

Male, Female, and Other: How Science,
Medicine and Law Treat the Intersexed, and the
Implications for Sex-Dependent Law

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In a world where science, technology, and growing cultural interchanges bring increasing levels of complexity, many people take comfort in the fact that there are immutable facts that they know to be true. Many people consider sex to be one of those immutable facts. While social and economic roles might change between the sexes,

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“[e]very schoolchild, even of tender years, is confident he or she can tell the difference [between a male and a female], especially if the person is wearing no clothes,”¹ and views the categories as clear-cut, oppositional, and binary. Yet advances in genetics and prenatal medicine, as well as the experiences of individuals who are “intersexed,” or who have “ambiguous genitalia,”² or genitalia that are neither standard male nor female, reveal that sex is much more nuanced than our binary categories would have us believe.

Unfortunately, as is often the case, the law has not yet caught up and responded to the new truths that science is revealing.³ Instead, the law still works on the same presumption that has prevailed for many years, although it is no longer included in dictionaries: *Hermaphroditus tam masculo quam fæminae comparatur secundum præalentiam sexus incalcentis* (The sex of a hermaphrodite will be determined by the predominance of the exciting sex).⁴ The predominate response to the birth of an intersexed child has been genital normalization surgery,⁵ a procedure that raises ethical, informed consent, and constitutional issues. Furthermore, as this Article will show, the sex one is assigned by a doctor at birth has substantial impacts upon one’s rights to marry and inherit property, participate in family life, or to ask the law’s protections. As explored in the context of marriage below, our overly simplified concept of sex denies scientific truth and justice. If the law truly strives to be just, it will acknowledge that science has shown that sex is not unambiguous, and that a determination that a person is a “male” or a “female” should not be a determination of one’s rights.

I. THE SCIENCE OF SEX AND GENDER: WHEN THE PHYSICAL, GENETIC, PSYCHOLOGICAL, HORMONAL, AND SOCIAL DO NOT AGREE

What does it mean to be “male”? Is one male because one has a penis? Or because one has a 46XY karyotype? Perhaps a preference for

1. Littleton v. Prange, 9 S.W.3d 223, 223 (Tex. Ct. App. 1999).

2. 29 C.J. § 45. This entry is for the term “hermaphrodite,” which is generally considered pejorative. However, none of the more modern references, including the C.J.S., the more recent editions of Black’s Law Dictionary, and Am. Jur. 2d, include materials regarding either “hermaphrodite” or “intersexed.”

3. Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265, 267-68 (1999).

4. Co. Litt. 8 (Lib. 1, ch. 1, sec. 1); Bract fol. 5.

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

Tonka trucks to Barbie dolls? A generous amount of androgens leading to a deep voice and facial hair? Is it being sexually attracted to females? A consideration of any of the traditional markers of sex, including the physical, genetic, psychological, hormonal, and social characteristics that a given individual may possess, illustrates that the idea of sex as a binary is a socialized construct, informed and defined by ideas of gender.

The most widely accepted ground for determining an individual's sex is the physical:⁶ Does she/he have a penis or a vagina? Yet between one and four percent of the population is believed to be intersexed;⁷ even at the lowest estimate, one tenth of one percent of the population, intersexed births are as common as Down's Syndrome or cystic fibrosis.⁸ Thus, for a nonnegligible segment of society, the doctor's cry is not "It's a boy!" or "It's a girl!" Rather, "it" may be a "boy" with a micropenis, a "girl" with an enlarged clitoris, or the child may have any of a number of other variations from the "standard" male or female genitalia. As discussed *infra*, the development of human sex is prone to the vagaries of development *in utero*—a variety of factors influence whether or not an individual actually develops into a "normal" male or female.

Sex is also difficult to pin down genetically. While most people learn in school that your sex is determined by getting an X or a Y chromosome from dad, approximately one of every 1666 children is born with a karyotype that is neither 46XX or 46XY.⁹ Individuals with Klinefelter Syndrome have a 47XXY karyotype, while individuals with Turner Syndrome have a 45XO karyotype.¹⁰ These individuals are often referred to as "Klinefelter males" and "Turner females," because they develop seemingly standard male and female genitalia.¹¹ Yet their secondary sexual characteristics tend to be nonstandard, and Klinefelter males fail to virilize in puberty without hormonal supplementation.¹²

6. Jessica Knouse, *Intersexuality and the Social Construction of Anatomical Sex*, 12 CARDOZO J.L. & GENDER 135, 135-36 (2005).

7. Anne Fausto-Sterling, *The Five Sexes: Why Male and Female Are Not Enough*, 33 SCIENCES 20, 21 (1993).

8. ALICE D. DREGER, HERMAPHRODITES AND THE MEDICAL INVENTION OF SEX 43 (1998).

9. Intersex Soc'y of N. Am., *How Common Is Intersex?*, ISNA.ORG, <http://www.isna.org/faq/frequency> (last visited Oct. 2, 2011) (citing Melanie Blackless et al., *How Sexually Dimorphic Are We? Review and Synthesis*, 12 AM. J. HUM. BIOLOGY 151, 159 (2000)).

10. Intersex Soc'y of N. Am., *Intersex Conditions: Klinefelter Syndrome*, ISNA.ORG, <http://www.isna.org/faq/conditions/klinefelter> (last visited Sept. 27, 2011) [hereinafter *Intersex Soc'y of N. Am., Intersex Conditions*]; Intersex Soc'y of N. Am., *Turner Syndrome*, ISNA.ORG, <http://www.isna.org/faq/conditions/turner> (last visited Sept. 27, 2011).

