally, the scarce data that *does* exist is mainly firsthand accounts of rage and depression due to the patients’ gender dysphoria or loss of sex-

cost [https://perma.cc/ZT7N-KAFA] (last updated Feb. 28, 2019); Andres Calvo et al., *Laparoscopic Approach for Gonadectomy in Pediatric Patients With Intersex Disorders*, 5 *TRANSLATIONAL PEDIATRICS* 295, 299 (2016).

52. *Orchiopexy*, *supra* note 51.

53. *Hysterectomy*, *supra* note 51.

54. *Penis Enlargement Surgery*, *supra* note 51.

55. *Frequently Asked Questions*, *supra* note 23.

56. Calvo et al., *supra* note 51, at 298.

57. *See, e.g.*, Blackless et al., *supra* note 8, at 151, 161.

58. *INTERACT & HUM. RTS. WATCH*, *supra* note 13, at 152.

59. *US: Harmful Surgery on Intersex Children*, *supra* note 39 (noting that “[o]perations to alter the size or appearance of children’s genitals” pose such physical risks).

60. *INTERACT & HUM. RTS. WATCH*, *supra* note 13, at 152 (referencing anecdotes from “generations of intersex adults” dealing with such emotional trauma).

61. *See id.* at 50–51.

62. *Id.*; *see* Elaine M. Burns et al., *Understanding the Strengths and Weaknesses of Public Reporting of Surgeon-Specific Outcome Data*, 35 *HEALTH AFF.* 415, 415 (2016).

63. *INTERACT & HUM. RTS. WATCH*, *supra* note 13, at 50–51.

64. *Id.*

ual function from involuntary youth surgeries, as well as accounts of shame from delayed knowledge of such person-altering interventions.⁶⁵ However, these anecdotes are largely unrefuted by science due to the fact that for the past fifty years, surgical correction of ambiguous genitalia has been “shrouded in shame and secrecy,”⁶⁶ so there was no medical follow-up.

Admittedly, some of these surgical interventions are “medically necessary,” such as repairing the child’s internal bladder that is exposed or removing abnormal gonadal structures that are high risk for malignancy.⁶⁷ The current controversy, however, lies in whether surgeons should be able to perform “risky and medically *unnecessary*[,] often purely] cosmetic[,] surgeries on intersex children . . . before they are even able to talk.”⁶⁸

D. AMERICAN SOCIAL AND MEDICAL CULTURE SURROUNDING THE DECISION TO PERFORM UNNECESSARY INTERSEX SURGERIES

American culture is obsessed with the idea that “there are *only* two sexes” despite the biological fact that humans are born with non-exclusively male or female sex anatomy as often as they are born with red hair.⁶⁹ Infant gender-assignment surgeries became popular in the mid-1900s after American psychologist and sexologist John Money published an extensive study, the results of which he coined his Sex Assignment Theory.⁷⁰ The premise of his theory was that in order for a child to have a “stable ‘normal’ gender identity,” the child *must* grow up with “unambiguous genitalia and unequivocal assurance from parents as to the[ir] chosen gender.”⁷¹ Money concluded that “correction of ambiguous genital appearance” is necessary for the child’s psychological health.⁷²

The shock-factor of such a radical and one-sided study, the subject of which was previously unspoken,⁷³ accentuated Money’s Sex Assignment

65. See GREENBERG, *supra* note 8, at 27 (detailing a true story about Cheryl, whose parents consented to operation on her at eighteen months that removed her phallus in order to conform her genitalia to that of a “feminine” girl). “By nineteen, she was filled with rage and had suicidal thoughts.” *Id.*

66. *Id.* at 17.

67. *US: Harmful Surgery on Intersex Children*, *supra* note 39, at 3; Caroline Lowry, *Intersex in 2018: Evaluating the Limitations of Informed Consent in Medical Malpractice Claims as a Vehicle for Gender Justice*, 52 COLUM. J.L. & SOC. PROBS. 321, 328 (2018) (discussing examples of surgeries performed on intersex minors required to improve necessary bodily functions); INTERACT & HUM. RTS. WATCH, *supra* note 13, at 24.

68. *US: Harmful Surgery on Intersex Children*, *supra* note 39, at 3 (emphasis added).

69. Anne Fausto-Sterling, *How Many Sexes Are There?*, N.Y. TIMES (Mar. 12, 1993), <https://www.nytimes.com/1993/03/12/opinion/how-many-sexes-are-there.html/> [<https://perma.cc/EHQ4-P5PA>] (discussing generally Americans’ obsession with “maintaining a two-party sexual system,” including the draft registration system which distinguishes males and females and until recently, laws regarding marriage between a male and a female) (emphasis added).

70. See Beh & Diamond, *supra* note 15, at 14.

71. Sarah Creighton, *Surgery for Intersex*, 94 J. ROYAL SOC’Y MED. 218, 218 (2001).

72. Beh & Diamond, *supra* note 15, at 14.

73. Children born with intersex conditions.

Theory in the late 1950s.⁷⁴ The increasing popularity of the theory—that genital ambiguity harms a child’s health—resulted in fear among the medical community.⁷⁵ Doctors (especially pediatric doctors) pervasively began using harsh and hysterical language, even publicly referring to a baby with intersex conditions as a “hopeless psychologic misfit *doomed to live always as a sexual freak in loneliness and frustration*” unless assigned a gender at birth.⁷⁶ Understandably, this domino effect led to societal mania in the 1960s.⁷⁷ That time period began the ever-existing “state of rigid uniformity”⁷⁸: physicians commonly advise parents to subject their babies to surgery to conform ambiguous sexual organs to “a binary sex norm.”⁷⁹ Existing pressure from this state is illustrated by a 2004 study. Eighty-nine percent of parents consented to genital surgery on their intersex child’s behalf, the motivation being “the potential for a more natural genital appearance” for the child’s social wellbeing.⁸⁰

The pressure on parents to subject their gender-ambiguous infants to surgery has persisted for over sixty years, despite the lack of research indicating positive outcomes of such procedures or that the doctor assigns the right gender even half of the time.⁸¹ In fact, American custom is to assign children with intersex conditions as female by removing extra tissue.⁸² Shockingly, more than *eighty* percent of the time that ambiguous genitalia are evident, doctors assign the baby as a female by performing one of the feminizing procedures detailed above.⁸³ However, nowhere near eighty percent of all babies with intersex conditions choose to iden-

74. Beh & Diamond, *supra* note 15, at 15.

75. See CHRISTOPHER J. DEWHURST & RONALD R. GORDON, *THE INTERSEXUAL DISORDERS* 1 (1969).

76. Doctors Dewhurst and Gordon published their opinion that a child’s gender being in doubt is a “tragic event” which will “conjure up [in the child] visions of [that] hopeless psychologic misfit.” *Id.* (emphasis added).

77. Beh & Diamond, *supra* note 15, at 15 (emphasizing parents’ resulting belief in the need to assign a child’s gender immediately after birth); Fausto-Sterling, *supra* note 69.

78. Fausto-Sterling, *supra* note 69.

79. GREENBERG, *supra* note 8, at 21.

80. Jennifer E. Dayner et al., *Medical Treatment of Intersex: Parental Perspectives*, 172 *J. UROLOGY* 1762, 1762–63 (2004) (a study of parents to intersex children ages eighteen months to thirteen years). “A common goal of medically unnecessary surgeries on intersex children who are too young to consent is to help them conform to gender and sexual norms and expectations, thereby easing psycho-social stresses through childhood and adolescence.” INTERACT & HUM. RTS. WATCH, *supra* note 13, at 94.

