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## INTERSEX CHILDREN IN FOSTER CARE: CAN THE GOVERNMENT ELECT SEX ASSIGNMENT SURGERY?

*Ashley Huddleston\**

The surgeon told [me] he was going to “fix [me].” But I didn’t know I was broken . . . . [I] knew I was different but not that I was broken.<sup>1</sup>

### INTRODUCTION

In December 2004, M.C. was born in a South Carolina hospital and pronounced a male.<sup>2</sup> However, doctors soon discovered that he had “ambiguous genitals and both male and female internal reproductive structures.”<sup>3</sup> M.C. had been born “intersex.”<sup>4</sup> For the first few years of M.C.’s life,<sup>5</sup> the doctors

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\* J.D. Candidate, Brooklyn Law School, 2015; B.A., University of Rochester, 2010. Thank you to my friends and family for their endless and unwavering encouragement, patience, and support. Thank you also to the editors and staff of the *Journal of Law and Policy* for their time and invaluable feedback.

<sup>1</sup> Martha Coventry, *Making the Cut*, Ms., Oct. 2000, at 52, 57.

<sup>2</sup> Complaint ¶¶ 3, 16, M.C. v. Aaronson, No. 2:13CV01303 (D.S.C. May 14, 2013), 2013 WL 1961775 [hereinafter M.C. Complaint]. All facts of the case in this Note are taken from the Complaint, which the District Court has incorporated into an order issues. *See* Order, M.C. v. Aaronson, No. 2:13-CV-01303-DCN (D.S.C. Aug. 29, 2013). Although defendants have treated plaintiff’s facts as true for purposes of motion filing, they have not waived a later challenge to the factual assertions or legal conclusions drawn from them. Motion to Dismiss, Rule 12(b)(6) Qualified Immunity and Memorandum in Support at 2 n.2, M.C. v. Aaronson, No. 2:13-CV-01303-DCN (D.S.C. June 7, 2013), 2013 WL 3091537.

<sup>3</sup> M.C. Complaint, *supra* note 2, ¶ 3.

<sup>4</sup> As discussed later, there is not one universally accepted definition for exactly what constitutes an “intersex” condition, but this Note adopts the

were unsure of his sex<sup>6</sup> and repeatedly indicated that he could be raised as either a male or a female.<sup>7</sup> Though the doctors had no way of knowing which gender M.C. would identify with as an adult,<sup>8</sup> they “decided to remove M.C.’s healthy genital tissue and radically restructure his reproductive organs in order to make his body appear to be female.”<sup>9</sup> But it was not M.C.’s parents who elected surgery for him; it was the doctors and the South Carolina Department of Social Services, whose custody he was in at all

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definition used by the Intersex Society of North America, which they say is “a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male.” Intersex Society of North America, *What is Intersex?*, [http://www.isna.org/faq/what\\_is\\_intersex](http://www.isna.org/faq/what_is_intersex) (last visited Apr. 2, 2014). M.C. was in fact born with the condition of ovotesticular DSD, which was formerly referred to as “true hermaphroditism.” M.C. Complaint, *supra* note 2, ¶ 40.

<sup>5</sup> *Id.* ¶ 42.

<sup>6</sup> Theorists argue that traditionally “sex” was considered biologically determined at birth, and “gender” was generally understood as the “sociocultural manifestation of one’s sex.” However, some theorists now believe that the two are more intertwined and reliant on one another for their proper meaning. They now theorize that sex is not objective, but rather has a cultural component, and gender is created by factors other than just “being an outgrowth of sex.” See Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics and the Law*, 11 ANNALS HEALTH L. 195, 200–01 (2002). The medical profession, through the theories and treatments now associated with intersex children, has moved away from the historically accepted principle of “true sex” based strictly on gonadal tissue. Instead, it has focused on the gender that they believe should be assigned to the child and match the sex to that gender. Alice Domurat Dreger, “*Ambiguous Sex*”— or *Ambivalent Medicine? Ethical Issues in the Treatment of Intersexuality*, HASTINGS CTR. REP., May–Jun. 1998, at 24, 26–27. Case management of intersex infants reflects that the physicians are concerned with “perpetuating the notion that good medical decisions are based on interpretations of the infant’s real ‘sex’ rather than on cultural understandings of gender.” Suzanne J. Kessler, *The Medical Construction of Gender: Case Management of Intersexed Infants*, 16 SIGNS 3, 10 (1990). For the purposes of clarity, this Note will use the terms in their traditional sense: “sex” as the biological determination and “gender” as the socialization.

<sup>7</sup> M.C. Complaint, *supra* note 2, ¶¶ 3, 42

<sup>8</sup> *Id.* ¶ 4.

<sup>9</sup> *Id.*

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relevant times.<sup>10</sup> In 2006, a couple learned about M.C.'s condition from the South Carolina adoption website and contacted the Department in an attempt to prevent the sex assignment surgery, but they were too late; they adopted M.C. after the surgery was already completed.<sup>11</sup> Now eight years old, M.C. has psychologically rejected his female gender assignment and is living as a boy.<sup>12</sup> But nothing can replace the permanent changes made to his body.<sup>13</sup>

Remarkably, such sex-change surgery is not a new procedure,<sup>14</sup> and hundreds of children<sup>15</sup> have been subjected to the same fate as M.C., usually at the mercy of their parents. Controversy over the surgery itself has been rampant for years as scholars and physicians question the foundational theory that an intersex child will always identify with whatever gender they are surgically assigned to, and whether parents can and should elect sex assignment surgery at all.<sup>16</sup> This Note will explore what has happened, and what should happen, when an intersex child is in the custody of the state, just as M.C. was.

The law is silent on whether or not government officials have the ability to consent to sex assignment surgery; but if they do

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<sup>10</sup> *Id.* ¶¶ 34–39. Though M.C. lived with two foster families before his adoption, South Carolina Department of Social Services “retained legal custody of M.C. while he was in foster care.” *Id.* ¶ 39.

<sup>11</sup> *Id.* ¶ 64.

<sup>12</sup> *Id.* ¶¶ 2, 7, 8.

<sup>13</sup> *Id.* ¶¶ 8, 9, 11.

<sup>14</sup> See SHARON E. PREVES, *INTERSEX AND IDENTITY: THE CONTESTED SELF* 50–52 (2003) (tracing the history of gender reassignment surgery to the 1920s and its application on intersex children through the 1950s).

<sup>15</sup> See Hazel Glenn Beh & Milton Diamond, *An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment on Infants With Ambiguous Genitalia?*, 7 MICH. J. GENDER & L. 1, 17 (2000) (“An estimated 100–200 pediatric surgical sex reassignments are performed in the United States annually.”).

<sup>16</sup> See *id.* at 2–4; see also Dreger, *supra* note 6, at 28; Melissa Hendricks, *Into the Hands of Babes*, 52 JOHNS HOPKINS MAG. (2000), available at <http://www.jhu.edu/jhumag/0900web/babes.html>; Mireya Navarro, *When Gender Isn't a Given*, N.Y. TIMES (Sept. 19, 2004), <http://www.nytimes.com/2004/09/19/fashion/19INTE.html>.

not, then the question becomes what those officials should do when confronted with that situation. The answer is that social workers and government officials must choose to do nothing—they should let the child develop as he or she naturally would—and if the parents or the child choose at a later time to undergo surgery, that is their own choice to make.<sup>17</sup> It is not appropriate, however, for a case worker to make such a major life decision for a child who is only temporarily in the government's custody, especially when that child will have to live with the results of that surgery for the rest of his or her life.

Part I discusses the background of intersexuality<sup>18</sup> and the theories that have led to the current clinical treatment of intersex children in the United States.<sup>19</sup> In particular, it will explore Dr. John Money's development of the fundamental theory<sup>20</sup> that any intersex child can successfully be assigned to either gender as long as his or her external genitals are surgically made to match that assignment.<sup>21</sup> In addition, Part I articulates the procedures that physicians follow in assessing a child that may have an intersex condition, and addresses the factors that physicians take into account when deciding how to assign a child to a particular

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<sup>17</sup> I do not suggest that adoptive parents either do or do not have the ability to seek surgery for their children if they adopt them at a young age, as there is already wide debate on whether or not biological parents should have that right. I simply suggest that surgery may be appropriate or desirable at a later stage in the child's life.

<sup>18</sup> See AM. PSYCHOLOGICAL ASS'N, ANSWERS TO YOUR QUESTIONS ABOUT INDIVIDUALS WITH INTERSEX CONDITIONS (2006), available at <http://www.apa.org/topics/sexuality/intersex.pdf> ("A variety of conditions that lead to atypical development of physical sex characteristics are collectively referred to as *intersex conditions*. These conditions can involve abnormalities of the external genitals, internal reproductive organs, sex chromosomes, or sex-related hormones."); sources cited *supra* note 6.

<sup>19</sup> See *infra* Part I.

<sup>20</sup> See generally JOHN COLAPINTO, AS NATURE MADE HIM: THE BOY WHO WAS RAISED AS A GIRL (2000); JOHN MONEY & ANKE A. EHRHARDT, MAN & WOMAN/BOY & GIRL (1972).

<sup>21</sup> See generally MONEY & EHRHARDT, *supra* note 20; JOHN MONEY, SEX ERRORS OF THE BODY: DILEMMAS, EDUCATION, COUNSELING 45 (1968). See also PREVES, *supra* note 14, at 3; Hermer, *supra* note 6, at 196–98.

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sex.<sup>22</sup>

Part II discusses the lawsuits recently filed in both federal court and South Carolina state court by M.C.'s adoptive parents on his behalf against the individual doctors and the employees of the South Carolina Department of Social Services who approved his sex assignment surgery.<sup>23</sup> Part III discusses the state laws governing health care consent in the foster care system and how those laws impact the government's ability to elect this kind of surgery for a child in their care.<sup>24</sup> Finally, Part IV discusses new policies that other countries have adopted to deal with the rising concerns over the surgical practice on intersex children, and what measures the United States can take when an intersex child is born into the care of a state Department of Social Services.<sup>25</sup>

#### I. MEDICINE'S RESPONSE TO INTERSEXUALITY

The strict division between female and male bodies and behavior is our most cherished and comforting truth. Mess with that bedrock belief, and the ground beneath our feet starts to tremble.<sup>26</sup>

##### *A. Background on Intersexuality*

It is estimated that “[b]etween 1.7% and 4% of the world population is born with intersex conditions.”<sup>27</sup> This means that the condition “occurs about as often as the well-known conditions of cystic fibrosis and Down syndrome.”<sup>28</sup> The number of people

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<sup>22</sup> See *infra* Part I.

<sup>23</sup> See *infra* Part II.

<sup>24</sup> See *infra* Part III.

<sup>25</sup> See *infra* Part IV.

<sup>26</sup> Coventry, *supra* note 1, at 55.

<sup>27</sup> Kate Haas, *Who Will Make Room for the Intersexed?*, 30 AM. J.L. & MED. 41, 41 (2004); Melanie Blackless et. al., *How Sexually Dimorphic Are We? Review and Synthesis*, 12 AM. J. HUM. BIOLOGY 151, 159 (2000) (estimating that 1.728% of live births result in individuals that do not categorically fit into male or female).

<sup>28</sup> PREVES, *supra* note 14, at 3.

born with an intersex condition is much higher than the public may be aware of, since it has only started receiving more attention as people come forward with their stories.<sup>29</sup>

“In medical terms the definition of intersex genitalia is somewhat arbitrary”<sup>30</sup> because there is not one medically standard measurement or criterion that determines the sex of a child.<sup>31</sup> In the broadest sense, “intersexuality constitutes a range of anatomical conditions in which an individual’s anatomy mixes key masculine anatomy with key feminine anatomy.”<sup>32</sup> The “[i]ntersex conditions are myriad in number and type; virtually all develop in utero”<sup>33</sup> when “the fetus is exposed to an inappropriate amount of hormones. . . .”<sup>34</sup> While the American Academy of Pediatrics (“AAP”) outlines seven clinical findings that raise the possibility of intersexuality,<sup>35</sup> most cases of

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<sup>29</sup> *Id.*

<sup>30</sup> Ursula Kuhnle & Wolfgang Krahl, *The Impact of Culture on Sex Assignment and Gender Development in Intersex Patients*, 45 PERSP. IN BIOLOGY & MED. 85, 87 (2002).

<sup>31</sup> Physicians have different measurements for when the penis is considered inadequate or the clitoris too large. Compare Committee on Genetics, Section on Endocrinology and Section on Urology, *Evaluation of the Newborn with Developmental Anomalies of the External Genitalia*, 106 PEDIATRICS 138, 139 (2000) [hereinafter *Evaluation of the Newborn*] (“In full-term newborns the stretched penile length should measure at least 2 [centimeters].”) with SUZANNE KESSLER, LESSONS FROM THE INTERSEXED 43 (1998) (measuring a “medically acceptable” clitoris as up to one centimeter, and a “medically acceptable” penis as between 2.5 and 4.5 centimeters); Alice D. Dreger, *supra* note 6, at 28 (noting that a clitoris is considered too big if it is larger than one centimeter, and a penis is too small if it is less than 2.5 centimeters).

<sup>32</sup> Dreger, *supra* note 6, at 26.

<sup>33</sup> Hermer, *supra* note 6, at 204.