11. Greenberg, *supra* note 3, at 283-84.

12. Intersex Soc'y of N. Am., *Intersex Conditions*, *supra* note 10.

Thus, the chromosomes of individuals who seem to be simply “male” or “female” belie the notion that there are only two genetic sexes.

Furthermore, there are autosomal disorders which lead to an intersexed individual, such as 5-alpha-reductase type 2 deficiency (5-ARD), which leaves a fetus with the 46XY karyotype unable to convert testosterone into the “more physiologically active [hormone required] . . . for the normal masculinization of the external genitalia in utero,”¹³ leading to ambiguous external genitalia. A review of the medical literature between 1955 and 1998 estimates the frequency of sex variations as follows:¹⁴

Not XX and Not XY	One in 1666 Births
Klinefelter (XXY)	One in 1000 Male Births
Androgen Insensitivity Syndrome	One in 13,000 Births
Partial Androgen Insensitivity Syndrome	One in 130,000 Births
Classical Congenital Adrenal Hyperplasia	One in 13,000 Births
Late Onset Adrenal Hyperplasia	One in 66 Births
Vaginal Agenesis	One in 6000 Births
Ovotestes	One in 83,000 Births
Idiopathic Intersexed Genitalia	One in 110,000 Births
Iatrogenic Intersexed Genitalia	No estimate
5-alpha-reductase Deficiency	No estimate
Mixed Gonadal Dysgenesis	No estimate
Complete Gonadal Dysgenesis	One in 150,000 Births
Hypospadias	One in 2000 Births
Total Number of People Whose Bodies Differ from “Standard” Male or Female	One in 100 Births
Total Number of People Receiving Surgery to “Normalize” Genital Appearance	Between One and Two in 1000 Births

The above table encompasses some of the many ways in which an individual can be born with sex abnormalities. While some of the disorders, such as Klinefelter’s Syndrome, Turner’s Syndrome, and 5-alpha-reductase Deficiency, involve variants in the sex chromosome, others, such as Androgen Insensitivity Syndrome, involve hormonal abnormalities, and yet others, such as hypospadias, have no known

13. Bruce E. Wilson, *5-Alpha-Reductase Deficiency*, WEBMD.COM, <http://www.emedicine.com/ped/topic1980.htm> (last visited Sept. 30, 2011).

14. Intersex Soc’y of N. Am., *supra* note 9.

cause.¹⁵ Even being genetically “male” or “female” is no guarantee that a particular fetus’s genitalia will match its genetic gender.

Given the many physical, genetic, and hormonal variants that can make a person fully intersexed, the idea that sex is easily determined on any of those bases is overly simplistic. This point becomes even clearer when one considers that many individuals who are physically and genetically “male” or “female” suffer from deficiencies in sex hormones that are not sufficient to render them intersexed and that wide variations exist in the range of what constitutes “normal” genitalia.¹⁶ The line between a micropenis and a very small penis is largely a line drawn in the sand by the medical profession, as is the line between a large clitoris and clitoromegaly.¹⁷

Of course, the fact that differences occur in nature does not mean that such differences are not pathological. However, individuals can be born intersexed without suffering physical ill effects outside of their abnormal genitalia.¹⁸ For example, a long-term study of males with micropenises shows those raised as “boys” often grow up to have normal penile function, including sexual function and urination.¹⁹ To be physically healthy, however, is not enough to protect an intersexed individual from suffering ill effects from being born with ambiguous genitalia.

In the case of the intersex, society often conflates and complicates the scientific issue of sex with the societal idea of gender. Thus, a sex disorder that causes an individual to have nonstandard genitalia with no other physical effect to the individual can still lead to identity pathology.²⁰ Feminist scholar Judith Butler has asserted that gender roles are the “performance” of sex and that gender and sex exist in a mutually defining relationship.²¹ Thus, while the binary idea of sex defines gender, gender in turn limits our idea of sex to a binary schema.²² Only those bodies that fit the schema “matter,” in other words, have a role within

15. *Hypospadias*, MAYO CLINIC (Jan. 22, 2011), <http://www.mayoclinic.com/health/hypospadias/DS00884/DSECTION=causes>.

16. DREGER, *supra* note 8, at 4-5.

17. *Id.* at 192-96.

18. *Id.* at 189.

19. J.M. Reilly & C.R. Woodhouse, *Small Penis and the Male Sexual Role*, 142 J. UROLOGY 569, 569-71 (1989).

20. Stephanie S. Turner, *Intersex Identities: Locating New Intersections of Sex and Gender*, 13 GENDER & SOC’Y 457, 457-79 (1999).

21. JUDITH BUTLER, BODIES THAT MATTER: ON THE DISCURSIVE LIMITS OF “SEX” 2-16 (1993).

22. *Id.*

society.²³ Thus, an individual with nonstandard genitalia must be made to fit the schema, often through surgical intervention. Society does not allow an individual to “matter” in a meaningful way, including legally, outside of the dimorphic gender/sex schema.²⁴ There is no “other” box for sex/gender; as discussed *infra*, the American legal and medical systems dictate that each person be assigned a sex/gender in accordance with the male-female binary, and that assignment carries with it serious implications for intersexed individuals.