81. INTERACT & HUM. RTS. WATCH, *supra* note 13, at 108 (“[T]here remains no research showing that early, medically unnecessary genital surgery is helpful to the intersex child[,] [n]or is there data to predict gender identity outcomes with confidence in many intersex conditions—meaning that doctors are sometimes conducting sex assignment surgeries that the children will later reject. . . . [D]octors give parents information about gender identity, surgical risks, and the reversibility of certain procedures that have no basis in medical literature.”).

82. Catherine L. Minto et al., *The Effect of Clitoral Surgery on Sexual Outcome in Individuals Who Have Intersex Conditions*, 361 *LANCET* 1252 (2003).

83. Reiner, *supra* note 42, at 550–51 (analyzing a study in which 82% of adults with intersex conditions had been surgically assigned female, but only 31% declared female as their gender).

tify as female adults. Studies show⁸⁴ that not even eighty percent of the *typically female* XX-chromosome infant patients—who are subject to male-hormone producing genetic disorders like CAH—later identify as females. Doctors commonly operate in a way to conform babies’ genitalia to that of a typical female solely because it is easier for them to construct or to keep a cosmetically attractive vagina and clitoris intact.⁸⁵ Thus, doctors’ decisions are not based on legitimate support such as increased health risks associated with masculinizing surgeries or on statistical data indicating overwhelming patient preference for a female identity; the decision is purely based on appearance and ease.⁸⁶

Although doctors believe that individuals with intersex traits “may be exposed to an increased risk of gonadal cancer over time,” there is sparse evidence of actual cancer rates or even of cancer risks for “specific intersex conditions.”⁸⁷ Additionally, physicians who tried to discover evidence that having atypical genitalia leads to psychological distress were unable to find any.⁸⁸ In fact, there is only one documented suicide resulting from “uncorrected” intersex conditions, that of Abel Barbin in 1860, and that suicide is detailed by experts as the result of society’s ostracizing reaction to his admission of genital ambiguity (not from his own detestation of such features).⁸⁹ Relatedly, physicians advocating for sexual normalizing surgeries point to transgender youth’s suicide rates, which is misguided. Transgender suicide is typically “driven by . . . discrimination and harassment . . . [and] ill-treatment by doctors—not by whether their genitals match their gender identity.”⁹⁰

Therefore, the pervasive hysteria surrounding abnormal genitals coupled with little medical evidence supporting cosmetic surgeries’ necessity leads to a reasonable conclusion that cancer and psychological risks are pretexts for doctors imposing on children their idea of normalcy. “Normalcy” is not a valid reason for altering children’s anatomy—and ultimately, identity—without their consent.

84. *Id.*; See Vickie Pasterski et al., *Increased Cross-Gender Identification Independent of Gender Role Behavior in Girls with Congenital Adrenal Hyperplasia: Results from a Standardized Assessment of 4- to 11-Year-Old Children*, 44 ARCHIVES SEXUAL BEHAV. 1363 (2015) (analyzing the gender self-identification of forty-three girls and thirty-eight boys with CAH all aged four to eleven years).

85. *Intersex*, *supra* note 18.

86. *See id.*

87. INTERACT & HUM. RTS. WATCH, *supra* note 13, at 95.

88. ALICE DREGER, GALILEO’S MIDDLE FINGER: HERETICS, ACTIVISTS, AND ONE SCHOLAR’S SEARCH FOR JUSTICE 39 (2016).

89. *See* ALICE DOMURAT DREGER, HERMAPHRODITES AND THE MEDICAL INVENTION OF SEX 19 (rev. ed. 2009).

90. *See* Russell B. Toomer et al., *Transgender Adolescent Suicide Behavior*, 142 PEDIATRICS 1 (2018); Kyle Knight, *If a Doctor Tells a Parent That Surgery Could Prevent Their Child’s Suicide, It’s Not True*, HUFFPOST (Sept. 11, 2017, 1:30 AM), https://www.huffpost.com/entry/if-a-doctor-tells-a-parent-that-surgery-could-prevent_b_59af2445e4b0c50640cd62da [<https://perma.cc/UFG9-4EHK>].

E. EMOTIONAL TRAUMA AND PHYSICAL AILMENTS CALL FOR LESS PERMANENT, NON-SURGICAL MEASURES

Current pediatric surgical practice is still based on the dated understanding that “one’s sexual identity is so entwined with the appearance of one’s genitals that it is worth subjecting infants to a major operation to assure visual concordance between one and the other.”⁹¹ Not only are these unnecessary intersex surgeries imposed on infants for illegitimate reasons, the irreversible results are often emotionally and physically harmful.⁹² In fact, these surgeries that are premised on preventing future psychological damage—from being slightly different than others—generally results in that very harm. For example, an individual subjected to intersex surgeries in childhood later lamented as an adult, “All of these exams on my body as a kid sent a strong message that I was freakish[] and that I had something wrong with me that had to do with my sex.”⁹³ Another—whose enlarged clitoris was trimmed as an infant—is considered a “*success stor[y]*” because she “still ha[s] clitoral sensation[] and [is] orgasmic” even though she said that “it’s taken [her] whole life to come to terms with [her] body and not to feel such terrible shame” due to the procedure.⁹⁴

Further negative repercussions include lack of sexual pleasure. A research study conducted by Dr. Catherine Minto indicated that feminizing surgery (specifically, clitoridectomies) could negatively affect a patient’s “sexual function—frequency of intercourse, degree of satisfaction, avoidance, sensuality, vaginal penetration, and orgasm.”⁹⁵ For example, forty-year-old Ms. Chase had her enlarged clitoris removed as a young child as “treatment” for her intersex condition; as a result of the procedure, she “has no clitoral sensation, has never had an orgasm and is still bitter about the loss.”⁹⁶ Minto’s study questioned thirty-nine adults with ambiguous genitalia, eighteen of whose clitorises had been trimmed or removed at birth⁹⁷: “Every one of the 18 women who had undergone clitoral surgery had higher rates of non-sensuality—a lack of enjoyment in being caressed and in caressing their partner’s body—than those who didn’t have surgery; 39% of those who had clitoral surgery were unable to achieve orgasm.”⁹⁸

Additional harmful outcomes include a lifetime of necessary hormone replacement therapy and irreversible gender assignments. Gonadectomies (removal of the ovaries or the testes) can amount to sterilization—

91. Angier, *supra* note 1.

92. *US: Harmful Surgery on Intersex Children*, *supra* note 39 (“[E]vidence does show that the [cosmetic] surgery itself can cause severe and irreversible physical harm and emotional distress”).

93. INTERACT & HUM. RTS. WATCH, *supra* note 13, at 67 (quoting Interview by Human Rights Watch with Theresa N., Cal. (Oct. 26, 2016)).