<sup>34</sup> Claudia Dreifus, *Declaring with Clarity, When Gender is Ambiguous*, N.Y. TIMES (May 31, 2005), <http://www.nytimes.com/2005/05/31/science/31conv.html>.

<sup>35</sup> The clinical findings that raise the possibility of intersexuality are as follows: Apparent male: “Bilateral nonpalpable testes in a full-term infant; hypospadias associated with separation of the scrotal sacs; undescended testis with hypospadias.” Ambiguous genitalia signify an indeterminate sex. Apparent female: “Clitoral hypertrophy; Foreshortened vulva with single

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ambiguous genitalia are not medically considered cases of “true intersex” conditions.<sup>36</sup> However, for the purposes of this Note, all such conditions will be referred to as “intersex”<sup>37</sup> and will use the definition provided by the Intersex Society of North America, which defines intersexuality as a condition where “a person is born with a reproductive or sexual anatomy that [does not] seem to fit the typical definitions of female or male.”<sup>38</sup>

The idea of a “normal” male or female body is in fact a man-made concept created by categories that society has arbitrarily and superficially defined.<sup>39</sup> Physical gender identification does not seem to exist as a strict male/female dichotomy, but rather as more of a continuum.<sup>40</sup> Modern societal standards have created two categories that bodies must fit into,<sup>41</sup> but “biologically speaking, there are many gradations running from female to male.”<sup>42</sup> In fact, the development of surgical methods to

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opening; Inguinal hernia containing a gonad.” *Evaluation of the Newborn*, *supra* note 31, at 139.

<sup>36</sup> “True intersexed” conditions refer to children who have both ovarian and testicular tissue in one or both of their gonads, but these cases represent less than five percent of those with ambiguous genitalia. Modern literature refers to those that have either testes or ovaries as “intersex” as well. Kessler, *supra* note 6, at 5. See also Dreger, *supra* note 6, at 30 (“[W]hile unusual genitalia may *signal* a present or potential threat to health, in themselves they just *look* different.” (emphasis in original)).

<sup>37</sup> Children with ambiguous genitalia are candidates for sex assignment surgery, whether or not their condition fits that of technically being intersex. The number of children subjected to these surgeries would be grossly underestimated if those with ambiguous genitalia were excluded. Sara R. Benson, *Hacking the Gender Binary Myth: Recognizing Fundamental Rights for the Intersexed*, 12 CARDOZO J.L. & GENDER 31, 33 (2005).

<sup>38</sup> *What is Intersex?*, INTERSEX SOC’Y OF NORTH AM., [http://www.isna.org/faq/what\\_is\\_intersex](http://www.isna.org/faq/what_is_intersex) (last visited Mar. 23, 2014).

<sup>39</sup> PREVES, *supra* note 14, at 3

<sup>40</sup> See Blackless et. al., *supra* note 27, at 162–63 (arguing that sexual distribution is properly represented as an overlapping bell curve instead of two totally separate genders that fail to ever overlap).

<sup>41</sup> See ANNE FAUSTO-STERLING, *SEXING THE BODY: GENDER POLITICS AND THE CONSTRUCTION OF SEXUALITY* 108–09 (2000) (discussing other cultures that have recognized a third gender).

<sup>42</sup> Anne Fausto-Sterling, *The Five Sexes: Why Male and Female Are Not*



“normalize” sexual variation evidences “the regularity with which sexual variation occurs.”<sup>43</sup> However, even doctors with ample experience in the field of pediatric intersexuality “hold an incorrigible belief in and insistence upon female and male as the only ‘natural’ options.”<sup>44</sup>

Presupposing the existence of only those two gender options, doctors are supposed to inspect any child born with potentially ambiguous genitalia before definitively pronouncing a sex.<sup>45</sup> Though the AAP characterizes intersexuality as a “social emergency”<sup>46</sup> and not a true medical emergency,<sup>47</sup> such a characterization belies the response from physicians, who often proceed as quickly as possible to definitively assign a sex.<sup>48</sup> Although some of the conditions that cause intersexuality can be life-threatening, being intersex is, by itself, not life threatening.<sup>49</sup> “‘Ambiguous’ genitalia do not constitute a disease. They simply constitute a failure to fit a particular (and, at present, a particularly demanding) definition of normality.”<sup>50</sup> Regardless, doctors and parents sometimes rush into surgery, as was the case for M.C., as if intersexuality is a medical emergency that must be remedied.

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*Enough*, THE SCIENCES, Mar.-Apr. 1993, at 20, 21.

<sup>43</sup> PREVES, *supra* note 14, at 3.

<sup>44</sup> Kessler, *supra* note 6, at 4.

<sup>45</sup> *Evaluation of the Newborn*, *supra* note 31, at 138.

<sup>46</sup> *Id.*

<sup>47</sup> There do not appear to be any other conditions that the AAP classifies as a “social emergency.”

<sup>48</sup> See Dreger, *supra* note 6, at 27 (“In the United States today . . . typically upon the identification of an ‘ambiguous’ or intersexed baby teams of specialists . . . are immediately assembled, and these teams of doctors decide to which sex/gender a given child will be assigned.”); Kessler, *supra* note 6, at 8 (“The doctors interviewed concur with the argument that gender be assigned immediately, decisively, and irreversibly . . .”).

<sup>49</sup> For example, those children “whose condition is caused by androgen insensitivity are in danger of malignant degeneration of the tests unless they are removed.” Kessler, *supra* note 6, at 5 n.6.

<sup>50</sup> Dreger, *supra* note 6, at 30.

*INTERSEX CHILDREN IN FOSTER CARE* 967*B. Doctor John Money's Theories and the John/Joan Case*

Most of the contemporary theory that guides the treatment of intersex children arose from the work of sexologist Dr. John Money in the 1950s.<sup>51</sup> When Dr. Money published his allegedly successful case study of John, a boy with a damaged penis who was surgically made into and raised as a girl, “the treatment’s purported success spread rapidly and [was] frequently recounted in the professional literature.”<sup>52</sup> The view that children are born “psychosexually neutral and would accept their gender of rearing . . . offered a relatively simple solution to what was seen as a difficult situation.”<sup>53</sup> One single case, widely reported as a success, “became the justification for surgical treatment of intersex infants.”<sup>54</sup>

Dr. Money developed his theory primarily from the case study that has come to be known as the John/Joan case.<sup>55</sup> John<sup>56</sup>

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<sup>51</sup> See KESSLER, *supra* note 31, at 6 (“Virtually all academic writing on sex and gender refers to a case first described by sexologist John Money in 1972.”); PREVES, *supra* note 14, at 53 (“John Money’s theory of gender identity development and suggested standards of care are at the center of late-twentieth-century debates on how to best respond to intersex.”); Alice Domurat Dreger, *A History of Intersex: From the Age of Gonads to the Age of Consent*, in *INTERSEX AND THE AGE OF ETHICS* 5, 11–12 (1999) (outlining Money’s theory and its influence on the development of medical practices); Kishka-Kamari Ford, “*First, Do No Harm*”—*The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants*, 19 *YALE L. & POL’Y REV.* 469, 471 (2001) (“The model of treatment of intersexed infants was established a half-century ago by Johns Hopkins Sexologist John Money and his colleagues.”). These surgical procedures “began in the late 1950s and 1960s and became standard in the 1970s.” Beh & Diamond, *supra* note 15, at 2–3.

<sup>52</sup> Beh & Diamond, *supra* note 15, at 17.

<sup>53</sup> *Id.* at 18.

<sup>54</sup> Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law’s Failure to Protect Intersex Infants*, 21 *BERKELEY J. GENDER L. & JUST.* 59, 60 (2006).

<sup>55</sup> See generally COLAPINTO, *supra* note 20; MONEY & EHRHARDT, *supra* note 20; John Colapinto, *The True Story of Joan/John*, *ROLLING STONE MAG.*, Dec. 1997, at 54, 54–97; Milton Diamond & H. Keith Sigmundson, *Sex Reassignment at Birth: Long-Term Review and Clinical Implications*, 151 *ARCHIVES OF PEDIATRIC MED.* 298 (1997).

was born an XY male<sup>57</sup> with an identical twin brother. He suffered a burn to his penis during a circumcision when he was eight months old,<sup>58</sup> causing it to essentially break away into pieces until nothing remained.<sup>59</sup> The doctors told his mother that reconstructive surgery would fail to give him a normal-looking penis,<sup>60</sup> and the urologist wrote in the medical record that “restoration of the penis as a functional organ is out of the question.”<sup>61</sup> A psychologist’s opinion of the situation was even less encouraging for John’s parents, saying that “[John] will be unable to consummate marriage or have normal heterosexual relations; he will have to recognize that *he is incomplete, physically defective, and that he must live apart.*”<sup>62</sup>

While searching for what to do next, John’s parents saw Dr. John Money on television talking about gender transformation and a clinic at Johns Hopkins University that was performing sex changes.<sup>63</sup> Shortly thereafter, John’s parents took him to see Dr. Money at Johns Hopkins, where Dr. Money explained the advantages of sex reassignment for John and told them that he

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<sup>56</sup> John is a pseudonym that has been used in all literature written about this case, as the person did not want to reveal his real name. See Colapinto, *supra* note 55, at 54–97; Diamond & Sigmundson, *supra* note 55, at 298–304. He revealed his true identity as David Reimer after a book published by John Colapinto in 2000 gave him a chance to tell his story. See *David Reimer, 38, Subject of the John/Joan Case, Dies*, N.Y. TIMES (May 12, 2004), <http://www.nytimes.com/2004/05/12/us/david-reimer-38-subject-of-the-john-joan-case.html>. For the purposes of this Note, I will use John/Joan.

<sup>57</sup> Genetic males are typically born with XY sex chromosomes, while females are born with XX sex chromosomes. *Y Chromosome*, GENETICS HOME REFERENCE, <http://ghr.nlm.nih.gov/chromosome/Y> (last updated January 2010). This indicates that John was not born with an intersex condition.

<sup>58</sup> COLAPINTO, *supra* note 20, at 12–15; Colapinto, *supra* note 55.

<sup>59</sup> COLAPINTO, *supra* note 20, at 15 (“Over the next few days, baby [John’s] penis dried and broke away in pieces. It was not very long before all vestiges of the organ were gone completely.”).

<sup>60</sup> *Id.*

<sup>61</sup> Colapinto, *supra* note 55, at 58 (internal quotation marks omitted).

<sup>62</sup> *Id.* (emphasis added).

<sup>63</sup> COLAPINTO, *supra* note 20, at 17–23.

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saw no reason why it would not work.<sup>64</sup> Dr. Money later wrote about this first meeting with the family and recalled that he used non-medical terms and photos to explain everything to them.<sup>65</sup> But in discussing the meeting years later, John's parents said that they were caught up in the confidence that Dr. Money exuded and could not appreciate until much later the fact that this procedure had only been performed on "hermaphrodites";<sup>66</sup> not on someone who had been born with normal genitalia.<sup>67</sup>

John's parents struggled with what to do, but worried about the embarrassment that John would face without an adequate penis, they decided to raise him as a girl.<sup>68</sup> In 1967, John underwent surgical castration. The surgeons removed his testicles and constructed an exterior vagina.<sup>69</sup> His parents were instructed to call him by his new female name, Joan, and to treat him as an ordinary girl without telling her<sup>70</sup> of the surgery.<sup>71</sup> The family continued to return to Johns Hopkins after the surgery to meet with Dr. Money for follow-up treatment and monitoring.<sup>72</sup>

Meanwhile, medical literature published during this time portrayed the sex reassignment procedure as a success, and such literature "had a significant impact on the standard of care that developed for certain intersex conditions . . . ."<sup>73</sup> One account

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<sup>64</sup> *Id.* at 49; Colapinto, *supra* note 55.

<sup>65</sup> COLAPINTO, *supra* note 20, at 50.

<sup>66</sup> *See Is a Person Who is Intersex a Hermaphrodite?*, INTERSEX SOC'Y OF NORTH AM., <http://www.isna.org/faq/hermaphrodite> (last visited Mar. 23, 2014) (explaining that the term "hermaphrodite" is the older terminology used for intersex conditions).

<sup>67</sup> COLAPINTO, *supra* note 20, at 50.

<sup>68</sup> *Id.* at 52 (discussing the potential embarrassment, his father said, "You know how little boys are . . . who can pee the furthest? Whip out the wiener and whiz against the fence. Bruce wouldn't be able to do that, and the other kids would wonder why." (internal quotation marks omitted)).

<sup>69</sup> *Id.* at 53-54.

<sup>70</sup> "Her", "she," or "Joan" will be used to describe the time period that John was treated as a girl by his parents and by the clinicians. "Him" or "he" will be used to discuss John at all other times.

<sup>71</sup> Colapinto, *supra* note 55 at 64.

<sup>72</sup> *Id.* at 68.