II. “MAKE IT A GIRL”: THE ASSIGNMENT OF SEX TO THE INTERSEXED AND ITS ETHICAL PROBLEMS

One of the issues which has raised the most controversy in regards to the intersexed is the “treatment” of intersexed children through sex-assignment surgery. This “treatment,” originally developed as a social experiment to prove psychologist John Money’s theory that gender is a complete social construct,²⁵ and the later reports of its success, helped lead to the acceptance and prevalence of sex-assignment surgery, also called genital normalization surgery or genital reconstruction surgery, as the standard treatment for intersexed children.²⁶ This course of treatment has been accepted despite the lack of scientific evidence showing efficacy, and indeed, in spite of evidence showing its detrimental effect on individuals so treated.²⁷ The prevalence of such surgery has had a variety of detrimental effects on intersexed individuals, especially as they have grown into adulthood.²⁸

The sex-assignment model raises serious ethical questions. An examination of the intellectual framework that girds the model shows that the treatment protocol is concerned with the interests of society and not of the child subjected to genital normalization surgery. One of the most commonly raised objections to genital reconstructive surgery is that it does not conform to appropriate informed consent standards.²⁹ A potential solution that has been proposed is the imposition of liability through medical malpractice litigation against the doctors who perform

23. *Id.* at 187-93.

24. Turner, *supra* note 20, at 458-60.

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

26. *Id.* at 60-61.

27. William G. Reiner, *To Be Male or Female: That Is the Question*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 224, 224-25 (1997).

28. Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics & the Law*, 11 ANNALS HEALTH L. 195, 212-14 (2002).

29. Beh & Diamond, *supra* note 5, at 42-57.

such surgery on children and others see potential due process privacy protection.³⁰ This Article, however, posits that the ideal solution to the problem of sex-assignment surgery is not judicial, but political, legislative, and ultimately, social.

A. *Ethical Issues*

Sex-assignment surgery and the gendered upbringing that typically accompanies it raises a variety of ethical concerns, many of which center around the future happiness (or, more typically, unhappiness) of the sex-assigned individual in his/her adult life. Intersexed children often undergo several surgeries throughout their childhood and adolescence without a truthful explanation as to their condition, often due to the medical community's recommendation of secrecy and families' sense of shame.³¹ This pervasive dishonesty leaves many intersexed individuals with feelings of confusion, shame, guilt, and often, once they learn of their condition and the cause of their surgeries, anger.³² The goal of sex-assignment surgery, ironically enough, is to make an intersexed child normal enough that he or she can, as Judith Butler would say, "matter," or exist socially,³³ and to enable such a child to lead a "normal" and happy life.³⁴

The flaw with the sex-assignment model is that it rests on the assumption that, by first choosing a gender, then matching the child's sex organs to that gender, and finally rearing the child in that gender, the child will grow up to be a "man" or a "woman" and will be content with his or her sex and gender identity.³⁵ This was the belief underlying Money's John/Joan experiment which was foundational to the use of sex-assignment surgery as the standard treatment of intersexed children.³⁶ Unfortunately, the theory has proven to be flawed, and many intersexed individuals reject their assigned gender.³⁷ One extreme example, David Reimer, the individual who was the subject of Dr. Money's famous experiment, returned to living as a man before eventually committing

30. Tamar-Mattis, *supra* note 25, at 98-104.

31. Kate Haas, *Who Will Make Room for the Intersexed?*, 30 AM. J.L. & MED. 41, 41-42 (2004).

32. Beh & Diamond, *supra* note 5, at 2-5.

33. BUTLER, *supra* note 21, at 187-93.

34. Hermer, *supra* note 28.

35. Tamar-Mattis, *supra* note 25, at 59-60.

36. *Id.*

37. William G. Reiner, *Gender Identity and Sex-of-Rearing in Children with Disorders of Sexual Differentiation*, 18 J. PEDIATRIC ENDOCRINOLOGY & METABOLISM 549, 549-51 (2005).

suicide.³⁸ Another study found, “[O]f 73 patients with a Y-chromosome, 60 were reared female. [Of those 60], 26 (43%) declared female sexual identity, 32 (53%) declared male sexual identity, and two (3%) persistently refused to discuss sexual identity with anyone for >1 year, after being informed . . . that they were ‘born a boy.’”³⁹ The statistics, combined with the anecdotal evidence of intersexed individuals, evince that sexual and gender identity are more complicated than having the appearance of one’s sex organs align with one’s assigned gender.

Even if the theory itself were perfect—if, as Money asserted, children were “gender-neutral” until age 2, and gender and sex could simply be assigned—the current practices accompanying sex-assignment surgeries raise serious ethical concerns.⁴⁰ As discussed above, intersexed children are often subject to multiple surgeries in an atmosphere of shame and secrecy, an aspect of their childhood which leads to psychosocial disconnect and often leads the intersexed child to wonder what is “wrong” with him or her.⁴¹ The secrecy surrounding such a diagnosis and its attendant surgeries is meant to protect the child from social othering and trauma,⁴² and to allow the child’s family to view the child as “normal.”⁴³ Unfortunately, it rarely works out that way.⁴⁴

One of the main problems with surgeries on intersexed children is the discourse that surrounds such surgery. Genital normalization surgeries are held out in the United States as neutral procedures based upon sound scientific principles, when in fact, they are deeply rooted in a cultural preference for gender and sex role normativity, and indeed, even heteronormativity.⁴⁵ Rather than responding to the needs of intersexed children and their families, the current treatment model largely responds to society’s need for simple sex/gender categorization and the elimination of threats to such categories. As Julie Greenberg states in her article on gender assignment:

The presence of an “adequate” penis (one that is capable of vaginal penetration and will allow the male to stand while urinating) in an XY infant has led to the label “male.” The absence of an “adequate” penis has