94. Angier, *supra* note 1 (emphasis added).

95. Minto, *supra* note 82, at 1253.

96. Angier, *supra* note 1.

97. Minto, *supra* note 82, at 1253.

98. *Id.*

making the patient unable to produce offspring—”without the patient’s consent.”⁹⁹ On top of potential infertility, the procedures also “require lifelong hormone replacement therapy [(HRT)].”¹⁰⁰ The most common types of HRTs include ingesting tablets of progesterone and estrogen but can also include hormonal creams and patches.¹⁰¹ These therapies are necessary after gonadectomies are performed on pre-pubescent children in order to later induce puberty; in turn, puberty aids in developing the child’s brain function and in developing the child’s features such as breasts, facial hair, and deepness of voice.¹⁰² These therapies do not end once puberty is induced. The child will have to undergo these therapies for the remainder of his or her life to ensure full sexual development and to prevent physical symptoms like hot flashes.¹⁰³ The risks of long-term hormone consumption is still highly unknown, but research studies indicate that “the risk of breast cancer is now thought to rise if HRT is used for over 5 years,” which is the case for most intersex individuals.¹⁰⁴ Lastly, other general repercussions of “[o]perations to alter the size or appearance of children’s genitals” include “incontinence, scarring,” severance of nerves which can never regrow, and “scar tissue [which] can limit options for future surgery.”¹⁰⁵

Conversely, not *all* patients who were operated on as infants have necessarily experienced more negative than positive side effects. It is impossible for us to definitively argue as such, due to the lack of research.¹⁰⁶ The fact is, however, that there *are* known harmful side effects from non-consensual gender-assignment surgeries while there is no scientific basis to support that the supposed positive psychological benefits outweigh those risks.¹⁰⁷ On the other hand, without such surgery, the child “can be raised as either [or neither] sex” without health complications.¹⁰⁸ To counter any potential psychological damage on the child, non-irreversible

99. *US: Harmful Surgery on Intersex Children*, *supra* note 39.

100. *Id.*

101. Yvette Brazier, *What You Need to Know About HRT*, MEDICALNEWSTODAY (Apr. 13, 2020), <https://www.medicalnewstoday.com/articles/181726.php> [<https://perma.cc/6RJL-TPKW>].

102. Lucia Lanciotti et al., *Different Clinical Presentations and Management in Complete Androgen Insensitivity Syndrome (CAIS)*, 16 INT’L J. ENVTL. RES. & PUB. HEALTH 1268 (2019).

103. *See id.*

104. Brazier, *supra* note 101 (citing research conducted for Women’s Health Concern in November 2017 and referencing a report published in 2012 by *The BMJ Journals* indicating that “HRT may increase the risk of breast cancer”).

105. *US: Harmful Surgery on Intersex Children*, *supra* note 39.

106. C.R.J. Woodhouse, *Intersex Surgery in the Adult*, 93 BJU INT’L 57, 62 (2004) (“The observation that adult outcome of babies born with intersex disorders is not uniformly satisfactory does not . . . imply that earlier management was wrong, let alone malevolent . . . [because] [m]edical protocols are based on the best evidence available at the time.”). “In the questionnaire survey of [the] hospital patients . . . the return rate was only 50%. The other 50% may have normal sexual function and might even be better off without the burden of knowing their diagnosis.” *Id.*

107. *See US: Harmful Surgery on Intersex Children*, *supra* note 39; Brazier, *supra* note 101; Lanciotti et al., *supra* note 102; Angier, *supra* note 1.

108. *US: Harmful Surgery on Intersex Children*, *supra* note 39.

alternative treatments can be offered, like psychological treatment.¹⁰⁹ The reasonable treatment of intersex conditions, therefore, seems to be reversible options that allow the child to determine for itself if and when irreversible gender assignment is fitting.

III. THE AMERICAN LEGISLATIVE FIGHT FOR INTERSEX AUTONOMY

American “laws do not specifically protect [intersex] children” against medical procedures that are forced on them without “free or informed consent.”¹¹⁰ Several areas of American law, such as those regulating sterilization and female genital mutilation, do “prohibit conduct that could be *interpreted* to include medically unnecessary intersex surgeries,” but they have never been enforced in that context.¹¹¹

The intersex community’s first (failed) fight for bodily autonomy occurred in the Texas, Indiana, and Nevada legislatures. Before the vehicle of this Comment¹¹² was proposed, those states attempted to pass legislation related to intersex surgical prohibition.¹¹³ In 2017, the Texas Legislature introduced Senate Bill 1342, which prohibited non-medically necessary intersex surgeries on *foster* children younger than twelve years old without a court order declaring the procedure to be “in child’s best interests.”¹¹⁴ The bill failed in committee before even going to a vote.¹¹⁵ There have been no further efforts in Texas to protect children from intersex surgeries. In 2019, “[Texas] legislators decided to pass a law protecting Texans from e-cigarettes until they reach the age of 21 . . . [but] [t]hey left children able to be sterilized and mutilated [at birth].”¹¹⁶

Similarly, Indiana’s 2017 House Bill 1461 also proposed to outlaw intersex surgeries on minors in foster care and also failed before receiving a hearing.¹¹⁷ Nevada’s Senate Bill 408 was more protective, in that it prohibited physicians from performing “anatomical sex” assignment on children without their assent unless “delaying the procedure [was] likely to endanger” the child.¹¹⁸ However, it has still left ambiguous discretion for parents and physicians. It died in the Senate’s Committee on Health and

109. See *Intersex*, GOODTHERAPY, <https://www.goodtherapy.org/blog/psychpedia/intersex> [<https://perma.cc/RBT4-665M>] (last updated Sept. 10, 2019).

110. INTERACT & HUM. RTS. WATCH, *supra* note 13, at 145 (referencing the 2016 US Department of State statement issued on Intersex Awareness Day, which acknowledged that American intersex children are still unprotected by law and are commonly subject to forced procedures that “jeopardize their physical integrity and ability to live free”).

111. *Id.* (emphasis added).

112. California’s broad moratorium on intersex surgeries.

113. See, e.g., Tex. S.B. 1342, 85th Leg., R.S. (2017).

114. *Id.*

115. See *id.*

116. Madlin Mekelburg, *What Does the Law Say About Children and Sex Reassignment Surgery?*, POLITIFACT (Nov. 11, 2019), <https://www.politifact.com/factchecks/2019/nov/11/cindi-castilla/what-does-law-say-about-children-and-sex-reassignm/> [<https://perma.cc/Y4N2-PZ9Y>].

117. H.B. 1461, 120th Gen. Assemb., Reg. Sess. (Ind. 2017).

118. S.B. 408, 79th Leg., Reg. Sess. (Nev. 2017).

Human Services.¹¹⁹

Then, on January 28, 2019, California Democratic Senator Scott Wiener authored and introduced California Senate Bill 201, a complete ban on doctors' performance of medically unnecessary treatments on variations in sex characteristics without the individual's informed consent.¹²⁰ As initially introduced, the bill did not define the age of consent.¹²¹ Instead, it generally outlawed such surgery unless the child born with intersex conditions could agree to the operation after "a physician and surgeon . . . [provided] a written and oral disclosure" of the operation's purpose and effects.¹²² After criticism for not drawing such a line, on January 6, 2020, Wiener chose six years to be the legal floor at which time doctors could even attempt such procedures.¹²³ He reasoned that "a 6 year[old] is old enough to express feelings so that a parent can make a more informed choice for the child."¹²⁴ In its current state, the short yet sweeping California Senate Bill 201 prohibits "treatment or intervention on the sex characteristics" of an individual "who is under 6 years of age *unless* the treatment or intervention is medically necessary."¹²⁵ It requires the Medical Board of California to consult with entities like the State Department of Public Health in order to publicly clarify "medically necessary" procedures before December 1, 2021.¹²⁶

On January 13, 2020, the current bill was voted on by the California Senate's Business, Professions and Economic Development Committee.¹²⁷ It failed with four senators' (one Republican and three Democrats) no votes and three senators' (one Republican and two Democrats) abstention, despite two Democratic senators' yes votes.¹²⁸ Although California Senate Bill 201 is a partisan Democrat bill, some of its own party supporters voted against it only because it "requires some narrowing."¹²⁹

119. See *Nevada Senate Bill 408*, LEGISCAN, <https://legiscan.com/NV/bill/SB408/2017> [<https://perma.cc/S7K9-D32X>].

120. S.B. 201, 2019–2020 Leg., Reg. Sess. (Cal. 2019).

121. *Id.*

122. *Id.* (quoting the bill's January 31, 2019 version, prior to both the March 2019 and January 2020 amendments).