<sup>73</sup> Beh & Diamond, *supra* note 15, at 4.

read: “This dramatic case . . . provides strong support . . . that conventional patterns of masculine and feminine behavior can be altered. It also casts doubt on the theory that major sex differences, psychological as well as anatomical, are immutably set by the genes at conception.”<sup>74</sup> Medical texts and social science writings well into the 1990s continued to reflect the impact of the purportedly successful case study.<sup>75</sup>

Based on the John/Joan case study, Dr. Money developed his theory regarding the malleability of sex and gender identification. “Money’s theory holds that (1) all children, intersexed and non-intersexed, are psychosexually neutral at birth, and (2) you can therefore make virtually any child either gender as long as you make the sexual anatomy reasonably believable.”<sup>76</sup> He believed that “children differentiate a gender role and identity by way of complementation to members of the opposite sex, and identification with members of the same sex.”<sup>77</sup> In addition, he thought it was crucial for a child to define the difference between males and females primarily by one’s sex organs and for that child to have confidence in how to identify his or her own sex organs.<sup>78</sup> Thus, “the boundaries of the masculine and feminine gender roles” needed to be clearly defined.<sup>79</sup> He also believed that a child’s “gender identity”<sup>80</sup> could be molded and changed until the age of eighteen months,<sup>81</sup> the time at which children are cognizant enough to differentiate between sexes and may have

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<sup>74</sup> Diamond & Sigmundson, *supra* note 55, at 299 (citation omitted).

<sup>75</sup> *Id.* (“The following quote is typical: ‘The choice of gender should be based on the infant’s anatomy, not the chromosomal karyotype. Often it is wiser to rear a genetic male as a female. It is relatively easy to create a vagina if one is absent, but it is not possible to create a really satisfactory penis if the phallus is absent or rudimentary. Only those males with a phallus of adequate size that will respond to testosterone at adolescence should be considered for male rearing. Otherwise, the baby should be reared as female.’” (citation omitted))

<sup>76</sup> Dreger, *supra* note 51, at 11.

<sup>77</sup> MONEY & EHRHARDT, *supra* note 20, at 13.

<sup>78</sup> *Id.* at 13–14.

<sup>79</sup> *Id.* at 19.

<sup>80</sup> Kessler, *supra* note 6, at 6.

<sup>81</sup> *Id.* at 6–7 & n.9.

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trouble adopting a newly assigned sex.<sup>82</sup>

Dr. Money claimed that children born intersex *should definitely* be assigned to one gender:

[T]he experts must insure that the parents have no doubt about whether their child is male or female [that is, the parents must fully believe that the child will identify with the gender assigned]; the genitals must be made to match the assigned gender as soon as possible; gender-appropriate hormones must be assigned at puberty; and intersexed children must be kept informed about their situation with age-appropriate explanations.<sup>83</sup>

He claimed that unambiguous genitalia is necessary for an intersex child to identify with a gender; that an intersex child who does not have surgery and develops either an ambiguous gender identity, or rejects the one assigned, does so in response to the ambiguous sex organs.<sup>84</sup> Dr. Money believed that the sex organ is not incidental to how a person internally identifies himself/herself, but is at the very definition of one's gender.

What nobody reported until 1997, years after Dr. Money had developed his theories, was that Joan had in fact rejected her female assignment very early on and had been living as a male since 1979, when he was 14 years old.<sup>85</sup> Two doctors conducted a follow-up interview with John in 1994 and 1995, and John exposed the psychological anguish that he experienced as a child, his feelings of knowing that he did not feel like a girl, and his ultimate decision to forego living as a female.<sup>86</sup> The follow-up paper not only fueled debate among medical professionals about the convention of performing sex assignment surgery, but also "raised troubling questions about why the case was reported in the first place, why it took almost 20 year for a follow-up to reveal the actual outcome and why that follow-up was conducted

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<sup>82</sup> MONEY & EHRHARDT, *supra* note 20, at 178.

<sup>83</sup> Kessler, *supra* note 6, at 7.

<sup>84</sup> See MONEY & EHRHARDT, *supra* note 20, at 19.

<sup>85</sup> See generally COLAPINTO, *supra* note 20, at 111-80; Diamond & Sigmundson, *supra* note 55, at 298-304.

<sup>86</sup> See generally Diamond & Sigmundson, *supra* note 55.

not by Dr. Money but by outside researchers.”<sup>87</sup>

In relaying the story, John’s mother recalls that as an infant, Joan did not want to stay in her female clothing, that she always preferred boy’s games and toys,<sup>88</sup> and that she was ridiculed by students in school as early as kindergarten because she was a tomboy.<sup>89</sup> As per Dr. Money’s instruction, the entire family returned to Johns Hopkins for follow-up visits,<sup>90</sup> but Joan began refusing to go because of her “discomfort and embarrassment with forced exposure of her genitals and [the] constant attempts, particularly after the age of 8 years, to convince her to behave more like a girl and accept further vaginal repair.”<sup>91</sup> She dreaded going to visit Dr. Money, and she continually refused to undergo any vaginal surgery or take the hormones that he insisted she take to further her change into a female.<sup>92</sup> Finally, “[a]fter age 14 years, Joan adamantly refused to return to the hospital [and] . . . came fully under the care of local clinicians.”<sup>93</sup> Joan did not fully realize she was not a girl until between age 9 and 11. John relates:

There were little things from early on. I began to see how different I felt I was, from what I was supposed to be. But I didn’t know what it meant. I thought I was a freak or something . . . I figured I was a guy but I didn’t want to admit it. I figured I didn’t want to wind up opening a can of worms.<sup>94</sup>

She regularly saw psychologists and physicians, but at the age of 14, she had had enough, and told her doctors that she did not want to be a girl.<sup>95</sup> It was only then that her father told her the truth of what happened. Joan recalls: “All of a sudden everything clicked. For the first time things made sense and I understood

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<sup>87</sup> Colapinto, *supra* note 55. At 56

<sup>88</sup> Diamond & Sigmundson, *supra* note 55, at 299.

<sup>89</sup> Colapinto, *supra* note 55 at 66.

<sup>90</sup> *Id.* at 68.

<sup>91</sup> Diamond & Sigmundson, *supra* note 55, at 300.

<sup>92</sup> Colapinto, *supra* note 55 at 70.

<sup>93</sup> Diamond & Sigmundson, *supra* note 55, at 300.

<sup>94</sup> *Id.* at 299–300 (internal quotation marks omitted).

<sup>95</sup> COLAPINTO, *supra* note 20, at 178–79.

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who and what I was.”<sup>96</sup> Joan affirmatively decided to live as a male starting at age 14, had surgeries to construct a phallus at age 15 and 16, and underwent hormone therapy to facilitate living as a male.<sup>97</sup> Joan then became John.

Unfortunately, John tragically committed suicide in 2004 at the age of 38.<sup>98</sup> John Colapinto, who chronicled John/Joan’s story, revealed that there were many things that contributed to his suicide: financial and marital problems, unemployment, genetics, and his childhood.<sup>99</sup> Colapinto recounts that John told him “that he could never forget his nightmare childhood, and he sometimes hinted that he was living on borrowed time.”<sup>100</sup> However, John did not blame his parents, instead saying, “[they] feel very guilty, as if the whole thing was their fault . . . . But it wasn’t like that. They did what they did out of *kindness* and love and desperation. When you’re desperate, you don’t necessarily do all the right things.”<sup>101</sup>

The truth about the results of John’s purported successful surgery did not enter professional medical literature until more than twenty years after the procedure, leaving nothing to “counter the positive reports of the case nor impact the standard of care as it had developed since the 1960s . . . .”<sup>102</sup> Dr. Money did not report in his literature some of the signs that Joan was possibly rejecting her female assignment, and when Joan finally refused to return to Johns Hopkins, he wrote that she was “lost to follow-up.”<sup>103</sup> The reality was that John was unwilling to continue on

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<sup>96</sup> Diamond & Sigmundson, *supra* note 55, at 300 (internal quotation marks omitted).

<sup>97</sup> *Id.*

<sup>98</sup> *David Reimer, 38, Subject of the John/Joan Case, Dies, supra* note 56. His mother reported that she thinks “he felt he had no options. It just kept building up and building up.” *Id.*

<sup>99</sup> John Colapinto, *Why Did David Reimer Commit Suicide?*, SLATE (June 3, 2004), [http://www.slate.com/articles/health\\_and\\_science/medical\\_examiner/2004/06/gender\\_gap.html](http://www.slate.com/articles/health_and_science/medical_examiner/2004/06/gender_gap.html).

<sup>100</sup> *Id.*

<sup>101</sup> COLAPINTO, *supra* note 20, at xvii (emphasis in original).

<sup>102</sup> Beh & Diamond, *supra* note 15, at 12.

<sup>103</sup> *Id.* at 8–9 (citation omitted).



Dr. Money's course of treatment, but that is not what he relayed to the public.<sup>104</sup> It is impossible to know whether the course of treatment for intersex infants would have developed differently had the truth been reported earlier, but it is unquestionable that Dr. Money's theories were critical in shaping the current medical practice.<sup>105</sup>

### C. *The Current Course of Intersex Treatment*

Without knowing that Dr. Money's experiment was in reality a failure, other doctors and researchers developed medical practices in accordance with his allegedly successful theory. The result being that "[o]ver the past four decades, early surgical intervention for infants who are born with ambiguous genitalia or who suffer traumatic genital injury often has been recommended as standard procedure."<sup>106</sup> The widespread adoption of Dr. Money's theory has resulted in few subsequent studies "evaluating the sexual and psychological success or failure of sex assignment surgeries, even though such surgeries have been performed long enough for a substantial cohort to have reached adulthood."<sup>107</sup> The few studies that have been done suggest that the procedures "cause[] substantial and unreasonable harm to infant subjects."<sup>108</sup> Two of the larger published studies in fact provide strong evidence that many intersex individuals fail to identify with their surgically assigned gender.<sup>109</sup> These two studies are not enough, though, given how widely circulated and

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<sup>104</sup> *Id.* at 9.

<sup>105</sup> *Id.* at 19 n.81 (citation omitted).

<sup>106</sup> *Id.* at 3 (citation omitted).

<sup>107</sup> Hermer, *supra* note 6, at 212.

<sup>108</sup> Ford, *supra* note 51, at 474.

<sup>109</sup> See Sarah M. Creighton et al., *Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood*, 358 LANCET 124, 125 (2001) (documenting the outcome of "a retrospective study of cosmetic and anatomical outcomes in 44 adolescent patients who had ambiguous genitalia in childhood and underwent feminising genital surgery"); Hermer, *supra* note 6, at 212–13 (noting that many of the individuals in one of the largest studies experienced psychological and identity problems).

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deeply engrained Dr. Money's theories are. In addition, people who underwent surgery as children have provided anecdotal evidence demonstrating widespread physical and mental dissatisfaction.<sup>110</sup> There is nothing to indicate that intersexed adults who did not undergo surgery fare any worse than those who did have sex assignment surgery.<sup>111</sup> It is clear that there is a pressing need for additional follow-up studies and data collection of those intersex individuals who were subjected to surgery at an early age.

Even with increased debate and discussion about sex assignment surgery for intersex infants,<sup>112</sup> surgery still remains the standard practice.<sup>113</sup> While the AAP notes that some have suggested "the current early surgical treatment be abandoned in favor of allowing the affected person to participate in gender assignment at a later time[,]"<sup>114</sup> the AAP itself still urges "a definitive diagnosis be determined as quickly as possible."<sup>115</sup> The AAP acknowledges that some people might "have conflicts between their psychosexual orientation and their genital appearance and function, [but that] the principles [it] outlined [for deciding how to determine which sex assignment is proper] . . . should minimize these problems when conducted by an appropriately constituted intersex team."<sup>116</sup> Effectively, the AAP has admitted that it is possible that a child could reject his or her assigned sex, but it still advocates for such surgical procedures.

The AAP guidelines, produced in 2000 for physicians treating intersex children, outline a number of factors that doctors need to consider when deciding which sex the child should appropriately be assigned to. The factors include fertility potential, capacity for normal sexual function, endocrine function, malignant change, testosterone imprinting, and timing of surgery.<sup>117</sup> However, "[the

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<sup>110</sup> See Navarro, *supra* note 16.

<sup>111</sup> Haas, *supra* note 27, at 48.

<sup>112</sup> Beh & Diamond, *supra* note 15, at 3.

<sup>113</sup> *Id.* at 18.

<sup>114</sup> *Evaluation of the Newborn*, *supra* note 31, at 141.

<sup>115</sup> *Id.* at 138.

<sup>116</sup> *Id.* at 141.

<sup>117</sup> *Id.* The exact medical effect that each factor has on the treatment and

AAP] still appear[s] to cling to the idea that the size of a boy's penis should be the deciding factor regarding how to raise a child."<sup>118</sup> Doctors may delay any surgery for an XY male with an underdeveloped penis until there is opportunity to see if the child's body responds to hormone treatment,<sup>119</sup> but "[i]f at the end of the treatment period the phallic tissue has not responded, what has been a potential penis . . . is now considered an enlarged clitoris . . . and reconstructive surgery is planned as for the genetic female."<sup>120</sup> Doctors seem to be most concerned with the size and outer physical appearance of the penis rather than its functionality, reflecting adherence to Dr. Money's approach that "chromosomes are less relevant in determining gender than penis size, and that, by implication, 'male' is defined not by the genetic condition of having one Y and one X chromosome . . . but by the aesthetic condition of having an appropriately sized penis."<sup>121</sup>

Under this analysis, if a genetic male's penis is "determined to be 'inadequate' for successful adjustment as [a male, he is] assigned the female gender and reconstructed to look female."<sup>122</sup> "Meanwhile, genetic females (that is, babies lacking a Y chromosome) born with ambiguous genitalia are declared girls—no matter how masculine their genitalia look."<sup>123</sup> Additionally, "surgeons seem to demand far more for a penis to count as 'successful' than for a vagina to count as such[.]"<sup>124</sup> so the odds

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outcome of intersex children is beyond the scope of this Note. For more extensive discussion on this topic, see generally *Gender and Genetics: Genetic Components of Sex and Gender*, WHO, <http://www.who.int/genomics/gender/en/index1.html> (last visited Mar. 23, 2014).