38. Tamar-Mattis, *supra* note 25, at 59-61.

39. Reiner, *supra* note 37, at 550.

40. Haas, *supra* note 31, at 41-42.

41. Elizabeth Weil, *What If It’s (Sort of) a Boy and (Sort of) a Girl?*, N.Y. TIMES MAG., Sept. 24, 2006, at 48.

42. Haas, *supra* note 31, at 42-44.

43. *Id.*

44. Tamar-Mattis, *supra* note 25, at 60-61.

45. Nancy Ehrenreich with Mark Barr, *Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of “Cultural Practices,”* 40 HARV. C.R.-C.L.L. REV. 72, 78 (2005).

led to the assignment of the [XY] child to the female sex An XX infant, who is capable of reproducing, typically has been assigned to the female sex to preserve her reproductive capability [M]ales have been defined by their ability to penetrate and females have been defined by their ability to procreate.⁴⁶

As Greenberg's research illustrates, the current treatment protocol rests largely on cultural beliefs.⁴⁷ There is an unchallenged assumption, embraced by our medical and legal systems, that gender is based on sex, and that sex is based on the appearance of one's genitalia.⁴⁸ This assumption is undermined by the experience of many intersexed individuals who, upon reaching puberty or adulthood, often reject their assigned gender.⁴⁹ Despite having the "right" genitalia, these individuals cannot accept the gender and sex that should correspond to those genitalia.⁵⁰

A secondary assumption exists that female is an easy default gender. Under the current model, if you dig out a vagina, put her in a dress, and hand her a Barbie, she's a girl. Partly due to the greater ease with which surgeons can create vaginas, intersexed children with XX, XY, and ambiguous genetic sex are often assigned as "female," with doctors telling parents that a properly gendered rearing and hormones during adolescence will turn such children into girls.⁵¹ This approach in no way reflects culturally neutral science; rather, it is responsive to deep-seated cultural beliefs about what makes an individual a successful male (sexual prowess) or female (procreative ability), and to beliefs that individuals who do not fit into either gender have no place within our society.

That sex-assignment surgery serves society's gender/sex biases is underscored by the common practice of performing clitoridectomies on girls whose clitorises are considered too large.⁵² This practice illustrates the gender role differentiation in the treatment of "males" and "females" through the performance of sex-assignment surgery. Whereas the standard for whether or not a phallus is sufficient to leave a child "male" is based in part on whether the phallus is sufficient for satisfactory sexual performance, the standard of treatment for intersexed children assigned

46. Julie Greenberg, *Legal Aspects of Gender Assignment*, 13 *ENDOCRINOLOGIST* 277, 277 (2003).

47. *Id.* at 277-78.

48. Hermer, *supra* note 28, at 196.

49. Beh & Diamond, *supra* note 5, at 8-12.

50. *Id.*

51. Alice D. Dreger, *A History of Intersexuality: from the Age of Gonads to the Age of Consent*, 9 *J. CLINICAL ETHICS* 345, 345-47 (1998).

52. Greenberg, *supra* note 46, at 278.

as “females” is indifferent to future sexual needs.⁵³ Clitoridectomies, performed to make the child’s genitals cosmetically pleasing, have the same effect on Western intersexed children that they do on African girls—loss of sexual function and sensation, loss of ability to achieve orgasm, and psychological trauma.⁵⁴ The difference between the two is in the discourse, not the surgery. We have orientalized clitoridectomies performed on African girls as a sexist, barbaric practice, often called “female genital mutilation,” while reassuring ourselves that sex-assignment surgery on Western intersexed children is a scientific procedure, neutral and civilized because it makes intersexed children “normal.”⁵⁵

The assumptions behind sex-assignment surgery illustrate that it is society, with its entrenched need to retain the gender binary, and not intersexed children, whose benefit these surgeries serve. The view that intersexuality “is a disease that must be ‘cured’” ignores the fact that,⁵⁶ with rare exception,⁵⁷ these surgeries are not necessary for the medical health of the intersexed child,⁵⁸ and the high potential for poor outcomes, discussed *infra*. The current treatment model reinforces “cultural norms of sexual abnormality” with little concern for the individual patient.⁵⁹ It is difficult, if not impossible, to reconcile genital reconstruction surgery with the first principle of the American Medical Association’s standards of medical ethics, which requires physicians to provide care “with compassion and respect for human dignity and rights.”⁶⁰

B. *Informed Consent*

One of the most common justifications for sex-assignment surgery is that it is ethical and necessary because, without immediate medical intervention, the intersexed child will not be able to function normally

53. *Id.*

54. Ehrenreich with Barr, *supra* note 45, at 83-87.

55. *Id.* at 83-90.

56. Greenberg, *supra* note 46, at 283.

57. For example, tissue with a Y chromosome (testes and gonadal tissue) that fails to descend into a scrotum is at risk of developing cancer. This risk, however, is usually not a strong consideration, if a consideration at all, in the decision to perform genital normalization surgery. See Am. Acad. of Pediatrics, *Evaluation of the Newborn with Developmental Anomalies of the External Genitalia*, 106 PEDIATRICS 138, 141 (2000).

58. Ehrenreich with Barr, *supra* note 54, at 120.

59. Greenberg, *supra* note 46, at 278.

60. Am. Med. Ass’n, *Principles of Medical Ethics*, AMA-ASSN.ORG (June 2011), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page?>

within a family, and by extension, within society.⁶¹ However, the standard of informed consent that typically protects patients' autonomy is not sufficient in the case of sex-assignment surgery. Sex-assignment surgery is by no means without risk. Undergoing the surgery can lead to problems such as "loss of reproductive capacity, a loss of erotic response, genital pain or discomfort, infections, scarring, urinary incontinence, and genitalia that are not cosmetically acceptable."⁶² Furthermore, sex-assignment surgery carries with it the unique risk of placing a child in an inappropriate gender—a common outcome with serious psychosocial implications.⁶³ Yet it is not the child, but the child's surrogate (typically parents) who decides whether the child will face those risks and the attendant difficulties of the surgery.⁶⁴ While this model is sufficient for many medical decisions made on behalf of children, it is not sufficient for sex-assignment surgery.