123. See Cal. S.B. 201 § 2295(c)(1) (analyzing the January 6, 2020 version of California Senate Bill 201).

124. Melody Gutierrez, *Legislation to Ban Surgery on Intersex Children Fails in California Senate Committee*, L.A. TIMES (Jan. 13, 2020, 4:13 PM), [latimes.com/california/story/2020-01-13/legislation-to-ban-surgery-on-intersex-children-fails-in-california-senate](https://www.latimes.com/california/story/2020-01-13/legislation-to-ban-surgery-on-intersex-children-fails-in-california-senate) [<https://perma.cc/6NGN-U45G>] (noting that the bill "would have been criticized no matter what age [was] put in").

125. Cal. S.B. 201 (emphasis added).

126. *Id.*

127. *Id.* (noting that the bill required a majority vote of yes to become law).

128. *Roll Call: CA SB201*, LEGISCAN, <https://legiscan.com/CA/rollcall/SB201/id/902217> [<https://perma.cc/B5P3-JTA5>].

129. Nora Neus, *Ban on Cosmetic Surgeries on Intersex Infants Fails Key California Vote*, CNN (Jan. 14, 2020, 7:28 AM), <https://www.cnn.com/2020/01/13/us/california-cosmetic-surgeries-intersex-infants-senate-vote/index.html> [<https://perma.cc/49DB-BZY9>] (quoting Senate Committee leader, Democrat Steve Glazer, who abstained from voting, "I oppose sex assignment surgery on infants born with ambiguous sex characteristics. [But] I believe a narrower bill could be crafted to achieve that objective.").

This argument is similar yet slighter than the medical community's general opposition to a ban on intersex surgeries, detailed below.

If the bill passed, California would have been the first state to mandate patient decision-making before the performance of feminizing or masculinizing intersex procedures. Wiener plans to continue this fight for intersex patient participation during California's next legislative session because "[a]s with many civil rights struggles, it sometimes takes multiple tries to prevail."¹³⁰

IV. RESPONDING TO THE MEDICAL COMMUNITY'S OPPOSITION TO A MORATORIUM ON INTERSEX SURGERIES

The California Medical Association (CMA), the most vocal opponent to California Senate Bill 201, is "opposed to legislating the practice of medicine" in general due to the complex nature of individual care.¹³¹ The CMA specifically opposes California Senate Bill 201 for its oversimplicity and unclearly defined "medically necessary" exception.¹³² Further, the association argues that the "emotional health and future of the patient" is jeopardized by the bill because it creates other risks such as the patient's family rejecting the child's abnormalities.¹³³ The Societies for Pediatric Urology also opposes the bill because it restricts families from considering "all viable [treatment] options" for their infants with intersex conditions.¹³⁴

Physicians typically prefer a more case-specific, individualized approach to medical care. A strong advocate of individualized care who vehemently opposes any legal interference in medical practice is bioethicist Claudia Wiesemann.¹³⁵ She argues that patient autonomy is actually *lost* with postponed informed consent.¹³⁶ For example, a child with AIS will, at puberty, face the "effects of male-typical pubertal development."¹³⁷ To avoid these affects, hormone therapy must start at a younger age.¹³⁸ Thus, physicians believe that postponing gender-assignment surgeries until the patient is old enough to consent (as California Senate Bill 201 proposes) "clos[es] an important window of opportunity for the child."¹³⁹ The CMA similarly argues that a total postponement of surgery is not appropriate

130. Neus, *supra* note 129.

131. Matthew S. Bajko, *CA Medical Group Opposes Intersex Surgery Ban*, BAY AREA REP. (Mar. 18, 2019), https://www.ebar.com/news/latest_news//273719 [<https://perma.cc/5Y49-WGUG>].

132. *Id.*

133. *Id.*

134. *Id.*

135. See Claudia Wiesemann et al., *Ethical Principles and Recommendations for the Medical Management of Differences of Sex Development (DSD)/Intersex in Children and Adolescents*, 169 EUR. J. PEDIATRICS 671, 671 (2009) (publishing the first exhaustive ethical guidelines for intersex medical management from physicians' points of view).

136. *Id.* at 673.

137. *Id.*

138. *Id.*

139. *Id.*

because there are still risks involved in waiting, and “clinical evidence for the methods of risk assessment at this stage are still inconclusive.”¹⁴⁰

However, these autonomy arguments by Wiesemann and the CMA imply that physicians’ assignments of gender prior to puberty likely have more *positive* than negative long-term, irreversible effects. But those arguments don’t acknowledge the fact that “benefits of early surgical intervention are unproven at best.”¹⁴¹ On the other hand, negative irreversible repercussions of early, nonconsensual operations are plenty.¹⁴² Finally, California Senate Bill 201’s ban is only enforced until the patient is six years old, which is typically well before puberty begins and is an age at which even Wiesemann admits people can start to make informed decisions.¹⁴³

V. SUPPORT FOR LEGISLATION PROTECTING AGAINST STANDARDS OF IRREVERSIBLE CARE

*“The [primary] goal of the intersex-rights movement is literally the right to exist.”*¹⁴⁴

As discussed, intersex surgeries’ popularity surged in the 1960s at a time when Americans were first learning about intersex characteristics but refusing to openly discuss them.¹⁴⁵ Society stigmatized the conditions and, out of fear, parents began consenting to “normalizing” surgeries on their gender-nonconforming children.¹⁴⁶ Consequently, such hysteria silenced parents and their intersex children from discussing their real experiences (in either having forced operations or foregoing them) to avoid ostracization.¹⁴⁷ Since that era, surgeries on babies with intersex conditions have become the standard protocol—albeit a risky, lazy, and unfair one—out of a perceived need to create for the child a binary, “normal” identity.¹⁴⁸

However, because a practice was considered acceptable in the past does not necessarily mean we should idly stand by it today.¹⁴⁹ There is

140. Bajko, *supra* note 131.

141. Lowry, *supra* note 67, at 332; see Milton Diamond & Jameson Garland, *Evidence Regarding Cosmetic and Medically Unnecessary Surgery on Infants*, 10 J. PEDIATRIC UROLOGY 2, 4 (2013) (indicating that “[t]here is no evidence at this time that either early surgery or late surgery better preserves sexual function” (alteration in original)).

142. See *supra* Part II.E.

143. Wiesemann, *supra* note 135, at 674.

144. Joseph Huff-Hannon, *Don’t Call Them Hermaphrodites*, DAILY BEAST (July 14, 2017, 5:16 PM), <https://www.thedailybeast.com/dont-call-them-hermaphrodites> [<https://perma.cc/HXH7-2TXL>] (discussing the plight of the intersex community to outlaw doctors from “offer[ing] to the parents of intersex babies] the immediate opportunity to surgically alter their child”).

145. See Beh & Diamond, *supra* note 15, at 6–7.

146. *Id.* at 15.

147. *Id.* at 24.