<sup>118</sup> Benson, *supra* note 37, at 35.

<sup>119</sup> Kessler, *supra* note 6, at 11–12.

<sup>120</sup> *Id.* at 13.

<sup>121</sup> *Id.* at 12.

<sup>122</sup> Dreger, *supra* note 6, at 28.

<sup>123</sup> *Id.*

<sup>124</sup> *Id.* at 29 ("For a penis to count as acceptable functional'—it must be or have the potential to be big enough to be readily recognizable as a 'real' penis. In addition, the 'functional' penis is generally expected to have the capability to become erect and flaccid at appropriate times, and to act as the conduit through which urine and semen are expelled, also at appropriate times . . . . [T]ypically, surgeons also hope to see penises that are 'believably' shaped and

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of having “successful” surgery seem to increase if the surgeons construct a vagina than if they take on the task of constructing a penis. The effect has been that “more intersex infants are being assigned to the female sex”<sup>125</sup> than the male sex; however, the number of individuals who actually accept their assigned gender is unclear because there have been very few long-term follow-up studies of intersex children.<sup>126</sup>

As soon as doctors suspect that a child may be intersex, they work rapidly to make a definitive diagnosis and proceed to surgery. The AAP guidelines indicate that laboratory and imaging studies should be done when a child has ambiguous genitalia in order to confirm a diagnosis,<sup>127</sup> but doctors indicate that they “feel an urgent need to provide an immediate assignment and genitals that look and function appropriately.”<sup>128</sup> One physician specializing in the area of intersex conditions said, “We can’t do [the diagnosis] early enough . . . . Very frequently a decision is made before all this information is available, simply because it takes so long to make the correct diagnosis . . . . There’s a lot of pressure on parents [for a decision] and the parents transmit that pressure onto physicians.”<sup>129</sup> Another endocrinologist<sup>130</sup> acknowledged that a family who was waiting to see if the infant’s

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colored. Meanwhile, very little is needed for a surgically constructed vagina to count among surgeons as ‘functional.’ For a constructed vagina to be considered acceptable by surgeons specializing in intersexuality, it basically just has to be a hole big enough to fit a typical-sized penis. It is not required to be self-lubricating or even to be at all sensitive . . . . [A]ll that is required is a receptive hole.”).

<sup>125</sup> Kuhnle & Krahl, *supra* note 30, at 89. *See also* Kessler, *supra* note 6, at 13 (“[A]s long as the decision rests largely on the criterion of genital appearance, and male is defined as having a “good-sized” penis, more infants will be assigned to the female gender than to the male.”).

<sup>126</sup> Hermer, *supra* note 6, at 212.

<sup>127</sup> *Evaluation of the Newborn*, *supra* note 31, at 139–40.

<sup>128</sup> Kessler, *supra* note 6, at 13.

<sup>129</sup> *Id.*

<sup>130</sup> “Endocrinologists are specially trained physicians who diagnose diseases related to the glands.” *What is an Endocrinologist?*, Hormone Health Network, <http://www.hormone.org/contact-a-health-professional/what-is-an-endocrinologist> (last visited Apr. 4, 2014).

phallus would grow with hormone treatment was so impatient that they “could only wait a month” before making a definitive decision about the child’s gender.<sup>131</sup> Physicians’ language regarding intersex children in their care suggests that though they try to speak neutrally about the child, it is difficult to think of and speak of a child as one whose gender has yet to be determined.<sup>132</sup> The hurry and impatience stem from the parents’ desire to have a “normal” child that they can unequivocally call a boy or girl,<sup>133</sup> which only fuels the speed with which doctors proceed to surgery.

In these situations, physicians have the dual responsibility of evaluating the child’s condition and “also [managing] the parents’ uncertainty about a genderless child.”<sup>134</sup> Dr. Money claimed that “the best procedure of sex education and counseling is one of not creating emotional indigestion by saying too much, too soon, and also of not allowing emotional malnutrition by saying too little, too late.”<sup>135</sup> Doctors encourage parents not to feel compelled to disclose their child’s sex to other people, but instead, to tell others that a problem is being resolved and that they would prefer not to get into the details of it.<sup>136</sup> However, a physician interviewed indicated that he does not believe it is really possible for parents to think of their child as gender neutral.<sup>137</sup> Physicians “respond to the parents’ pressure for a resolution of psychological discomfort”<sup>138</sup> by using technology to make a child fit in to one of the two genders society defines as normal.

Doctors engage in a normalizing process with the child’s

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<sup>131</sup> Kessler, *supra* note 6, at 13.

<sup>132</sup> See KESSLER, *supra* note 31, at 19 (“[Doctors’] language suggests that it is difficult for them to take a completely neutral position and to think and speak only of a *phallic tissue* that belongs to an infant whose gender has not yet been determined or decided.”).

<sup>133</sup> Kessler, *supra* note 6, at 13.

<sup>134</sup> KESSLER, *supra* note 31, at 21.

<sup>135</sup> MONEY, *supra* note 21, at 45.

<sup>136</sup> KESSLER, *supra* note 31, at 21.

<sup>137</sup> *Id.*

<sup>138</sup> Kessler, *supra* note 6, at 25.

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parents to educate them about their child's intersex condition.<sup>139</sup> "First, physicians teach parents about usual fetal development and explain that all fetuses have the potential to be male or female."<sup>140</sup> This description can be done with diagrams or pictures that show how a fetus develops and the point at which all fetuses start to differentiate into either male or female.<sup>141</sup> Second, the doctors stress the other features of the child that are normal.<sup>142</sup> Doctors aim to redirect the parents' attention away from the problem and toward the "good things" about their child.<sup>143</sup> Third, physicians use language to imply that it is the child's genitals, not the child's gender, that are ambiguous.<sup>144</sup> Doctors use medical terminology instead of words like "hermaphrodite" to show that it is the child's physiology that is unusual and "*not* that [the intersex child] constitute[s] a category other than male or female."<sup>145</sup> This language places emphasis on "the premise of the child's having been born sexually unfinished."<sup>146</sup> The situation is illustrated by using terms implying that "the trouble lies in the doctor's ability to determine the gender, not in the baby's gender per se."<sup>147</sup> The doctors portray their work as a task of uncovering the child's "true sex,"<sup>148</sup> instead of changing the child's condition to conform to one of the two established sexes. Finally, the doctors stress the social factors that shape a child's gender development; they deter attention from the biological factors even as they search for the biological cause of the intersexuality.<sup>149</sup> The doctors stress that

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<sup>139</sup> KESSLER, *supra* note 31, at 22.

<sup>140</sup> *Id.*

<sup>141</sup> *Id.*

<sup>142</sup> *Id.*

<sup>143</sup> Kessler, *supra* note 6, at 15–16.

<sup>144</sup> KESSLER, *supra* note 31, at 22.

<sup>145</sup> FAUSTO-STERLING, *supra* note 41, at 50–51 (emphasis in original).

<sup>146</sup> MONEY, *supra* note 21, at 46. In fact, Dr. Money wrote that "the concept of being sexually unfinished is invaluable" to the parents. *Id.* at 62.

<sup>147</sup> KESSLER, *supra* note 31, at 23.

<sup>148</sup> PREVES, *supra* note 14, at 55.

<sup>149</sup> KESSLER, *supra* note 31, at 23. "[D]octors make decisions about gender on the basis of shared cultural values that are unstated, perhaps even unconscious, and therefore considered objective rather than subjective."

“gender is fluid” and “not a biological given,”<sup>150</sup> while noting that much of the child’s gender identification will “depend, ultimately, on how everybody treats [the] child and how [the] child is looking as a person.”<sup>151</sup> Thus, Dr. Money’s principles regarding social gender construction are still very much present and pervasive among physicians.<sup>152</sup>

The fact that the physicians go through this “normalizing process”<sup>153</sup> with parents illustrates how society, and even the medical community, continues to cling to the idea that there are only two genders, despite “incontrovertible physical evidence that [it] is not mandated by biology.”<sup>154</sup> Sex assignment surgery is thought to offer children a more “normal” way of life, but it fails to account for the fact that “the child might one day have a different concept of ‘normal’ and want to choose a different course of treatment, or none at all.”<sup>155</sup> The process that doctors use to diagnose and treat intersex children reflects their adherence to the two-gender system.

Once a doctor has suspicion that a child may be intersex, they proceed with a course of treatment plan. Generally, one physician has chief responsibility for an intersexed child’s case and acts as a liaison between the doctors and the parents,<sup>156</sup> while a team of

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Kessler, *supra* note 6, at 18. The almost definitive role that penis size has in the determination of sex assignment shows doctors’ focus on only one physical characteristic, “one that is distinctly imbued with cultural meaning.” *Id.*

<sup>150</sup> Kessler, *supra* note 6, at 17.

<sup>151</sup> *Id.*

<sup>152</sup> MONEY, *supra* note 21, at 48 (“First and foremost, [parents] need to know that gender identity and role are not preordained by genetic and intrauterine events alone, but that psychosexual differentiation is largely a postnatal process and highly responsive to social stimulation and experience.”).

<sup>153</sup> Kessler, *supra* note 6, at 15.

<sup>154</sup> *Id.* at 25.

<sup>155</sup> Beh & Diamond, *supra* note 15, at 57.

<sup>156</sup> KESSLER, *supra* note 31, at 27. Remarkably, the specialist in charge of the case can sometimes have an impact on the sex that the child is assigned to. Some doctors acknowledge that when there is a decision to be made, pediatric endocrinologists tend to choose making the child into a female, while urologists gravitate toward making the child into a male. *Id.* at 27–28.

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specialists work collaboratively to make a treatment plan for the child.<sup>157</sup> The specialists involved usually include a “pediatrician, pediatric urologist,<sup>158</sup> pediatric psychiatrist, [and] pediatric endocrinologist<sup>159</sup> . . . .”<sup>160</sup> It is also recommended that the parents consult with a child psychiatrist who can aid parents not only at the time of diagnosis, but also as the child grows and may have questions about his or her condition.<sup>161</sup> It is important that “the team . . . form a bond with the parents, assisting them even if some members of the team disagree with the parents’ decision.”<sup>162</sup> Though doctors are the experts and guide the parents’ decision, it is ultimately the child’s parents who have the final word on how their child’s treatment should be carried out.<sup>163</sup>

The parents of an intersex child are positioned uniquely in that they have the ability and the burden of choosing their child’s gender. Once the parents make a choice, the “physicians merely provide the right genitals to go along with that socialization.”<sup>164</sup> But as one scholar notes, “at normal births, when the infant’s genitals are unambiguous, the parents are not told that the child’s gender is ultimately up to socialization. In those cases, doctors do

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<sup>157</sup> William G. Reiner, *Sex Assignment in the Neonate with Intersex or Inadequate Genitalia*, 151 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 1044, 1045 (1997).

<sup>158</sup> “A urologist is a physician who is trained to evaluate the genitourinary tract, which includes the kidneys, urinary bladder and genital structures in men and women, and the prostate and testicles in men.” AM. UROLOGICAL ASSOC. FOUND., WHAT IS A UROLOGIST?, *available at* [http://www.urologyhealth.org/\\_media/\\_pdf/whatisaurologist.pdf](http://www.urologyhealth.org/_media/_pdf/whatisaurologist.pdf).

<sup>159</sup> “A pediatric endocrinologist is a doctor who specializes in the diagnosis and treatment of children with diseases of the endocrine system . . . . [T]he glands of the endocrine system produce hormones, which are chemical substances that regulate many important body functions.” *Definition: Pediatric Endocrinologist*, SEATTLE CHILDREN’S HOSP., <http://www.seattlechildrens.org/kids-health/page.aspx?kid=41020> (last visited Mar. 23, 2014).

<sup>160</sup> Reiner, *supra* note 157, at 1045.

<sup>161</sup> *Id.*

<sup>162</sup> *Id.*

<sup>163</sup> *See id.*

<sup>164</sup> Kessler, *supra* note 6, at 17.



treat gender as a biological given.”<sup>165</sup> Thus, as the AAP concedes, an intersex child presents a “social emergency,” not a biological one.<sup>166</sup> In fact, most of the discussion surrounding surgical intervention is not about what is in the best social interest of the child, but what is in the best social interest for the family unit.<sup>167</sup> Doctors acknowledge the importance of family socialization by stating that “the family’s perceptions, expectations, and desires should be assessed and included in the decision regarding the sex of rearing.”<sup>168</sup> The perceived societal pressures to be either a male or female, and the family’s desire to have a son or daughter, push both the parents and the doctors to make the decision to fit an intersex child into a specified category with surgery.