Surrogate decision-making is standard when a patient lacks capacity to consent.⁶⁵ The choice of parents as surrogates in American jurisprudence reflects "Western civilization[']s concept[] of the family as a unit with broad parental authority over minor children."⁶⁶ And indeed, there is a certain logic to assigning parents as surrogate decision-makers for children without the capacity to make their own medical decisions. Parents may be depended upon to act in their child's best interest,⁶⁷ and situations arise in which medical decisions must be made for a child, even an infant. When a medical decision must be made for a child, the law generally presumes that parents are the best surrogates to make such a decision.⁶⁸

This presumption, however, must be examined anew in the case of intersexed infants and sex-assignment surgery. Why is this case different? First, one of the risks of genital normalization surgery is sterility.⁶⁹ Involuntary sterilization is treated differently from most other medical procedures by the courts, in no small part due to the fact that it deprives an individual of their substantive due process right to

61. Alice D. Dreger, "Ambiguous Sex"—Or Ambivalent Medicine? *Ethical Issues in the Treatment of Intersexuality*, 28 HASTINGS CTR. REP. 24, 27-28 (1998).

62. Greenberg, *supra* note 46, at 278.

63. See Reiner, *supra* note 37, at 549-51.

64. Beh & Diamond, *supra* note 5, at 37.

65. Laurence B. McCullough et al., *Informed Consent: Autonomous Decision Making of the Surgical Patient*, in SURGICAL ETHICS 32-35 (Laurence B. McCullough et al. eds., 1998).

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

67. *In re Fiori*, 673 A.2d 905, 912 (Pa. 1996).

68. Beh & Diamond, *supra* note 5, at 38.

69. Greenberg, *supra* note 46, at 278.

reproductive freedom.⁷⁰ The choice of whether to reproduce is considered a fundamental right, and the courts carefully scrutinize the decision to sterilize an incompetent person without his or her consent.⁷¹ Thus, for the majority of intersexed infants for whom genital normalization surgery endangers fertility, the otherwise unusual step of judicial involvement in surrogate medical decision making may well be legally warranted.

The case of genital normalization surgery is also different from most cases in which parents serve as surrogates because of the cultural implications of the decision and the shame that often accompanies the birth of an intersexed child.⁷² Because an infant or very young child has no past judgments from which a surrogate can form a substituted judgment, parents who make medical decisions for the very young generally must act to protect the child's best interests, rather than its autonomy.⁷³ Parents of the intersexed, however, must make their decisions within the context of their own socialization and biases: they do not just have a "sick" baby, they have a "freak" baby. If they follow the treatment protocol, most parents believe, they will be creating a normal life, not just for the child, but for themselves.⁷⁴ On the other hand, allowing the intersexed child to remain intersexed is a decision fraught with social anxiety for parents, who, in all likelihood, have themselves been acculturated to accept gender and sex as an oppositional, immutable binary. To choose any path other than surgery requires the parent of an intersexed child to confront his or her own cultural upbringing and biases regarding sex and gender. No matter how well-meaning and loving a parent might be, when faced with choosing whether to leave a child intersex or to have a surgeon assign the child a sex, the odds that the child's best interests are the overriding factor in the parent's decision-making process are poor indeed.

Even a parent who is acting purely for the best interests of the child still faces significant hurdles in providing proper informed consent to genital normalization surgery. The Colombia Constitutional Court, which heard a case concerning sex-assignment surgeries, found that these surgeries present special problems in ensuring that parents are not acting from self-interest, discussed *supra*, and in ensuring that parents are

70. See *In re Grady*, 426 A.2d 467, 472-76 (N.J. 1981).

71. *In re Romero*, 790 P.2d 819, 821 (Colo. 1990).

72. Tamar-Mattis, *supra* note 25, at 59-60.

73. Beh & Diamond, *supra* note 5, at 38.

74. Tamar-Mattis, *supra* note 25, at 67.

truly informed when they consent.⁷⁵ Parents of intersexed infants are often presented by beneficent medical professionals with a false sense of medical urgency, incomplete medical information, and secrecy.⁷⁶ These aspects of the treatment model, premised on the assumption discussed *supra* that an intersex child must be given a “normal” gender and sex and be reared in accordance with that assignment in order to grow up to be “normal,” prohibit a parent, without even a trace of self-interest in his or her decision making, from giving *informed* consent to sex-assignment surgery. Based on principles of autonomy, informed consent requires disclosure that “includes salient features of the [physician’s] clinical thinking in arriving at the recommended therapy and explains to the patient the basic thought process that brought the [physician] to the conclusion that [the proposed treatment] is a reasonable course of therapeutic action for the patient in this case.”⁷⁷

Parents who are being presented with the birth of an intersexed child as a medical emergency, which such a birth very rarely is,⁷⁸ may well be handicapped from making an independent, informed decision by being made to believe that there is no time in which to consider the decision.⁷⁹ Instead, such parents are likely to acquiesce to the physicians’ apparent authority and accept a decision that is based, not on medical fact and a careful weighing of the risks and benefits of such surgery, but rather on the sense of a “social emergency.”⁸⁰ If physicians and surrogates were to examine the foundations of the “social emergency” that is the birth of an intersexed child, it would emerge that such an emergency is predicated on the fact that allowing the intersexed child to grow and develop as it is, without forcing it to assume a “male” or “female” label, would lead to social dissonance by directly challenging the gender/sex binary.⁸¹ Such decision making is clearly not based upon protecting the best interests of the child, but the status quo. Any “consent” provided by parents in response to the current treatment model does not meet the standards of “informed consent” required for medical intervention.