148. See *id.* at 25.

149. Consider, for example, the history of nonconsensual human experimentation, like American doctors in the 1940s who infected prisoners with malaria to test anti-malaria drugs; such “atrocit[y]” is considered ubiquitously unethical now but was common practice at one time. Nina Amramova, *Unethical Experiments’ Painful Contributions to Today’s*

little reason to condone forced sex-assignment operations in light of a newer and better understanding of their negative repercussions and the ability to live with sexual abnormalities without health risks.¹⁵⁰ Today, there is a prevalence of openly intersex community members acknowledging their nonconforming reproductive traits.¹⁵¹ Intersex advocacy and education groups, which were unheard of in the 1960s, now exist.¹⁵² There is an accessible dialogue—which did not exist fifty years ago—from adults who were subjected to binary-identity imposing surgeries as children.¹⁵³ Our evolving awareness demands protection against these uninformed, emotion-driven, and nonconsensual operations on children, and our laws should not allow physicians to cater to an unaccepting society.¹⁵⁴

A. LIMITED PARENTAL AUTHORITY IS APPROPRIATE IN THE INTERSEX SURGICAL CONTEXT

*“While an adult . . . is quite free to submit [one]self to a ritual or tradition, a child has no formed judgment and does not consent, but simply undergoes the operation while . . . totally vulnerable.”*¹⁵⁵

Narrow parental authority is appropriate in the intersex surgical context because surrogate medical decision-making can reasonably be read narrowly under the Family Code, federal courts have suggested limitations, legislative resisters agree with restricted discretion, and the risk of harm is too great to leave in the hands of impressionable parents. If a competent patient does not consent to surgery, then the medical intervention amounts to illegal battery.¹⁵⁶ However, state statutes grant parental authority to consent to medical decisions on behalf of their child.¹⁵⁷ Specifically, family codes like those in Texas grant parental right to consent for “medical care” and “surgical treatment.”¹⁵⁸ Even a textual interpretation leads to an understanding that medical “care” or “treatment” imply parents’ decisional discretion is appropriate only when it involves a disfunction that necessarily needs to be corrected for the child’s health.¹⁵⁹

Medicine, CNN HEALTH (Jan. 21, 2019, 8:07 PM), <https://www.cnn.com/2019/01/09/health/unethical-experiments/index.html> [<https://perma.cc/WXQ9-GWMB>].

150. Today, it is not presumed that the intersex individual will be isolated as a “sexual freak.” See DEWHURST & GORDON, *supra* note 75.

151. See Zieselman, *supra* note 11.

152. See *id.*

153. See *id.*

154. Rejecting the CMA’s argument that the “emotional health and future of the patient” is jeopardized by [a moratorium] because it creates . . . risks such as the patient’s family rejecting the child’s abnormalities.” *Supra* text accompanying note 133.

155. Cheryl Chase, *Genital Surgery on Intersexed Children*, HEALTHYPLACE (Feb. 7, 1998), <https://www.healthyplace.com/gender/inside-intersexuality/genital-surgery-on-intersexed-children> [<https://perma.cc/SR5U-965H>].

156. Wiesemann et al., *supra* note 135, at 673.

157. See TEX. FAM. CODE Ann. § 151.00(6) (West 2001) (noting that parents have the right to consent to their minor child’s medical care).

158. *Id.*

159. See *Medical Care*, VOCABULARY.COM, <https://www.vocabulary.com/dictionary/medical%20care> [<https://perma.cc/WBF3-ZQDX>] (defining “medical care” as “intend[ing] to relieve illness or injury”).

As noted, these cosmetic intersex surgeries are not aimed at improving the child's health; thus, parents' authority should at the least not be granted freely.¹⁶⁰

Although the United States Supreme Court has acknowledged the "traditional presumption that the parents act in the best interests of their child," the Court did observe that "parents cannot always have absolute and unreviewable discretion" to make life-altering decisions for their child.¹⁶¹ Additionally, the Court has never held that the right of the parent to make decisions regarding childcare is "fundamental"—but it *has* held as unconstitutional the absolute decision-making power of parents over minors for some medical treatments, such as abortion.¹⁶² The CMA would surely counter that a parent's decision to allow genitalia-altering operations on his or her child is made only after review and informed advice by physicians.¹⁶³ However, the Court has very significantly precludes parents' substantial decision-making roles in the instance of resulting "abuse."¹⁶⁴ Although the Court has not yet addressed the abusive nature of intersex surgeries, it is clear from intra-comment research that such surgeries lead to permanent, severe ailments.¹⁶⁵

In fact, the Supreme Court *did* explicitly find nonconsensual removal of a prisoner's reproductive organs to be abusive.¹⁶⁶ Further, a federal court condemned as "abusive" a father imposing his own "cure" to his son's "girlie" and "queer" behavior by calling the son "faggot" in order to reverse such inherent behavior.¹⁶⁷ According to the Court, subjecting a child to mistreatment because the parent is "embarrass[ed]" by the child is not acceptable in the home;¹⁶⁸ undoubtedly, mistreatment for those same reasons should not be acceptable in an operating room either. Therefore, the Supreme Court would likely hold intersex surgeries to be abusive, thus negating the argument for parental right to consent to a child's unnecessary operation.

Notably, legal-moratorium opposer and bioethicist Claudia Wiesemann, who believes that parents should take a "major" decision-making role in intersexual medical management, also believes that par-

160. *See supra* Part II.

161. *Parham v. J.R.*, 442 U.S. 584, 604 (1979) (limiting the parents' decision-making ability in the context of institutional commitment); *see also* *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) ("Minors, as well as adults, are protected by the Constitution . . .").

162. JEFFREY SHULMAN, *THE CONSTITUTIONAL PARENT: RIGHTS, RESPONSIBILITIES, AND THE ENFRANCHISEMENT OF THE CHILD* 8 (2014); *Danforth*, 428 U.S. at 75.

163. *See supra* Part IV.

164. *See Parham*, 442 U.S. at 604.

165. *Supra* Part II (discussing the negative repercussions like irreversible removal of reproductive capability, physical pain, lack of sexual stimulation, and emotional trauma).

166. *See Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 538 (1942) (emphasizing that nonconsensual sterilization is "cruel"); *see Abusive*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/abusive> [<https://perma.cc/4VFR-E4Z9>] (noting that "abusive" is interchangeable with "cruel").

167. *In re Shane T.*, 453 N.Y.S.2d 590, 593 (N.Y. Fam. Ct. 1982).

168. *Id.*

ents' discretion *should* be limited.¹⁶⁹ Because children are “able to understand biological processes . . . [and] reflect on their identity” by the young age of six,¹⁷⁰ the child is arguably able to—and should—be involved in sexual developmental decisions.