Both doctors and parents share the responsibility and blame in deciding to surgically alter an intersexed infant’s body. The doctors act in accordance with the developed medical course of treatment, which may be faulty in and of itself because it is premised on faulty and outdated principles of sex and gender, to correct something that may not necessarily need correcting.<sup>169</sup> The family, on the other hand, acts in response to social pressure, which requires that a child fit into the standard “male” or “female” category. Parents seem to be generally concerned about the psychological well-being of their child and the future of both the individual child and the family unit. Though parents seem to make the wrong decision in electing sex assignment surgery at all for their child, they presumably also act out of love and a desire to create the best situation for the child. When a government agency has custody of a child, though, as they did in M.C.’s case,<sup>170</sup> that family interest, sense of love and attachment, and deeply rooted concern for the future are absent.

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<sup>165</sup> *Id.*

<sup>166</sup> See *Evaluation of the Newborn*, *supra* note 31, at 138.

<sup>167</sup> PREVES, *supra* note 14, at 53.

<sup>168</sup> *Id.* at 55 (citation omitted).

<sup>169</sup> In general, intersex conditions are not medically harmful to the child’s health. See Kessler, *supra* note 6, at 5.

<sup>170</sup> See *generally* sources cited *supra* note 2 and accompanying text.

*INTERSEX CHILDREN IN FOSTER CARE* 983II. THE CASE OF *M.C. v. AARONSON*

The case of *M.C. v. Aaronson* presents the question of whether or not the government has the ability to elect sex assignment surgery for an intersex child in his or her control. M.C., through his adoptive parents Pamela Crawford and John Mark Crawford, filed two lawsuits against all parties allegedly responsible for the sex assignment operation performed on him when he was an infant, including the South Carolina Department of Social Services (“SCDSS”), its employees, and individual physicians who treated him.<sup>171</sup> The first complaint, filed in federal court, asserts two causes of action against the SCDSS and the physicians. First, that in approving and performing the surgery their actions violated M.C.’s “substantive due process rights to bodily integrity, privacy, procreation, and liberty. . . .”<sup>172</sup> This violation occurred because

the removal of M.C.’s phallus and potential sterilization was not medically necessary, caused significant physical pain, imposed unreasonable risks of future physical and mental pain and suffering, and deprived M.C. of the opportunity to make his own deeply intimate decisions about whether to undergo genital surgery, if any, when he reached maturity.<sup>173</sup>

Second, the SCDSS and the physicians violated M.C.’s fourteenth amendment right to procedural due process because defendants chose to perform surgery on M.C. without requesting or initiating any hearing on the procedure.<sup>174</sup> The second complaint, filed in state court in the Court of Common Pleas in Richmond County, South Carolina, also asserts two causes of action: medical malpractice and gross negligence.<sup>175</sup> The facts

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<sup>171</sup> See M.C. Complaint, *supra* note 2; Complaint, Crawford v. Medical Univ. of S.C., No. 2013CP4002877 (S.C. Ct. Com. Pl. May 24, 2013) [hereinafter Crawford Complaint].

<sup>172</sup> M.C. Complaint, *supra* note 2, ¶¶ 72, 74, 77.

<sup>173</sup> *Id.* ¶ 71.

<sup>174</sup> *Id.* ¶¶ 80, 82, 84, 86–87.

<sup>175</sup> Crawford Complaint, *supra* note 171, ¶¶ 40, 49.

presented in the federal complaint, which were adopted by the District Court in a subsequent order,<sup>176</sup> demonstrate that because M.C. was in the custody and care of SCDSS at the time his surgery took place,<sup>177</sup> “SCDSS officials made decisions whether to authorize medical treatment [of M.C.], including the sex assignment surgery . . . .”<sup>178</sup>

M.C. was born to his biological parents in South Carolina in 2004<sup>179</sup> with a type of intersex condition that is “characterized by the presence of both ovarian and testicular tissue.”<sup>180</sup> Due to other medical complications, M.C. remained in the hospital for two and a half months after his birth,<sup>181</sup> during which time “SCDSS began an investigation into possible neglect by M.C.’s biological parents.”<sup>182</sup> He was released from the hospital into the care of his biological parents but a week later, his biological parents “notified SCDSS that they wanted to relinquish their parental rights.”<sup>183</sup> Pursuant to a court order, M.C. was placed in SCDSS’s custody on February 16, 2005 and “[t]he court terminated M.C.’s biological parents’ parental rights on September 9, 2006.”<sup>184</sup> He was placed with two foster families prior to his adoption by the Crawfords in 2006,<sup>185</sup> but “SCDSS retained legal custody of M.C. while he was in foster care,”<sup>186</sup> during which time he received the sex assignment surgery.

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<sup>176</sup> Order, *supra* note 2. As these facts have been accepted as true by the Court and there have been subsequent findings and orders on the federal complaint, all facts in this Note are drawn from the federal complaint. It should be noted, though, that both the federal and state complaints essentially allege the same facts.

<sup>177</sup> M.C. Complaint, *supra* note 2, ¶ 39.

<sup>178</sup> *Id.*

<sup>179</sup> *Id.* ¶ 16.

<sup>180</sup> *Id.* ¶ 40. The specific disorder is called ovotesticular difference/disorder of sex development.

<sup>181</sup> *Id.* ¶ 35. M.C. had complications from being born prematurely and acid reflux.

<sup>182</sup> *Id.* ¶ 36.

<sup>183</sup> *Id.* ¶ 37.

<sup>184</sup> *Id.* ¶ 38.

<sup>185</sup> *Id.* ¶ 39.

<sup>186</sup> *Id.* ¶ 55.

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M.C. was initially identified as a male at birth; his medical records “noted that his ‘phallus was rather large’ . . . [and] [r]outine blood tests indicated that [his] testosterone levels were ‘extremely elevated.’”<sup>187</sup> But he also had “male and female internal reproductive structures,” as well as a “small vaginal opening below a ‘significant’ phallus . . . .”<sup>188</sup> In fact, M.C.’s medical records indicate that, for the first few months of his life, the doctors were unsure what sex he was, as he was sometimes referred to as a male and sometimes as a female.<sup>189</sup> During a surgery to correct M.C.’s acid reflux condition, the doctor “performed exploratory surgery to inspect M.C.’s sex organs” and reported that he had “ambiguous” genitalia.<sup>190</sup> Over the next year or so, the doctors working on M.C.’s case agreed “that there was no compelling biological reason to raise M.C. as either a male or female.”<sup>191</sup> However, they also repeatedly emphasized that they had the ability to make M.C. into either sex with surgery and that, based on whichever surgery was performed, M.C. could be raised as either a male or a female.<sup>192</sup> For example, one doctor stated, “Due to the nature of M.C.’s external genital anatomy, either sex of rearing is possible with appropriate surgery.”<sup>193</sup> Later, this same doctor stated that “[c]urrently [M.C.] could be potentially raised, surgically reconstructed, and treated to be male or female.”<sup>194</sup> Though one doctor did consider the possibility that there would be problems with assigning M.C. to the female gender,<sup>195</sup> the team ultimately urged the SCDSS officials to allow them to perform sex

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<sup>187</sup> *Id.* ¶41.

<sup>188</sup> *Id.*

<sup>189</sup> *Id.* ¶42.

<sup>190</sup> *Id.*

<sup>191</sup> *See id.* ¶46.

<sup>192</sup> *Id.* ¶46a.

<sup>193</sup> *Id.*

<sup>194</sup> *Id.* ¶46c.

<sup>195</sup> *See id.* ¶46d (“My bias at the moment is towards female, although I have raised the possibility, because of the substantial virilization of the external genitalia, that there may have been sufficient testosterone imprinting to question ultimate gender identity.”).

reassignment surgery on M.C. in order to make his body look like that of a female.<sup>196</sup> It is important to note that M.C.'s condition at this point did not present any negative physical side effects, and the surgery was not necessary for this physical health.<sup>197</sup> However, when M.C. was sixteen-months old, doctors performed sex reassignment surgery to make M.C.'s body look like a female.

Defendant employees, in their capacity as M.C.'s guardians, were charged with making all medical decisions for M.C. from the time he was removed from his biological parents until the day he was adopted.<sup>198</sup> As such, they were instrumental not only for the purposes of ultimate legal consent for the surgery, but also in the treatment plan itself and its implementation.<sup>199</sup> Among other things, SCDSS "coordinated [all] the logistical steps needed to implement [M.C.'s sex assignment,]"<sup>200</sup> told M.C.'s foster parents when to bring M.C. to the hospital for the surgery,<sup>201</sup> and authorized the surgery both over the telephone<sup>202</sup> and in writing.<sup>203</sup>

The Crawfords contacted SCDSS in June 2006 after they saw M.C.'s profile on the State's adoption website and were interested in adopting him.<sup>204</sup> They learned of his condition and "called the agency and clearly expressed the family's desire not

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<sup>196</sup> *Id.* ¶49.

<sup>197</sup> *Id.* ¶ 52. Defendants, in their motions following filing of the complaint, have accepted the facts presented by Plaintiff in the Complaint as true. However, they do not concede to all of the facts and stated that "[t]he fact that these Defendants reference or incorporate certain of the Plaintiff's factual assertions in this motion does not represent a waiver of these Defendants to later challenge any of those factual assertions." Motion to Dismiss, *supra* note 2, at 2 n.2.

<sup>198</sup> M.C. Complaint, *supra* note 2, ¶55.

<sup>199</sup> *Id.* ¶¶ 55-63.

<sup>200</sup> *Id.* ¶57.

<sup>201</sup> *Id.* ¶58.

<sup>202</sup> *Id.* ¶59.

<sup>203</sup> *Id.* ¶61. The defendants even signed a form called the "check list of necessary information" that SCDSS requires when a child in their care undergoes "any 'major surgery' requiring in-patient hospitalization." *Id.*

<sup>204</sup> *Id.* ¶64.

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to subject M.C. to unnecessary sex assignment surgery.”<sup>205</sup> Unfortunately, the Crawfords were too late, as the surgery was already completed on April 18, 2006.<sup>206</sup> M.C. might not have been subjected to this sex assignment surgery if the Crawfords learned of his condition sooner, but the damage was already done. The Crawfords “gained custody of M.C. in August, 2006, and legally adopted him on December 11, 2006.”<sup>207</sup> They “initially raised M.C. as a female in accordance with the gender” assigned through surgery,<sup>208</sup> but “[h]is interests, manner and play, and refusal to be identified as a girl indicate that M.C.’s gender has developed as a male.”<sup>209</sup> “M.C. is currently eight years old”<sup>210</sup> and “is living as a boy with the support of his family, friends, school, religious leaders, and pediatrician.”<sup>211</sup> That does not change the fact, though, that the government gave their legal consent to a medically unnecessary and invasive surgery.<sup>212</sup> Defendants permanently altered M.C.’s body, and though he has the ability to live as a boy in his community, there is no way to regain what the government took from M.C.—his autonomy.<sup>213</sup>

### III. HEALTH CARE CONSENT IN FOSTER CARE

State foster care systems have specific procedures in place to determine whether or not the government has the ability to consent to medical treatment for a child in their care, and the analysis shows that they do not have the legal ability to consent to sex assignment surgery. As established by federal law, every

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<sup>205</sup> *Id.* Mrs. Crawford was knowledgeable about the surgery from the negative experience of a childhood friend and did not want M.C. to likewise undergo unnecessary surgery.

<sup>206</sup> *Id.* ¶ 51.

<sup>207</sup> *Id.* ¶ 64.

<sup>208</sup> *Id.* ¶ 65.

<sup>209</sup> *Id.* (“His interests, manner and play, and refusal to be identified as a girl indicate that M.C.’s gender has developed as male.”).

<sup>210</sup> *Id.* ¶ 2.

<sup>211</sup> *Id.* ¶ 65.

<sup>212</sup> *Id.* ¶ 8.

<sup>213</sup> *Id.* ¶¶ 8–11.

child in foster care<sup>214</sup> is entitled to a minimum set of health services.<sup>215</sup> Federal law serves as the base guidelines for care, but since states are afforded some discretion, particularly with those programs funded by Medicaid, there is often some difference between state and federal laws.<sup>216</sup> Each state has its own agency, such as an Office of Health and Human Services or Department of Social Services (“DSS”),<sup>217</sup> which ensures proper care and safety for children and families.<sup>218</sup> The goal of the foster care system is to return the child to his or her parents when possible, or to place the child in a different permanent home.<sup>219</sup> This is the case whether children are placed into the foster care system voluntarily or removed by a court proceeding.<sup>220</sup> Though each state has its own set of regulations, the laws often closely

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<sup>214</sup> “Foster care means 24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility.” 45 C.F.R. § 1355.20 (2012). As M.C.’s case illustrates, the State Department of Social Services retains ultimate decision-making control for children in the state foster care system. *See* M.C. Complaint, *supra* note 2, ¶39.

<sup>215</sup> *See* HARVEY SCHWEITZER & JUDITH LARSEN, FOSTER CARE LAW: A PRIMER 10 (2005); *see also* 42 U.S.C. § 1396 (2012).

<sup>216</sup> SCHWEITZER & LARSEN, *supra* note 215, at 10.

<sup>217</sup> The exact name of the agency varies by state but Department of Social Services will be used for this Note to encompass all alike agencies.