75. Corte Constitucional [C.C.] [Constitutional Court], mayo 12, 1999, Sentencia SU 337/99, Gaceta de la Corte Constitucional [G.C.C.] (Colom.); Corte Constitucional [C.C.] [Constitutional Court], agosto 2, 1999, Sentencia T551/99, Gaceta de la Corte Constitucional [G.C.C.] (Colom.).

76. Beh & Diamond, *supra* note 5, at 53-54.

77. McCullough et al., *supra* note 65, at 32-35.

78. Tamar-Mattis, *supra* note 25, at 86-87.

79. *Id.*

80. Am. Acad. Pediatrics, *supra* note 57, at 139.

81. Greenberg, *supra* note 3, at 325-27.

Given the variety of factors that make informed consent an inadequate protection of the future decision-making capacity of the intersexed child, as well as the potential extreme physical and legal consequences of inappropriate assignment, many intersex advocates and scholars have called for a cessation of sex-assignment surgery on individuals not old enough to exercise their own decision-making capacity.⁸² The Colombia Constitutional Court has called for the institution of what could be called “exceptional informed consent” before the performance of sex-assignment surgery.⁸³ Others have called for a more litigious solution, advocating the use of medical malpractice suits to bring an end to sex-assignment surgeries on intersexed infants and children.⁸⁴ And one scholar has proposed that the protection of intersexed children rests in the substantive due process jurisprudence of the United States Supreme Court.⁸⁵ In the end, however, the extant protections will likely not prove sufficient. If we are truly committed to protecting intersexed infants from unnecessary surgery, changes must be implemented at a social and legislative level.

C. Protection from the Bench: Medical Malpractice

Innovative scholars have proposed protecting intersex infants from sex-assignment surgery through litigation.⁸⁶ One proposal would use the flaws in the informed consent process for such surgeries, discussed *supra*, to impose medical malpractice liability on the physicians who recommend and perform the surgeries.⁸⁷ The flaw with using medical malpractice as such a tool is that the majority of jurisdictions determine whether medical malpractice exists based on whether the doctor failed to “use minimally sound medical judgment and render minimally competent care.”⁸⁸ This minimal level of care is typically proven when a doctor follows customary practice, with courts giving the medical profession’s custom conclusive weight.⁸⁹ As established above, sex-assignment surgery is the customary practice in the treatment of intersexed infants. In jurisdictions that abide by customary practice as the standard of care for physicians, medical malpractice suits against physicians performing sex-assignment surgery will almost certainly fail.

82. See INTERSEX SOC’Y OF N. AM., <http://www.insa.org/> (last visited Sept. 27, 2011).

83. Greenberg, *supra* note 46, at 279-80.

84. Hermer, *supra* note 28, at 214-20.

85. Haas, *supra* note 31, at 41-42.

86. Knouse, *supra* note 6, at 149-51.

87. *Id.* at 151.

88. See *Hall v. Hilbun*, 466 So. 2d 856, 866 (Miss. 1985).

89. See *Holt v. Godsil*, 447 So. 2d 191, 191-92 (Ala. 1984).

The medical malpractice model does have a slim chance of success in those jurisdictions that have moved away from the customary practice standard, declaring that “what is usual or customary procedure might itself be negligence”⁹⁰ and embracing instead a “reasonableness standard.”⁹¹ In these jurisdictions, the courts have left it to the trier of fact “to weigh without expert testimony the relative risks of using [a] procedure or omitting it.”⁹² The use of a reasonable standard of care gives medical malpractice suits against physicians recommending and/or performing sex-assignment surgeries a chance of succeeding without the shield of customary practice to hide behind. Unfortunately, the ultimate decision in reasonable standard jurisdictions rests with the trier of fact—and the trier of fact often carries the same sociocultural biases regarding gender normativity as the physicians who originally suggest “normalizing” the infant.

D. An Alternative Treatment Model

The “problem” of intersex is not medical—it is cultural and social. Therefore, the solution ideally is not purely juridical, but social and cultural as well. The medical establishment has begun to recognize the flaws in the current treatment model; the American Association of Pediatrics (AAP), in new guidelines on the treatment of intersexed infants, recommends that parents and physicians abstain from assigning or registering sex at birth, and instead determine the sex of rearing on a variety of factors.⁹³ Unfortunately, all but one of the factors considered in such assignment are anatomical, and thus the new model fails to acknowledge the variety of other elements that contribute to an individual’s gender and sex identity. Nonetheless, the new AAP guidelines represent progress towards a better future for intersexed children.

Intersexed children will probably continue to be subject to sex-assignment surgery at some point in their childhood, until we begin to confront the inadequacy of the male-female binary on a societal level. The new AAP guidelines recognize that immediate surgery is not the answer; they do not recognize that children do not need to be assigned a

90. *Lundahl v. Rockford Mem’l Hosp. Ass’n*, 235 N.E.2d 671, 674 (Ill. App. Ct. 1968).

91. *See, e.g., Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974) (holding that failure to administer a harmless glaucoma test to a patient under 40 was malpractice even though it was not customary practice to administer such a test).

92. BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 361 (6th ed. 2008).

93. Hermer, *supra* note 34, at 209.

sex at all. As explored *infra*, the sex binary is pervasive in American society. Social and political change must happen, and the way we view sex and gender must be revolutionized, before there will not be the impulse to surgically alter children's genitals so that they match our idea of how a little boy or a little girl "should" look. The law can help foment such change by creating protections for intersexed children at the legislative level.

The legislature, rather than the judiciary, is the logical and perhaps even the only choice for creating protections against sex-assignment surgery that will have any power or consistency. The legislature is the body empowered to respond to social problems. When the social discourse leads to unjust results, well-crafted legislative responses supported by good jurisprudence that respond to the nascent changes in the social discourse can help lead to a swell in the changes across the broader society. Thus, while the Civil Rights Act of 1964 responded to a changing social discourse regarding race, its impact was to not just solidify, but to help create a new social understanding regarding race relations and racial justice. Legislation shielding intersexed children from sex-assignment surgery, similar to that currently in place to protect girls from genital mutilation,⁹⁴ creates a legal wrong that, over time, comes to be accepted as an ethical and moral wrong.

Sex-assignment surgeries will cease to be utilized if and when the law and the broader society create room within the discourse for more sexes, or even for a legal system that does not rely on sex-definition at all.

III. BEYOND MEDICINE: HOW THE LAW TREATS SEX AND THE IMPLICATIONS FOR THE INTERSEXED

The American legal system presumes that there are two sexes, male and female, and that all human individuals fit roughly into one or the other of these two sexes.⁹⁵ This distinction is treated as universal and fundamental; a medical text addressing the treatment of the intersexed encapsulates the American views on sex and gender thus:

[The] normal functioning of sex is vital to the survival of our race, essential to our full assimilation as individuals into society, and pervades every aspect of our lives. To visualize individuals who properly belong neither to one sex nor to the other is to imagine freaks, misfits, curiosities, rejected by society and condemned to a solitary existence of neglect and frustration. Few of these unfortunate people meet with tolerance and understanding

94. 18 U.S.C. § 116 (2000).

95. Greenberg, *supra* note 3, at 292-96.

from their fellows and fewer still find even limited acceptance in a small section of society: all are constantly confronted with reminders of their unhappy situation.⁹⁶

The law itself embraces this idea that society needs a “normal functioning of sex.”⁹⁷ From birth to death, an individual’s legal identity and rights are tied to his/her/its sex. Documents of identity—birth certificates, drivers licenses, passports, even death certificates—require us to check the box, declare ourselves male or female, one or the other.⁹⁸ The same holds true of the intersexed; there is no “other” box for gender/sex. Beyond simply forming a required part of our legal identities, American views on gender and sex prescribe and proscribe our legal rights in some of the most fundamental aspects of life, including the right to marry, to acquire custody of or to adopt children and participate in family life, and claim the protection of the law against discrimination. The below Part examines marriage as one example of how the law’s overly simplistic view of sex and gender shuts the intersexed out of full participation in legal life.

A. *Defining Sex Under the Law*

Despite the fact that sex is treated as fundamental in the law, very few authorities have attempted to legally define what makes an individual a male or female. Most authorities in the United States rest comfortably on the assumption that there are two sexes, and they are easily differentiated on the basis of external morphology.⁹⁹ As the Kansas Supreme Court stated, “The words ‘sex,’ ‘male,’ and ‘female’ are words in common usage and understood by the general population.”¹⁰⁰ This definition of sex is obviously problematic for the intersexed. Most other definitions considered heretofore by American courts, in cases considering the rights of postoperative transsexuals, are equally problematic for the intersexed.¹⁰¹ Chromosomes do not provide a clear sex for individuals with anomalous karyotypes,¹⁰² and a standard that

96. CHRISTOPHER J. DEWHURST & RONALD R. GORDON, *THE INTERSEXUAL DISORDERS* vii (1969).

97. *Id.*

98. Knouse, *supra* note 87, at 140.

99. *Id.*

100. *In re Estate of Gardiner*, 42 P.3d 120, 135 (Kan. 2001), *cert. denied*, 537 U.S. 825 (2002). This case, which has since been overruled, considered the validity of a man born male and a postoperative male-to-female transsexual who had had her sex changed on her birth certificate.

101. Greenberg, *supra* note 3, at 266-70.

102. *Littleton v. Prange*, 9 S.W.3d 223, 224-29 (Tex. Ct. App. 1999).

measures an individual's ability to engage in "normal" sexual intercourse or reproduction,¹⁰³ in addition to being vague and heteronormative, fails to account for the many intersexed individuals who are without any sex under such a definition.

B. Sex and Marriage

The right to marry is considered one of an American's fundamental unenumerated rights, and is accorded a great deal of respect.¹⁰⁴ Currently, marriage in America is deeply rooted in heterosexual norms; both case law and statutes emphasize that marriage is between a man and a woman.¹⁰⁵ These statutes severely limit the ability of intersexed individuals who do not conform to or identify with the sex/gender assigned to them to engage in marital relationships with individuals of their sex of attraction.