Finally, the power that our society places in parents' hands can be dangerous because “parental reaction [does not] always dictate[] the proper, or the best, treatment of infants.”¹⁷¹ The decisions that parents should be able to decide for babies could be its own paper topic. However, it is worth considering two timely topics in which parents have been understood to abuse their discretion: vaccinations and conversion therapy. Adults' vulnerability in the face of a global pandemic reflects babies' vulnerability in the face of their parents' choice not to vaccinate them. The parents' choice not to vaccinate, like the choice to modify organs, leaves the child at risk to irreversible ailments.¹⁷² But it is especially dangerous for traditionally trusted doctors to *give* parents the advice to “correct” sexual abnormalities when parents are at their most anxious—immediately after childbirth.¹⁷³

Legislators who wish to “enhance the rights of people with an intersex condition” share the same goal as those working on behalf of the LGBTQ+ community—to “eliminat[e] harmful practices based on sex and gender stereotypes.”¹⁷⁴ Therefore, it is especially relevant that twenty states so far have adopted “conversion therapy laws,” which prohibit medical practitioners like psychiatrists from subjecting LGBTQ+ minors to harmful conversion therapy practices that attempt to change their sexual orientation or gender identity.¹⁷⁵ These twenty states, including California, but not Texas, disallow parents from forcing children to undergo such therapy.¹⁷⁶ These states recognize that harms like “depression, anxiety and self-destructive behavior”—which real conversion therapy patients have related—are not worth the risk, which remains by allowing parents that discretion.¹⁷⁷ As detailed throughout this Comment, similar psychological risks remain when parents have the authority to consent to surgeries to “normalize” children's gender identity.¹⁷⁸ As experts at the highly respected, nonpartisan Hastings Center declared,

169. See Wiesemann et al., *supra* note 135, at 674.

170. *Id.*

171. Beh & Diamond, *supra* note 15, at 28–29.

172. See Jean Gough, *Saying No to Vaccines is Risking a Child's Life*, UNICEF (Apr. 25, 2019), <https://www.unicef.org/rosa/stories/saying-no-vaccines-risking-childs-life> [<https://perma.cc/K2UR-T7VF>] (children whose parents “reject routine vaccinations” are suffering from “deadly outbreaks of diseases that could have been prevented, like measles”).

173. See *supra* Part II.A.

174. GREENBERG, *supra* note 8, at 4.

175. LGBT POLICY SPOTLIGHT: CONVERSION THERAPY BANS, MOVEMENT ADVANCEMENT PROJECT (2017), <https://www.lgbtmap.org/file/policy-spotlight-conversion-therapy-bans.pdf> [<https://perma.cc/D3QY-Q692>]; see S.B. 1172, 2011–2012 Leg., Reg. Sess. (Cal. 2012) (California's law prohibiting forced “sexual orientation change efforts”).

176. LGBT POLICY SPOTLIGHT, *supra* note 175.

177. *Id.*

178. *Supra* Part II.

“surgical expediency [to normalize the appearance of genitalia] could [likely] [n]ever outweigh the psychosocial and ethical arguments for waiting until . . . children reach the age at which they can meaningfully participate in the decision.”¹⁷⁹

Ultimately, in the cases of infants with intersex conditions, their parents are granted full discretionary power in deciding whether the physician can operate. Since courts have not limited parental authority in the intersex context yet condemn parental abuse, and legislators have recognized the need to protect children from other gender-identity altering therapies, legislators should also necessarily initiate protection for intersex newborns against the scalpel.

B. EVOLVING KNOWLEDGE WARRANTS SIMILARLY EVOLVING LAW

The federal court system has been a public forum for expressing the evolution of societal perceptions. In the 1960s, not only were intersex conditions taboo but so were gay, lesbian, and bisexual sexual orientations.¹⁸⁰ However, in 2015, the United States Supreme Court made a ruling that propelled America out of that outdated perception.¹⁸¹ The Court in *Obergefell* legalized same-sex marriage, rejecting the outdated societal belief that “normal” marriage is between a man and a woman and recognizing *all* couples’ right to marry.¹⁸² Five years later (to the month), the Supreme Court, in a landmark decision, continued on the trajectory of equality for all sexual orientations and gender identities.¹⁸³ In *Bostock*, the Court addressed the issue of whether firing an employee “simply for being homosexual or transgender” constitutes discrimination “on the basis of sex” under Title VII of the Civil Rights Act of 1964.¹⁸⁴ The Court ruled that it does.¹⁸⁵ The resonance of this case lies in the majority’s arguably pragmatic approach to the reading of the word “sex”: Justice Gorsuch acknowledged that “[t]hose who adopted the Civil Rights Act might not have anticipated their work would lead to this particular result. . . . But the limits of the drafters’ imagination supply no reason to ignore the law’s demands.”¹⁸⁶ In 1964, homosexuality and nonbinary gender identity and gender-expansive identity were almost invisible, and therefore, Congress surely did not take it into consideration in lawmaking.¹⁸⁷ However, Congress’s lack of knowledge on sexual orientation and gender identity at the time of enactment should not dictate the Court’s statutory interpretation in a modern society where we have a clearer understanding of sex-

179. GREENBERG, *supra* note 8, at 22.

180. *See 1960s in LGBT Rights*, EQUALDEX, <https://www.equaldex.com/timeline/1960s> [<https://perma.cc/72PM-6M34>].

181. *Obergefell v. Hodges*, 135 S. Ct. 2584, 2608 (2015).

182. *Id.* at 2607–08.

183. *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020).

184. *Id.* at 1737.

185. *Id.*

186. *Id.*

187. *See id.*

ual minorities.¹⁸⁸ Years ago, the Court would not have understood, as the majority did here, that “[s]ex play[ed] a necessary . . . role in the [adverse employment] decision[s]” because “[a]n employer who fires an individual for being homosexual or transgender fires that person for traits or actions it would not have questioned in members of a different sex.”¹⁸⁹

The Court’s decision in *Bostock* is significant not only for showing an evolved understanding of sexual traits but also for aligning with the protection of intersex conditions, which are those that take the form of nonbinary gender identity. Analogously, federal courts are now specifically adopting a new understanding of intersexuality into law. In 2018, United States District Court Judge Jackson for the District of Colorado declared irrational a law that required an American citizen to identify as either male or female on one’s passport.¹⁹⁰ The court recognized that citizens with intersex conditions exist and should not be forced to choose a binary identity that doesn’t correspond neatly to their physical attributes or emotional beliefs.¹⁹¹ Thus, the law now allows citizens to instead indicate nonbinary gender identity (by marking “X”) on their passport.¹⁹² Federal courts have now acknowledged necessary protections for multiple sexual orientations and gender identities, which history disregarded. We need to reject the outdated idea that a “normal” upbringing requires strict, immutable male or female anatomy and identity, and recognize individuals’ right to exist as whatever gender (or nongender) they wish.

C. LAWS PROHIBITING NONCONSENSUAL STERILIZATION AND GENITAL MUTILATION ALREADY EXIST

Current American laws prohibiting sterilization and female genital mutilation (FGM) do not specifically address medically unnecessary intersex surgeries but *could* be interpreted as holding them unlawful. Nonconsensual sterilization was once common in the United States, but since 1942, it has been considered, in some circumstances, as an unlawful Constitutional violation of one’s “fundamental right to reproductive freedom.”¹⁹³ Bolstering the Supreme Court’s support for minors’ bodily autonomy, it more recently emphasized that “[c]onstitutional rights [such as those relating to reproduction] do not . . . come into being magically only when one attains the state-defined age of majority.”¹⁹⁴ Opponents of intersex surgical bans could argue that the more recent Supreme Court case, *Stump v. Sparkman*, allows those who intentionally sterilize minors with-

188. *See id.*

189. *Id.*

190. *See Zzyym v. Pompeo*, 341 F. Supp. 3d 1248, 1251 (D. Colo. 2018).

191. *Id.*

192. *Id.*

193. INTERACT & HUM. RTS. WATCH, *supra* note 13, at 146; *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942) (holding that “sterilization . . . is [a] cruel and unusual punishment and violative of the Fourteenth Amendment”).

194. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) (holding that a parent cannot decide whether the minor child will terminate or maintain her pregnancy—that decision is to be made by the pregnant minor).

out their consent to go unscathed.¹⁹⁵ However, that controversial case is distinguishable because it explicitly granted a judge—who allowed doctors to sterilize minors without their consent—legal immunity.¹⁹⁶ The case did not comment on the constitutionality of the actual act of nonconsensual sterilization.¹⁹⁷ In typical cases of nonconsensual intersex surgeries, the doctors are making the final determination to operate only after speaking exclusively with the child’s parents; judges are not the final decision makers and thus *Stump* is not relevant.

The removal of both ovaries or both testes, which is common in a gender-assigning gonadectomy, severely impairs the individual’s fertility.¹⁹⁸ Thus, intersex procedures are easily comparable to nonconsensual sterilization. However, the comparison is not as clear to all doctors, who sometimes conceptualize sterilizing procedures differently when performed on children with intersex conditions.¹⁹⁹ First, doctors sometimes do not equate “reproductive capacity” with “fertility” if the child’s assigned sex does not typically allow for “th[at] mode of potential reproduction” (for example, an assigned male having reproductive-necessary female ovaries).²⁰⁰ Second, doctors sometimes don’t characterize a procedure as sterilization “if its *primary* purpose is something other than terminating reproductive capacity.”²⁰¹ Scientifically, though, the surgeries—whether deemed sterilizing or gender-conforming—all sever one’s ability to procreate. Thus, gonadectomies necessarily must be deferred until consent is possible.

Female genital mutilation (FGM) includes “all [nonconsensual] procedures involving partial or total removal of the external female genitalia or injury to the female genital organs for non-medical reasons.”²⁰² These procedures are identical to some feminizing intersex surgeries.²⁰³ A federal law,²⁰⁴ as well as twenty-five state laws resembling it, criminalize FGM.²⁰⁵ The federal law does not mention surgeries performed for the purpose of assigning a female gender to those with intersex conditions; North Dakota and Wisconsin’s laws, on the other hand, egregiously “exempt from their FGM statutes any procedure intended to ‘correct an ana-

195. See *Stump v. Sparkman*, 435 U.S. 349 (1978).

196. *Id.* at 359–60.

197. See *id.*

198. See Sam Rowlands & Jean-Jacques Amy, *Preserving the Reproductive Potential of Transgender and Intersex People*, 23 EUR. J. CONTRACEPTION & REPROD. HEALTH CARE 58 (2018).

199. INTERACT & HUM. RTS. WATCH, *supra* note 13, at 5–6.

200. *Id.* at 146.

201. *Id.* (emphasis added).

202. INTERACT & HUM. RTS. WATCH, *supra* note 13, at 149 (quoting the World Health Organization, which defines four classifications of FGM: (1) “the partial or total removal of the clitoris,” (2) also removing the labia, (3) “the narrowing of the vaginal orifice with the creation of a seal that is formed by cutting and then stitching the labia[s],” and (4) all other harmful female genitalia procedures including “pricking, piercing, incising, scraping, and cauterization”).

203. *Supra* Part II.

204. 18 U.S.C. § 116 (2006).

205. See INTERACT & HUM. RTS. WATCH, *supra* note 13, at 150.

tomical abnormality’”; and Oklahoma counterintuitively allows prohibited procedures as long as they are “necessary” for *cosmetic* purposes.²⁰⁶ However, modifying the current federal FGM law by allowing only such surgeries for conditions that pose a *physical* health risk would eliminate all doctors’ ability to perform feminizing clitoral reduction surgeries without the child’s consent.²⁰⁷ This modification would not excuse doctors who premise their surgeries on preventing “psychological and mental trauma for the child.”²⁰⁸ This excuse used by American pediatric surgeons is not wholly different from the excuse used by doctors in other countries like Somalia, Sudan, and Egypt, which universally *encourage* the removal of young females’ clitorises.²⁰⁹ The accepted practice also responds to communal attitudes, which illustrates the dangers of societal perceptions.²¹⁰

Based on the nuances, prevalent runarounds, and nonconformity in the intersex context regarding current sterilization and FGM laws, there needs to be a more protective solution for children with intersex conditions. Thus, broad legislation should be adopted to end both types of surgeries—those that prohibit one’s ability to reproduce and those that cut off genitalia based on perceived social necessity—unless the patient consents.

D. INTERSEX SURGERIES ARE AKIN TO TORTURE

The United Nations (UN) is an international organization made up of 193 member countries—including the United States—whose mission is to maintain international peace and protect human rights.²¹¹ In its 2013 Special Report on Torture (UN Report), the UN first recognized abuses on marginalized groups in the healthcare setting as potentially torturous.²¹² The report noted that medical operations “that cause[] severe suffering for no [legitimate medical purpose]” are considered “cruel, inhumane, or degrading treatment.”²¹³ When a country allows such operations and the doctor specifically intends its results, the criteria for “torture” are met.²¹⁴

206. *Id.*

207. See 18 U.S.C. § 116 (stating that genital surgery is not violative if it is “necessary to the health of the person on whom it is performed”).

208. Angier, *supra* note 1, at 5.

209. Nancy Ehrenreich & Mark Barr, *Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of “Cultural Practices”*, 40 HARV. C.R.-C.L. L. REV. 71, 115 (2005) (noting the practice is generally accepted in those countries based on the premise “that women who fail to undergo genital surgery will be seen as dirty, promiscuous, and unmarriageable”).

210. Ehrenreich & Barr, *supra* note 209, at 115 (noting that with female genital cutting in both Africa and in the U.S., “practitioners are responding to very real societal attitudes that can . . . be expected to negatively affect the individuals in question”).

211. *About the UN*, UNITED NATIONS, <https://www.un.org/en/about-un/index.html> [<https://perma.cc/JK3Q-DW6J>].

212. Juan E. Mendez (Special Rapporteur), *Report of the Special Rapporteur on Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment*, ¶ 79, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013).

213. *Id.* at ¶ 39.

214. *See id.*

In its report, the UN specifically addressed physicians' treatment of children's "atypical sex characteristics" with involuntary and irreversible procedures like sex assignment, sterilization, and "genital normalizing surgery."²¹⁵ This inclusion implies that internationally, such medically unnecessary procedures on young intersex patients are denounced as torturous.

Further, it can be argued that the United States Supreme Court has held punishments that involve torturous treatment to be an unconstitutional violation of the Eighth Amendment, which states that "cruel and unusual punishments [shall not be] inflicted."²¹⁶ The United States also has a federal statute outlawing torture (called the "Torture Act"),²¹⁷ but it has been interpreted as only applying in military context.²¹⁸

A European judge observed that "America's idea of what is torture . . . does not appear to coincide with that of most civili[z]ed nations."²¹⁹ The American government has been criticized as inhumane for allowing intentional maltreatment of prisoners at medical bases²²⁰ and for not explicitly banning degrading treatment of human beings in the medical setting.²²¹ Nevertheless, intersex procedures as described in the UN Report *are* comparable to torture due to the lack of consent by patients; their "permanent, irreversible," and painful results, such as infertility and "severe mental suffering"; the United States' acquiescence of intersex surgeries; and surgeons' specific intention of performing them merely to "fix" the child's gender.²²² Thus, American laws need to formally recognize inhumane treatment by physicians in hospitals, just as they have recognized inhumane treatment by military and government officials in prisons.

215. *Id.* at ¶ 77.

216. U.S. CONST. amend VIII; *In re Kemmler*, 136 U.S. 436, 447 (1890) ("Punishments are cruel when they involve torture or a lingering death . . .").

217. 18 U.S.C. § 2340 (2006).