<sup>218</sup> *See, e.g., About DSS*, S.C. DEP’T OF SOC. SERVS., <https://dss.sc.gov/content/about/index.aspx> (last visited Mar. 24, 2014) (“The mission of the South Carolina Department of Social Services is to efficiently and effectively serve the citizens of South Carolina by ensuring the safety of children and adults who cannot protect themselves and assisting families to achieve stability through child support, child care, financial and other temporary benefits while transitioning into employment.”); *About the Department of Children & Families*, MASS. OFFICE OF HEALTH & HUMAN SERVS., <http://www.mass.gov/eohhs/gov/departments/dcf/about-the-department-of-children-and-families.html> (last visited Mar. 23, 2014) (“The Department of Children and Families is charged with protecting children from abuse and neglect and strengthening families.”).

<sup>219</sup> *See, e.g.,* MASS. GEN. LAWS ch. 110, § 1.03 (2011).

<sup>220</sup> *See, e.g., id.* ch. 119, § 23 (outlining the rules and regulations of the department for providing foster care).

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resemble each other.<sup>221</sup> The Massachusetts and New York laws will be used as the prototypical systems for purposes of this Note.<sup>222</sup> While there are some variations between state foster care laws, no officials in any state should be able to legally consent to surgery for intersex infants in their custody and under their care.

In deciding “who can consent to medical care, the first determination is whether an emergency exists[,]”<sup>223</sup> since consent is not required for emergency circumstances.<sup>224</sup> As discussed earlier, physicians and the AAP acknowledge that intersex conditions do not present immediate health risks that would constitute a medical emergency.<sup>225</sup> A medical emergency is generally a condition that is life-threatening and, as such, necessitates immediate attention in order to prevent death or hindrance to the individual’s mental or physical well-being.<sup>226</sup> Even M.C.’s physicians said that he could live with the condition and that it was not necessary to immediately perform surgery.<sup>227</sup>

When there is no emergency circumstance, the next “question is whether the treatment is routine . . . or extraordinary” as defined by the state statutes.<sup>228</sup> Routine medical care includes treatments such as dental care, developmental assessments, immunizations, preventative health services, and vision tests.<sup>229</sup> If the treatment is not routine, there are two ways to proceed: either the DSS must obtain a court order,<sup>230</sup> or the parent or patient may

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<sup>221</sup> See generally 110 MASS. CODE REGS. § 11.01; N.J. ADMIN CODE § 10:122D-2.5 (2013); N.Y. COMP. CODES R. & REGS. tit. 18, § 507.1 (2013); 55 PA. CODE § 3130.91 (2013).

<sup>222</sup> Massachusetts and New York present the most comprehensive set of state laws regarding medical consent and the foster care system.

<sup>223</sup> 110 MASS. CODE REGS. § 11.01.

<sup>224</sup> *Id.*; see also N.Y. PUB. HEALTH LAW § 2504.4 (McKinney 2012).

<sup>225</sup> *Evaluation of the Newborn*, *supra* note 31, at 138.

<sup>226</sup> 110 MASS. CODE REGS. § 11.03.

<sup>227</sup> M.C. Complaint, *supra* note 2, ¶46.

<sup>228</sup> 110 MASS. CODE REGS. § 11.01.

<sup>229</sup> *Id.* § 11.04. The examples provided are not an exhaustive list, as other treatments listed in the statute are considered routine as well.

<sup>230</sup> See *id.* § 11.17(2) (“The Department shall not give its consent to extraordinary medical treatment for any child in the care or custody of the Department. For all such children, the Department shall seek prior judicial



provide informed consent.<sup>231</sup> There are certain treatments that are explicitly deemed extraordinary, such as sterilization,<sup>232</sup> life-prolonging medical treatment,<sup>233</sup> and administration of antipsychotic drugs.<sup>234</sup> Since treatment for intersex children is not one specifically outlined in any state statutes, it becomes necessary to weigh certain factors outlined in the state statutes to determine if the care is considered extraordinary.<sup>235</sup> “If it is not extraordinary, it is routine. There is no other possibility.”<sup>236</sup> While the Department may consent to routine health care,<sup>237</sup> if it is found that extraordinary or non-routine health care is necessary, there is a higher burden on the DSS.<sup>238</sup>

Physicians are obligated to seek consent to treatment either from the patient himself or the parent, unless there is an emergency circumstance that makes consent impossible.<sup>239</sup> When a child is under the control of the DSS, the DSS takes the legal

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approval for any extraordinary medical treatment (unless parental consent is obtained . . . .”); 55 PA. CODE § 3130.91(1)(iii) (“If the child is placed under a voluntary placement agreement [the county agency] shall obtain an order of the court authorizing routine or nonroutine treatment if the child’s parent refuses, or cannot be located to provide consent.”).

<sup>231</sup> See NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVS., WORKING TOGETHER: HEALTH SERVICES FOR CHILDREN IN FOSTER CARE 6-9 (2009), available at [http://ocfs.ny.gov/main/sppd/health\\_services/manual/Chapter%206%20Consent.pdf](http://ocfs.ny.gov/main/sppd/health_services/manual/Chapter%206%20Consent.pdf) [hereinafter WORKING TOGETHER] (stating that the worker’s actions for consent depends on the legal authority with which the child was placed in foster care., as a parent must still provide consent for non-routine care if they voluntarily placed their child in foster care).

<sup>232</sup> 110 MASS. CODE REGS. §11.11.

<sup>233</sup> *Id.* §11.12.

<sup>234</sup> *Id.* §11.14.

<sup>235</sup> *Id.* §11.01.

<sup>236</sup> *Id.*

<sup>237</sup> *Id.* § 11.04(2); N.Y. COMP. CODES R. & REGS. tit. 18, § 441.22 (2013).

<sup>238</sup> See 110 MASS. CODE REGS. § 11.17(2) (“The Department shall not give its consent to extraordinary medical treatment for any child in the care or custody of the Department. For all such children, the Department shall seek prior judicial approval for any extraordinary medical treatment (unless parental consent is obtained . . . .)); WORKING TOGETHER, *supra* note 231, at 6–9.

<sup>239</sup> RESTATEMENT (SECOND) OF TORTS § 892D (1979).

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place of a child's parent, which means that it has the power to give consent as a parent ordinarily would.<sup>240</sup> The Restatement (Second) of Torts provides that an emergency situation is one in which the person needs immediate care "in order to prevent harm to [him]" and where "the actor has no reason to believe that the other, if he had the opportunity to consent, would decline."<sup>241</sup> A child born with an intersex condition does not require immediate care or surgery to prevent harm to his or her well-being, as the condition is not considered a medical emergency.<sup>242</sup> Further, with the new evidence to suggest that many children would have chosen not to undergo the surgery had they had the option at the time,<sup>243</sup> the second requirement that the actor believe the person, if possible, would choose the same thing, cannot be satisfied.

*A. Court Order Necessary for Extraordinary Care*

Sex assignment surgery for intersex children is clearly an extraordinary procedure when the factors outlined in state statutes are evaluated. If the DSS officials deem a procedure extraordinary, they must obtain a court order to proceed with the treatment.<sup>244</sup> Once there is an indication that a treatment necessitates a court order, the question, which in the area of sex assignment surgery an American court has never had the opportunity to decide,<sup>245</sup> is whether or not the court should allow

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<sup>240</sup> See SCHWEITZER & LARSEN, *supra* note 215, at 2–6.

<sup>241</sup> RESTATEMENT (SECOND) OF TORTS, *supra* note 239, § 892D.

<sup>242</sup> See *Evaluation of the Newborn*, *supra* note 31, at 138. One scholar writing about the issue of informed consent noted that "it is the parents and doctors of intersexed infants who are experiencing a medical emergency, not the intersexed infant. Intersexed genitalia make almost everyone—doctors, parents, and society as a whole—uncomfortable." Ford, *supra* note 51, at 477.

<sup>243</sup> See Coventry, *supra* note 1, at 56; Hendricks, *supra* note 16; Tamar-Mattis, *supra* note 54, at 68–72, 76, 78.

<sup>244</sup> 110 MASS. CODE REGS. § 11.17(2) (2013). See also 55 PA. CODE § 3130.91(2) (2012) (stating that the Department must obtain either parental consent or a court order for non-routine treatment).

<sup>245</sup> See Tamar-Mattis, *supra* note 54, at 81 ("[N]o one in the United States has questioned in court the parental authority to make this decision."). Likewise, M.C.'s case is the first challenge to the government's ability to

the procedure to go forward. Massachusetts provides an outline of factors to consider when determining whether medical treatment is extraordinary.<sup>246</sup> They include: “complexity, risk and novelty of the proposed treatment,”<sup>247</sup> “possible side effects,”<sup>248</sup> “intrusiveness of proposed treatment,”<sup>249</sup> “prognosis with and without treatment,”<sup>250</sup> “clarity of professional opinion,”<sup>251</sup> “presence or absence of an emergency,”<sup>252</sup> “prior judicial involvement,”<sup>253</sup> and “conflicting interests.”<sup>254</sup> Sex assignment surgery on infants must be deemed extraordinary, especially when the factors of intrusiveness and prognosis with and without treatment<sup>255</sup> are analyzed.

The guidelines outlined by state statutes provide that “[t]he more intrusive the treatment the greater the need to determine that the treatment is extraordinary, and obtain parental consent or to seek judicial approval prior to authorizing treatment.”<sup>256</sup> The Massachusetts statute cites case law to illustrate the kind of treatment that has been deemed intrusive and necessary for judicial approval.<sup>257</sup> Because DSS, not a court, decides whether the procedure should be deemed extraordinary,<sup>258</sup> the court merely concludes whether or not the treatment sought is appropriate. Examples of treatments deemed extraordinary by both the DSS and the courts, as cited by the Massachusetts legislature, include life sustaining procedures,<sup>259</sup> but there is also

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make this decision.

<sup>246</sup> 110 MASS. CODE REGS. § 11.17(1).

<sup>247</sup> *Id.* § 11.17(1)(a).

<sup>248</sup> *Id.* § 11.17(1)(b).

<sup>249</sup> *Id.* § 11.17(1)(c).

<sup>250</sup> *Id.* § 11.17(1)(d).

<sup>251</sup> *Id.* § 11.17(1)(e).

<sup>252</sup> *Id.* § 11.17(1)(f).

<sup>253</sup> *Id.* § 11.17(1)(g).

<sup>254</sup> *Id.* § 11.17(1)(h).

<sup>255</sup> *Id.* § 11.17(1).

<sup>256</sup> *Id.* § 11.17(1)(c).

<sup>257</sup> *Id.*

<sup>258</sup> *Id.* § 11.17.

<sup>259</sup> *See, e.g., In re Hier*, 464 N.E.2d 959 (Mass. App. Ct. 1984); *In re*

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a case where the court evaluated a petition for an order to sterilize a mentally handicapped woman.<sup>260</sup> Sex assignment surgery should be considered extraordinary. It is not only physically invasive, but it also deeply affects the child's ability to make decisions regarding his or her identity and reproductive future.<sup>261</sup> Those individuals who undergo surgery may be denied the right to reproduce in the future.<sup>262</sup> The invasive nature of the procedure renders it intrusive enough to be submitted to the court.

Once the Department uses the outlined factors to determine that a procedure is extraordinary, it must "seek prior judicial approval for [the] extraordinary medical treatment."<sup>263</sup> The courts then use a "substituted judgment" view for evaluating whether or not the procedure should be authorized, and ask whether, given all surrounding circumstances, the individual patient would want the treatment, regardless of what the ordinary or prudent person might want.<sup>264</sup> The standard seems to be one that is reasonable and takes into account the individual's circumstances, but there is reason to think that the standard of judicial review of a proposed sex assignment surgery should be even higher. There is no way to accurately predict whether or not the child will accept the sex that the doctors assign, and given that many of the intersex individuals that have undergone sex assignment surgery have spoken out against it,<sup>265</sup> it seems unlikely that a court would be able to conclude that a patient would want to undergo surgery at such a young age.

Another factor that weighs in favor of deeming sex assignment surgery as an extraordinary procedure is that of the

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Spring, 405 N.E.2d 115 (Mass. 1980).

<sup>260</sup> See *In re Mary Moe*, 432 N.E.2d 712 (Mass. 1982).

<sup>261</sup> See Haas, *supra* note 27, at 42–43 ("Genital reconstruction surgery may result in scarred genitals, an inability to achieve orgasm, or an inability to reproduce naturally or through artificial insemination.").

<sup>262</sup> *Id.* at 48.

<sup>263</sup> 110 MASS. CODE REGS. § 11.17(2).

<sup>264</sup> See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 429–32 (Mass. 1977).

<sup>265</sup> Tamar-Mattis, *supra* note 54, at 68–72.

“prognosis with and without treatment.”<sup>266</sup> “The less clear the benefit from the proposed treatment the greater the need for parental consent or prior judicial approval.”<sup>267</sup> Many children born with intersex conditions have the ability to live healthy lives without any surgical intervention<sup>268</sup> and instead can be assigned a gender without surgery.<sup>269</sup> The alleged benefit of this surgery is said to be one of “normality,”<sup>270</sup> but there is no indication either that children who have the surgery feel “normal” or that they are any better off later in life.<sup>271</sup> In fact, “rather than alleviating feelings of freakishness, in practice the way intersexuality is typically handled may actually produce or contribute to many intersexuals’ feelings of freakishness.”<sup>272</sup> There has been an inadequate amount of follow-up with large groups of intersex individuals who have undergone surgery to determine the exact results.<sup>273</sup> However, anecdotal evidence and those studies that

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<sup>266</sup> 110 MASS. CODE REGS. § 11.17(d).