218. *See* Definition of Torture Under 18 U.S.C. §§ 2340–2340A, 28 Op. O.L.C. 297, 298 (2004).

219. Richard Norton-Taylor & Suzanne Goldenberg, *Judge's Anger at US Torture: Stinging Comments Come as America Dismisses UN Report on Guantanamo*, *GUARDIAN* (Feb. 16, 2006), <https://www.theguardian.com/uk/2006/feb/17/politics.world> [<https://perma.cc/S6HW-ZG4Q>].

220. *See* Lewis Sanders IV, *U.S. Torture Continues at Guantanamo Bay*, *U.N. Expert Warns*, *USA TODAY* (Dec. 13, 2017, 2:02 PM), <https://www.usatoday.com/story/news/world/2017/12/13/united-states-torture-continues-guantanamo-bay-united-nations-expert/949052001/> [<https://perma.cc/56DM-Z5HX>].

221. *See* INTERACT & HUM. RTS. WATCH, *supra* note 13, at 139 (noting that "[t]he US in the only UN member state that has not ratified the Convention on the Rights of the Child (CRC), the primary [international] instrument . . . that elaborates the rights of children[.]" nor has the US "condemned surgery on intersex children" like nine other countries have).

222. *See id.* (emphasis added).

VI. THE FEDERAL GOVERNMENT SHOULD ADOPT
PROTECTIVE INTERSEX LEGISLATION, MODIFIED
BASED ON EXISTING OPPOSITION

*“Real change, enduring change, happens one step at a time.”*²²³

To make a complex and contentious topic simple, physicians’ Hippocratic Oath says to “do no harm,” but research does not tell us that conducting feminizing and masculinizing surgeries on infants “does no harm.”²²⁴ If all physicians took an ethical and multidimensional approach to intersex patient care like bioethicist Claudia Wiesemann suggests,²²⁵ or if there was already a workable solution to ensure her standards were upheld, there would likely be no need for this commentary begging for protection of infants with variable sex characteristics.²²⁶ There is clearly a need to protect young patients from physicians who prioritize perceived normalcy and convenient operations over the patient’s autonomy.²²⁷ A sweeping moratorium on intersex surgeries in early childhood is a reasonable protective solution. However, a ban accompanied by only one page of text and a lack of supplemental resources²²⁸ is admittedly not sufficient to address the complexity of balancing parental authority with the protection of the child’s decision-making rights and bodily autonomy.²²⁹

The introduction of California Senate Bill 201 highlights the momentum for a legal ban from correcting minors’ sexual abnormalities and indicates that “legislative reform [can be] a viable long-term strategy for protecting intersex infants.”²³⁰ Although difficult, the United States should outlaw surgical procedures on intersex patients in early childhood while *also* incorporating aspects of the multidisciplinary patient-care approach favored by bioethicists and medical practitioners.

Bioethicist Wiesemann rejects a legalized moratorium on early intersex procedures due to the negative effect that it can have on familial relations.²³¹ She does, however, demand solutions to the stigmatizations that “arise due to the lack of a social environment in which children with [intersex traits] can experience their ‘otherness’ as normal.”²³² To thrive,

223. IRIN CARMON & SHANA KNIZHNIK, NOTORIOUS RBG: THE LIFE AND TIMES OF RUTH BADER GINSBURG 60 (2015) (quoting Supreme Court Justice Ruth Bader Ginsburg as she discusses the effort for social and political change).

224. See, e.g., Angier, *supra* note 1; INTERACT & HUM. RTS. WATCH, *supra* note 13, at 5; Carmona, *supra* note 88; Garland, *supra* note 141.

225. See Wiesemann et al., *supra* note 135 (promoting individualized care that emphasizes the best interest of the child by taking an approach that weighs patient autonomy, familial cohesiveness, and cultural beliefs in creating the patient’s treatment plan).

226. See *supra* Part II (detailing some physicians’ approach to intersex procedures as one of convenience and binary gender beliefs, rather than of a genuine intent on serving the patient family’s best interests); *supra* Part III (illustrating the difficulty of passing a law that both intersex-rights advocates and physicians agree on).

227. See Angier, *supra* note 1.

228. See S.B. 201, 2019–2020 Leg., Reg. Sess. (Cal. 2019).

229. See Wiesemann et al., *supra* note 135, at 674.

230. Lowry, *supra* note 67, at 355.

231. See Wiesemann et al., *supra* note 135, at 671.

232. See *id.* 675.

“[a]ll youth require the support and acceptance of their . . . communities.”²³³ Thus, the government needs to acknowledge that gender is not binary but instead lies on a spectrum.²³⁴ To do so, all federal forms like passport applications and birth certificates should include an additional gender option, such as “nonbinary” or “neither of the above.”²³⁵ This initiative implies that the government recognizes nothing inherently wrong with choosing not to identify in a binary fashion. As a result, it may instill a sense of normalcy and mitigate the current issue of most ambiguous-genitalia bearing individuals choosing not to self-identify as “intersex” or of feeling shame for their irregularities.²³⁶ Additionally, once society begins widely recognizing the common occurrence of intersex conditions, parents may be more willing to embrace their young child’s intersex traits until the child is old enough to decide its own identity.

Additionally, Wiesemann suggests that intersex health care is most effective when it is not two-dimensional—solely decided between the surgeon and the patient’s parents—but rather invites additional medical disciplines to lend expertise.²³⁷ According to Wiesemann, “to strengthen the ability of parents to cope with the situation and to support their child[,] . . . parents have to receive professional support and assistance.”²³⁸ As such, the law should require psychologists to be actively involved in the process of informing parents of their child’s intersex condition. They should immediately engage with parents by informing them of the prevalence of intersex conditions, and empirical data on the harm that youth surgeries could ultimately cause. This will ease parents’ anxiety by showing them that their child is not as different as they likely believe, and they are not harming the child more than helping by waiting on surgical gender assignment.

A final major criticism by the CMA is the broad use of the term “medically necessary” in the exception to California Senate Bill 201’s ban.²³⁹ To mitigate this issue, before proposing federal legislation, the government needs to work with medical associations to narrowly define exactly which reproductive organ-altering surgeries are deemed “necessary.”

Ultimately, the federal government should protect one’s autonomy to choose one’s identity. Thus, it must adopt legislation which bans noncon-

233. Deborah Temkin & Claudia Vega, *Research Shows the Risk of Misgendering Transgender Youth*, CHILD TRENDS (Oct. 23, 2018), <https://www.childtrends.org/research-shows-the-risk-of-misgendering-transgender-youth> [<https://perma.cc/V73V-9ALQ>].

234. See Fausto-Sterling, *supra* note 69.

235. See *Zzyym v. Pompeo*, 341 F. Supp. 3d 1248, 1261 (D. Colo. 2018) (holding that requiring passport applicants to choose either a “male” or “female” gender is irrational).

236. See Ann P. Haas et al., *Suicide Attempts Among Transgender and Gender Non-Conforming Adults*, WILLIAMS INST. 1, 6 (Jan. 2014), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf> [<https://perma.cc/6KX5-2NRK>] (reporting that only 6% of people with the medically defined identity of “intersex” strongly self-identified with that label, while 79% did not at all).

237. See Wiesemann et al., *supra* note 135, at 675.

238. See *id.*

239. Bajko, *supra* note 131.

sensual intersex procedures in early childhood, eliminates necessary binary self-identification on federal documents, requires a multidisciplinary approach which incorporates psychological patient and family care, and defines with precision those “medically necessary” exceptions to the ban.