<sup>267</sup> *Id.*

<sup>268</sup> *Evaluation of the Newborn*, *supra* note 31, at 138.

<sup>269</sup> *See How Can You Assign a Gender (Boy or Girl) Without Surgery?*, INTERSEX SOC’Y OF NORTH AM., [http://www.isna.org/faq/gender\\_assignment](http://www.isna.org/faq/gender_assignment) (last visited Mar. 23, 2013) (discussing the option of assigning a gender to the intersex child without performing surgery to make the body appear as that gender); Alice Domurat Dreger, *A History of Intersexuality: From the Age of Gonads to the Age of Consent*, 9 J. CLINICAL ETHICS 345, 353 (1998) (“A child—no matter how intersexed—can and should be assigned a male or female gender.”).

<sup>270</sup> *See Dreger*, *supra* note 6, at 30–31 (noting that much of the treatment is fueled by desire to fit within the definitions of normality); Tamar-Mattis, *supra* note 54, at 67 (noting that parents want their children to have a normal childhood, which includes having a “normal” gender identity).

<sup>271</sup> *See Haas*, *supra* note 27, at 48 (indicating that there is no proof to support the idea that people who have sex assignment surgery are any better off than those that do not have it).

<sup>272</sup> Dreger, *supra* note 6, at 31.

<sup>273</sup> *See FAUSTO-STERLING*, *supra* note 41, at 85 (“[L]ong-term studies of genital surgery are as scarce as hen’s teeth.”); *KESSLER*, *supra* note 31, at 53 (“Surprisingly, in spite of the thousands of genital operations performed every year, there are no meta-analyses from within the medical community on levels of success.”); Elizabeth Weil, *What if it’s (Sort of) a Boy and (Sort of) a Girl?*, N.Y. TIMES MAG. (Sept. 24, 2006), <http://www.nytimes.com/2006/09/>

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have been conducted lend themselves to the idea that more people would have preferred not to have the surgery and been given the freedom to decide at a later point whether or not they wanted it.<sup>274</sup> Given the lack of adequate scientific knowledge, it is difficult for physicians to argue that there are any real substantial benefits from the surgery.

It seems clear that sex assignment surgeries would undoubtedly qualify as extraordinary procedures that necessitate judicial approval, because it is so intrusive into the individual's well-being and future, and the benefits are so unclear. Sex assignment surgery denies an intersex child the opportunity to make a decision at a later point about whether or not to undergo a medically unnecessary procedure that will forever affect his or her life. If DSS sought court approval for one like M.C.'s, the court could prevent the surgery from happening in the first place, instead of assessing the consequences of a surgery only after it happens.

*B. The Doctrine of Informed Consent*

Instead of requiring a court order for extraordinary medical treatment, some states allow for consent to non-routine medical treatment as long as that consent is informed.<sup>275</sup> There are three prongs that must be satisfied in order for a medical decision to be considered legally informed: (1) the decision must be informed; (2) it must be voluntary; and (3) the patient must "have an appreciation of the nature, extent, and probable consequence of

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24/magazine/24intersexkids.html ("[F]ew well-controlled studies exist that prove much of anything, in part because the success of these treatments cannot be meaningfully assessed for at least 20 years, and by then most patients are lost to follow-up."). See also PREVES, *supra* note 14, at 154–56 (discussing the many unanswered questions that still remain to be answered through research).

<sup>274</sup> See Coventry, *supra* note 1; Hendricks, *supra* note 16; Tamar-Mattis, *supra* note 54, at 68–72, 76, 78. Cf. KESSLER, *supra* note 31, at 94–96 (recounting stories of parents who were happy that they chose not to have their child undergo sex assignment surgery).

<sup>275</sup> See, e.g., WORKING TOGETHER, *supra* note 231.

the conduct consented to.”<sup>276</sup> The informed consent doctrine protects “the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”<sup>277</sup> Because minors are unable to legally give consent to medical treatment,<sup>278</sup> parents must give “proxy consent” on their behalf.<sup>279</sup> The AAP recognizes that such consent “poses serious problems for pediatric healthcare providers”<sup>280</sup> because they must balance doing what is in the “best interest of the child” with the wishes of the parents.<sup>281</sup> It is difficult for physicians to define what is best for a certain child<sup>282</sup> given the differences in “religious, social, cultural, and philosophic positions on what constitutes acceptable child rearing and child welfare.”<sup>283</sup> “Courts have upheld parental consent on the basis that parents, as natural guardians of their children, are best situated and best able to make important decisions on their behalf.”<sup>284</sup>

However, some scholars contend that parents make decisions about what sex to assign their child without full disclosure from doctors about the ramifications for the future.<sup>285</sup> Doctors use

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<sup>276</sup> Ford, *supra* note 51, at 475 (internal quotation marks omitted).

<sup>277</sup> *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990) (internal quotation marks and citations omitted).

<sup>278</sup> Ford, *supra* note 51, at 477 (“Infants’ underdeveloped communication and comprehension abilities preclude appreciation of the nature, extent, and probable consequences of a proposed treatment. Nor can they weigh its alternatives. Therefore, infants are literally unable to give legal informed consent for their own medical treatment.”).

<sup>279</sup> Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 315 (1995).

<sup>280</sup> *Id.*

<sup>281</sup> *Id.*

<sup>282</sup> 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, 674 (2010).

<sup>283</sup> Committee on Bioethics, *supra* note 279, at 315.

<sup>284</sup> Ford, *supra* note 51, at 478.

<sup>285</sup> See Beh & Diamond, *supra* note 15, at 47–50.

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language that is thought to comfort the parents,<sup>286</sup> but it often “leaves parents ill-equipped to make thoughtful decisions.”<sup>287</sup> Many authors argue that because of this failure to disclose all necessary facts, parents cannot truly provide informed consent for their children to undergo surgery.<sup>288</sup> If parents cannot provide informed consent for sex assignment surgery on their child, it seems even less likely that a governmental department has the ability to give consent. Such a department lacks the same relationship and set of interests that any biological parent has with the child and therefore cannot really provide informed consent.

Thus, the central issues that scholars tend to focus on when discussing consent for intersex surgery are two-fold. First, that they do not have all of the information necessary to make a truly informed decision,<sup>289</sup> and second, that the parents and the child have potentially conflicting interests that prevent the parent from acting in the true best interest of the child.<sup>290</sup> As discussed earlier, doctors often relay information to parents with the aim of catering to the parents’ emotional needs,<sup>291</sup> but that also means many of the facts central to the decision-making process are not conveyed.<sup>292</sup> Further, even if parents do have all of the necessary information, it is possible that they could consent to surgery not because they believe it is in the best interest of the child, but for any other reason.<sup>293</sup>

Parents are also often driven by their own values and

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<sup>286</sup> See KESSLER, *supra* note 31, at 22–24.

<sup>287</sup> Beh & Diamond, *supra* note 15, at 48.

<sup>288</sup> See Beh & Diamond, *supra* note 15, at 1; Dreger, *supra* note 6, at 32–33; Ford, *supra* note 51; Hermer, *supra* note 6, 222–25.

<sup>289</sup> See *id.* at 1.

<sup>290</sup> Tamar-Mattis, *supra* note 54, at 88.

<sup>291</sup> Hazel Glenn Beh & Milton Diamond, *David Reimer’s Legacy: Limiting Parental Discretion*, 12 *CARDOZO J.L. & GENDER* 5, 27 (2005). See also FAUSTO-STERLING, *supra* note 41, at 63–77.

<sup>292</sup> Haas, *supra* note 27, at 62.

<sup>293</sup> Tamar-Mattis, *supra* note 54, at 88 (asserting that parents could “authorize the surgery *for any reason*—parental discomfort, embarrassment over raising a son with a small penis or a daughter with a noticeable clitoris, desire for a child of one gender or the other—as long as they were fully informed of the risks.”)



worries,<sup>294</sup> and by their guilt that they are responsible for their “imperfect” child.<sup>295</sup> One parent, concerned about what she thought her child would experience in the future if she did not have the surgery said, “Growing up a teenage girl is hard enough. I never want her to feel different. I never want her to have extra issues to deal with.”<sup>296</sup> While parents do the best they can in this situation, “the decision to perform surgery may be centered more around the needs of the caregivers than the needs of the child.”<sup>297</sup> That is not to suggest that parents do not have genuine intentions when they have to make the decision to have surgery; our cultural norms force people into one of two genders, and many parents do not want to “risk what they believe to be the well-being of their child in order to protest a cultural norm.”<sup>298</sup> “Parents and families are . . . accorded a certain sphere of privacy to pursue their personal aims and find out what is their best in child care.”<sup>299</sup> However, “intersex babies are not having difficulty with sexual identity or self-image. The parents are, and parental anxiety about the appearance of a child’s genitals should be treated with counseling, not with surgery to the child.”<sup>300</sup> If there is this much debate and speculation among scholars about whether or not parents have the ability to provide informed consent for their own children, then it bears asking the question of whether or not the government, in the form of a state Department of Social Services, should have the ability to provide

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<sup>294</sup> Navarro, *supra* note 16.

<sup>295</sup> Ford, *supra* note 51, at 487.

<sup>296</sup> Navarro, *supra* note 16 (internal quotation marks omitted).

<sup>297</sup> Tamar-Mattis, *supra* note 54, at 89.

<sup>298</sup> CARL ELLIOTT, *BIOETHICS, CULTURE AND IDENTITY: A PHILOSOPHICAL DISEASE* 40 (1999) (“I suspect parents are often terrified at the prospect of their children being outcasts, of being seen as freaks of nature, of being desperately unhappy, of being completely bewildered about their place in the world, of never being able to attract a sexual partner, of being forced to live a life of secrecy and shame, of being tortured and bullied and ridiculed by other children while they are growing up. And who is to say that these fears are not justified? It would be a mistake to overlook the consequences of damaging and stigmatizing cultural pressures an intersexed child may face.”).

<sup>299</sup> Wiesemann et. al., *supra* note 282, at 674.

<sup>300</sup> Weil, *supra* note 273.

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such consent.

The government does not aim to keep children in its care for the entirety of the children's life, but instead aims to have only temporary care until the child can be placed in a permanent home.<sup>301</sup> The government's intent to keep a child for the shortest amount of time possible runs counter to the idea that they should be able to make such a life changing and permanent decision as the sex of a child. When there are multiple social workers working on one child's case, as was the situation for M.C.,<sup>302</sup> there seems to be a greater possibility that not all information is being funneled through one person who is legally charged with giving consent.<sup>303</sup> Thus, the chance that full comprehension of the condition and appreciation for the ramifications of surgery will be lost only increases. A team of social workers was responsible for making and coordinating all of M.C.'s medical decisions,<sup>304</sup> but there is no indication that one person was primarily responsible for collecting all medical information from the doctors and communicating with other members of the team.<sup>305</sup> Unlike parents who are able to hear all information from a physician and weigh the options, case workers may be forced to compile piecemeal information from different sources and present it to the person able to give legal consent.<sup>306</sup> Even if one case worker spoke with the doctor at all times, his or her ability to provide

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<sup>301</sup> See, e.g., 110 MASS. CODE REGS. § 1.03 (2013).

<sup>302</sup> M.C. Complaint, *supra* note 2, ¶¶ 21–28.

<sup>303</sup> See *id.* ¶¶ 55–63 (stating that there were multiple case workers that spoke with medical officials and a supervisor who signed the consent form for the procedure).

<sup>304</sup> *Id.* ¶¶ 55–61.

<sup>305</sup> Five of the defendants named in the complaint received communications from the defendant doctors. *Id.* ¶ 57.

<sup>306</sup> In M.C.'s case, there was "sporadic attendance of multiple SCDSS case workers at conferences regarding M.C.'s medical treatment within different time frames . . . ." Crawford Complaint, *supra* note 171, ¶ 38. The Director of the South Carolina Department of Social Services was required to sign a checklist of information before the surgery could be performed, which she did sign. M.C. Complaint, *supra* note 2, ¶ 61. Verbal authorization was given via telephone to the surgical nurse by one of the social workers. *Id.* ¶ 59.

proxy consent for such an invasive surgery is severely hindered because they lack the same continued interest that parents have.

One may argue that the lack of parental relationship makes the government a better candidate for making this decision because it does not have the same emotional guilt and set of fears that a parent would have.<sup>307</sup> But the government employees making the actual decisions have the same feelings of discomfort that any adult may experience with ambiguous genitalia.<sup>308</sup> Arguing that the government is in a better position to make a decision about surgery because of its lack of emotional connection fails to appreciate that government officials are still driven by society's pervasive idea of "normality" and a strictly defined gender system. Further, it also means that the government may not truly know what is in the best interest of the child since there is no way to predict what kind of environment the child will subsequently be raised in. Finally, a government agency is not committed to seeing the sex assignment process through to completion. One surgical procedure "does not alter the chromosomal, genetic or hormonal determinants of sex and so does not change an intersex child . . . into an infant of the assigned sex."<sup>309</sup> There is most often the need for more than one surgery<sup>310</sup> and there are complex psychological ramifications that both parent and child have to address as the child matures.<sup>311</sup> The social worker, by virtue of his relationship to the child, does not have the ability to make sure that the child gets the follow-up care and psychological counseling that is essential for his or her development.<sup>312</sup>

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<sup>307</sup> Ford, *supra* note 51, at 487.

<sup>308</sup> See Tamar-Mattis, *supra* note 54, at 89.

<sup>309</sup> See Beh & Diamond, *supra* note 15, at 49.

<sup>310</sup> FAUSTO-STERLING, *supra* note 41, at 86-87 ("From 30 to 80 percent of children receiving genital surgery undergo more than one operation. It is not uncommon for a child to endure from three to five such procedures.").

<sup>311</sup> See generally PREVES, *supra* note 14, at 60-86 (recounting the stories of people who underwent surgery and worked to accept their identity); Kessler, *supra* note 6, at 22 (noting that "at adolescence, the child may be referred to a physician for counseling.").

<sup>312</sup> KESSLER, *supra* note 31, at 27-29. There is also most often the need

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Thus, the problems with government officials providing true informed consent for a child to undergo gender assignment surgery are multi-fold. The person who is charged with providing legal consent might not have all of the necessary and relevant information,<sup>313</sup> making consent is impossible; and even if he or she does have all of the information, they lack the ability to know what is truly in the best interest of the child.

While it is the case that children in foster care are entitled to receive certain basic health care services from their own state's Department of Social Services,<sup>314</sup> as the government has legal responsibility over the child,<sup>315</sup> that does not give the government the unfettered discretion to consent to any procedure. The Department may authorize treatment for children in any emergency circumstance,<sup>316</sup> but intersex conditions do not qualify as such; they are merely a deviation from society's conception of normality.<sup>317</sup> Even the doctor's treating M.C. recognized that there was no urgent reason to surgically make M.C. into either a definitive male or female.<sup>318</sup> The government may provide consent for routine medical care,<sup>319</sup> but when care is deemed extraordinary, the officials must either obtain a court order<sup>320</sup> or provide true informed consent<sup>321</sup> to proceed with the treatment. Sex assignment surgery on intersex children is undoubtedly an extraordinary procedure that requires an elevated level of consent either from the court or from the DSS. The DSS officials

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for hormonal therapy as the child develops to ensure that he or she continues to develop into the sex assigned by the doctors. ELLIOTT, *supra* note 298, at 37.

<sup>313</sup> See, e.g., M.C. Complaint, *supra* note 2, ¶¶ 55–61.

<sup>314</sup> SCHWEITZER & LARSEN, *supra* note 215, at 10.

<sup>315</sup> See 45 C.F.R. § 1355.20 (2012).

<sup>316</sup> See 110 MASS. CODE REGS. § 11.01 (2013); N.Y. PUB. HEALTH LAW § 2504.4 (McKinney 2012).

<sup>317</sup> Dreger, *supra* note 6, at 30.

<sup>318</sup> M.C. Complaint, *supra* note 2, ¶ 46.

<sup>319</sup> See 110 MASS. CODE REGS. § 11.04(2); N.Y. COMP. CODES R. & REGS. tit. 18 § 441.22(d) (2013).

<sup>320</sup> See 110 MASS. CODE REGS. § 1117(2); 5 PA. CODE § 3130.91(2) (2013); MICH. COMP. LAWS § 722.124a (2012).

<sup>321</sup> See WORKING TOGETHER, *supra* note 231.

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handling M.C.'s case did not obtain consent of either type<sup>322</sup> and overstepped their legal authority to elect procedures for a child in their care.

## IV. INTERNATIONAL RESPONSE AND SOLUTION

Several countries outside of the United States have started to address surgical procedures on intersex children and have adopted resolutions and laws to decrease both the ability and pressure to elect sex assignment surgery. Just a few months ago, the Parliamentary Assembly of the Council of Europe “addressed the issue of bodily integrity of intersex children”<sup>323</sup> when they adopted a novel resolution,<sup>324</sup> the “children’s right to physical integrity”<sup>325</sup> resolution. It calls for “Council of Europe Member States to ‘undertake further research to increase knowledge about the specific situation of intersex people, ensure that no-one is subject to unnecessary medical or surgical treatment that is cosmetic rather than vital for health during infancy or childhood, guarantee bodily integrity, autonomy and self-determination to persons concerned, and provide families with intersex children with adequate counselling and support . . . .’”<sup>326</sup> The resolution looks at the issue of intersex children from the “human rights perspective, rather than a medical approach.”<sup>327</sup> The resolution categorizes “medical interventions in the case of intersex

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<sup>322</sup> See generally M.C. Complaint, *supra* note 2.

<sup>323</sup> *Parliamentary Assembly of the Council of Europe Adopts Historical Intersex*, ILGA EUROPE, [http://www.ilgaeurope.org/home/news/latest/parliamentary\\_assembly\\_of\\_the\\_council\\_of\\_europe\\_adopts\\_historical\\_intersex\\_resolution](http://www.ilgaeurope.org/home/news/latest/parliamentary_assembly_of_the_council_of_europe_adopts_historical_intersex_resolution) (last updated Oct. 3, 2013).

<sup>324</sup> *Id.*

<sup>325</sup> PARLIAMENTARY ASSEMBLY OF THE COUNCIL OF EUR., RESOLUTION 1952: CHILDREN’S RIGHT TO PHYSICAL INTEGRITY (2013) [hereinafter RESOLUTION 1952]. The resolution also addresses other issues regarding cosmetic medical procedure, such as tattooing, piercing, and female genital mutilation.

<sup>326</sup> *Id.*

<sup>327</sup> Heather Cassell, *Europe Adopts Historic Intersex Resolution*, BAY AREA REP. (Oct. 10, 2013), <http://www.ebar.com/news/article.php?sec=news&article=69165>.

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children” as “procedures that tend to present as beneficial to the children themselves despite clear evidence to the contrary[.]”<sup>328</sup> perhaps giving credence to all of the first-hand statements from intersex individuals who were subjected to surgery.

There is also hope for a decrease in the societal pressure on parents to quickly choose a gender for an intersex child. Just a few months ago, Germany became the first European country to allow parents to register their child’s birth certificate with neither the male nor female designation.<sup>329</sup> Prior to the implementation of this new law, German parents experienced pressure to decide which sex to assign their intersex child and often made rushed decisions, as they had only a week to register their child at the registry office.<sup>330</sup> This new law allowing parents to decide their child’s sex later “is an effort to create legal recognition for intersex individuals”<sup>331</sup> and “to give parents and children more time before making life-changing sex reassignment decisions.”<sup>332</sup> According to the interior ministry, passports will soon have an “X” designation, in addition to the already-present male and female.<sup>333</sup> Other countries, including Australia, New Zealand, and Bangladesh, already have similar laws that allow individuals to select “X” or “other” on their passport application.<sup>334</sup> In contrast, birth certificates in the United States must be submitted within a

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<sup>328</sup> RESOLUTION 1952, *supra* note 325.

<sup>329</sup> *Germany Allows “Indeterminate” Gender at Birth*, BBC NEWS (Nov. 1, 2013), <http://www.bbc.co.uk/news/world-europe-24767225>.

<sup>330</sup> Jacinta Nandi, *Germany Got it Right by Offering a Third Gender Option on Birth Certificates*, THE GUARDIAN (Nov. 10, 2013), <http://www.theguardian.com/commentisfree/2013/nov/10/germany-third-gender-birth-certificate>.

<sup>331</sup> James Nichols, *Germany to Allow Parents to Choose No Gender for Babies on Birth Certificates*, HUFFINGTON POST (Oct. 31, 2013), [http://www.huffingtonpost.com/2013/10/31/germany-intersex\\_n\\_4181449.html](http://www.huffingtonpost.com/2013/10/31/germany-intersex_n_4181449.html).

<sup>332</sup> Michelle Castillo, *Germany to Allow Third Gender Designation on Birth Certificates*, CBS NEWS (Nov. 1, 2013), <http://www.cbsnews.com/news/germany-to-allow-third-gender-designation-on-birth-certificates/>.

<sup>333</sup> *Germany Allows “Indeterminate” Gender at Birth*, *supra* note 329.

<sup>334</sup> *Id.*

period of time set by the state<sup>335</sup> and must have a female or male designation; there is no other option.<sup>336</sup>

Some argue that Germany's law does not go far enough: without an outright ban on the surgeries, they will continue because "we live in a world where having a baby classified as 'other' is still considered undesirable."<sup>337</sup> However, the mere fact that parents have the option of avoiding the narrow male or female designation on the birth certificate is a step forward that the United States can emulate. The societal change to accepting someone designated as a gender other than male or female may take much longer than seems desirable, but there are more immediate options to ensure that foster children born with an intersex condition are not subject to sex assignment surgery. The legal change for birth certificate designation may alleviate the pressure that a child's caregiver feels to make an immediate assignment,<sup>338</sup> but until then, case workers must be educated about intersex conditions and care for the child just as they would any other child.

Resolutions like those in Europe that call attention to the impact of sex assignment surgery on intersex children can help the United States approach the problem from a new perspective. Allowing parents and government officials to register a child as something other than just "male" or "female" would allow them to consider all options without the pressure of having such a short time constraint. M.C. and children like him might be in a very different, and presumably better, situation if social workers allow

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<sup>335</sup> Kessler, *supra* note 6, at 14 ("New York State requires that a birth certificate be filled out within forty-eight hours of delivery, but the certificate need not be filed with the state for thirty days.").

<sup>336</sup> States have different laws that allow people to change their designated sex on their birth certificates, generally referencing transgender individuals. Some state laws require that the individual have surgery to change his or her sex before they will be eligible to change their birth certificate sex designation, but others do not require surgery. See *Sources of Authority to Amend Sex Designation on Birth Certificates*, LAMBDA LEGAL, <http://www.lambdalegal.org/publications/sources-of-authority-to-amend> (last modified Mar. 17, 2014).

<sup>337</sup> Nichols, *supra* note 331.

<sup>338</sup> See Nandi, *supra* note 332.

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them to make decisions about surgery themselves at a later point in life.

## CONCLUSION

Modern culture has created a sharply divided system of gender normality<sup>339</sup> that deeply affects the way in which someone that does not fit neatly into one of those two categories is perceived.<sup>340</sup> The debate over whether parents can elect sex assignment surgery will most likely continue, but there is no room or basis of authorization for a foster care system to elect that same surgery. Social Services officials have temporary care<sup>341</sup> of a child in their custody and are unable to foresee the environment a child will be adopted into and raised in. Their interests are significantly different from those of a child's biological parents and as such, they are unable to provide truly informed consent.

Adults may experience discomfort with the appearance of ambiguous genitalia and the uncertainty of a child's sex,<sup>342</sup> but the solution is not to subject the child to surgery that will have permanent and lasting effects on his or her body. M.C.'s life has forever been changed, no matter what the courts decide in his case. The policy and legal changes made recently around the world<sup>343</sup> can serve as a template and guide for policies that the United States may adopt to aid parents in making this kind of difficult decision and allowing them more time to do so.<sup>344</sup> But whether or not those changes come to the United States, state governments must allow intersex children to grow as they ordinarily would without surgery and provide the support that

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<sup>339</sup> See FAUSTO-STERLING, *supra* note 41, at 108–09 (discussing other cultures that have recognized a third gender).

<sup>340</sup> Beh & Diamond, *supra* note 291, at 15 (“Fear of the monster still continues to dominate the decisional process.”)

<sup>341</sup> See, e.g., 110 MASS. CODE REGS. § 1.03 (2013).

<sup>342</sup> Tamar-Mattis, *supra* note 54, at 89.

<sup>343</sup> See *supra* Part IV.

<sup>344</sup> Castillo, *supra* note 332 (writing that a goal of the German law was to allow more time for parents to decide on their child's sex).



they need.

There is also little indication at this point that children who had gender assignment surgery are any better off than those who did not.<sup>345</sup> In fact, the few studies that have been conducted indicate that adults who underwent surgery wish they had not had them,<sup>346</sup> or have transitioned from the gender that was surgically assigned to it.<sup>347</sup> Some suggest that surgery is the best fix because it helps to “normalize” people who would otherwise have a hard time because of their differences.<sup>348</sup> But as one scholar aptly analogized: “[W]e still live in a nation where dark-skinned people have a harder time than light-skinned people do. But would he suggest we work on technologies to ‘fix’ dark skin?”<sup>349</sup> Surely not.

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<sup>345</sup> Haas, *supra* note 27, at 48; Beh & Diamond, *supra* note 15, at 24 (“[C]ritics point to evidence that persons born with genitalia that fall outside our normal expectations can achieve a satisfying psychosexual adjustment without surgical intervention and argue that the imperative to create typical genitalia is of overrated significance.”).

<sup>346</sup> Beh & Diamond, *supra* note 291, at 24–25 (recounting testimony of people who wish they had the ability to choose for themselves whether or not they wanted surgery); Kuhnle & Krahl, *supra* note 30, at 96.

<sup>347</sup> See Dreifus, *supra* note 34 (“The most important [of findings] is that about 60 percent of the genetic male children raised as female have retransitioned into males.”).

<sup>348</sup> Alice Dreger, *Essay: When Medicine Goes Too Far in the Pursuit of Normality*, N.Y. TIMES (July 28, 1998), <http://www.nytimes.com/1998/07/28/science/essay-when-medicine-goes-too-far-in-the-pursuit-of-normality.html>.

<sup>349</sup> *Id.*