Most intersexed children will be assigned to be girls, even if they are chromosomally male.¹⁰⁶ Furthermore, several intersexed disorders lead to androgen exposure *in utero*, resulting in masculinized brains even among intersexed individuals with female gonads.¹⁰⁷ The masculinization of the brain often leads to the sexual attraction pattern typical of heterosexual men, for example, attraction to "females" and stereotypically "male" behaviors.¹⁰⁸ Yet, because they are assigned "female" at birth, such individuals will never be able to marry a person of the sex to which they are attracted, because most states, with the exception of a few including New Jersey, that have considered the rights of transsexuals have held that sex at birth is a person's sex through life.¹⁰⁹ Even in cases where individuals have successfully altered their birth certificate to reflect their sex-of-choice, courts have still held that those individuals are the same sex that they were at birth.¹¹⁰ Clearly, American

103. *M.T. v. J.T.*, 355 A.2d 204, 209-11 (N.J. Super. Ct. App. Div. 1976). In holding that postoperative male-to-female transsexual was female for the purposes of marriage, the court found that "sex" embraces "gender," and that an individual's sex must be evaluated at the time of marriage. Under the holding, being male or female "requires the coalescence of both the physical ability and the psychological and emotional orientation to engage in sexual intercourse as either a male or a female."

104. *Loving v. Virginia*, 388 U.S. 1, 12 (1967).

105. *See, e.g.*, ARIZ. REV. STAT. ANN. § 25-101 (1996). While "[m]arriage between persons of the same sex is void and prohibited," such language poses the interesting question of whether intersexed individuals, if not assigned a sex, would be free to marry individuals of either sex.

106. Beh & Diamond, *supra* note 5, at 16.

107. *Am. Acad. Pediatrics*, *supra* note 57, at 141.

108. *Id.*

109. *See, e.g.*, *Corbett v. Corbett*, [1970] 2 All E.R. (P. 1970) (holding that the sex designated on a birth certificate is permanent and immutable).

110. *Littleton v. Prange*, 9 S.W.3d 223, 223 (Tex. Ct. App. 1999).

marriage law and its current attempt to ensure compliance with heterosexual norms, oversimplifies the concept of sex and excludes those who do not match the simple binary.

IV. MALE, FEMALE, AND OTHER: TOWARD A MORE EQUITABLE FUTURE

How, then, should the law cope with the intersexed? If we acknowledge what science, particularly genetics, has shown us, that there is more than 46XX and 46XY in the world, then the status quo is clearly insufficient. A law that relies on “sex” to determine an individual’s rights, and leaves the determination of what sex a person is to the whims of courts and legislatures steeped in heteronormativity, is simply unfair to those who do not match the heteronormative binary. As an institution of justice, the law should acknowledge its power to interrupt the discourse, and to influence how we view sex and gender. Much like the progress we have seen in terms of racial justice required the cooperation of the law in interrupting our binary understanding of race, progress in our understanding of sex requires the law to abolish its old binary. Legally, we must begin to recognize the “other” that the scientific spectrum shows us exists.

The options for the law to cope with the case of the intersexed are myriad. At the most radical (and politically unlikely) end of the spectrum is the elimination of sex-based law. The most conservative potential solution would be to carve small legal exceptions specifically for the intersexed, allowing them to change their legal sex upon proof of a biological basis that their current sex is “incorrect,” a solution that could accommodate the forces within our society that demand the current sex-law structure remain intact. Various possibilities lie between the two. We will examine the spectrum of possible solutions; however, it is this author’s contention that the best solution would be to eliminate sex as a category that determines peoples’ rights.

The conservative solution outlined above would appeal to those who most strongly insist on the binary sex-gender construct largely by pathologizing the state of the intersexed. Those groups who insist upon the maintenance of sex-dependent law could quite possibly be convinced to carve out an exception for those whose nonconformity was demonstrably physical—such a small exception would allow the rights of the intersexed, particularly those assigned a nonmatching sex, such as an XY male with a “male” brain who was reassigned due to micropenis, to be expanded. Such a solution, while perhaps the most politically tenable, would also be deeply unsatisfactory. By appealing to the view that sex-

gender nonconformity deserves respect and legal equality only when it is a “disease,” such a solution actually serves to reinforce the legitimacy of the law’s current assignment of rights based upon sex. Furthermore, it delegitimizes and separates from the intersexed individuals with similar concerns but no acceptable “reason” for their nonconformity with the norm: transsexuals.

In some jurisdictions, transsexuals and, presumably, intersexed individuals, can “rectify” their legal situation by having their legal sex changed after having reassignment surgery.¹¹¹ Again, however, the law places a stumbling block before the blind—individuals who would change their legal status must match their physical selves to our perception of a physical norm. For intersexed individuals, who have often been through many surgeries and medical treatments to bring their bodies into line with their originally assigned sex, such a standard is a slap in the face. Considering, further, that there are intersexed individuals who view themselves as neither male nor female, merely allowing such individuals to “switch” from male to female or vice-versa fails to address the fundamental questions of equity at play.

A third potential solution would be the creation of an “other” sex, assignable at birth to intersexed individuals, and available through appeal to the courts to individuals who discover later their intersexed status. Such a category could allow the intersexed individual to operate as either a male or a female when exercising their rights. This, however, would likely be a difficult pill for the defenders of heteronormativity to swallow: families would be formed that appeared homosexual (yet were not), seemingly homosexual couples could adopt and participate fully in family life, and an individual could seek protection from the courts, asserting that discrimination had been encountered, not because he was a he or she was a she, but precisely because the victim was neither.

The “other” category also gets at the heart of the equitable concerns at the center of the questions posed by sex-dependent law. If intersexed individuals can operate in society according to their sex of choice, including none, why should the same rights not be accorded to the Gay, Lesbian, Bisexual, Transgender community, and indeed, to all of us? If, in examining the case of the intersexed, we conclude that they deserve full participation within society, and for the law to acknowledge their right to such participation, how can we decide that other individuals who fail to match our sex-gender norms for reasons that cannot be nailed down to chromosomes or *in utero* exposure, do not deserve such rights?

111. Greenberg, *supra* note 3, at 292.

For this reason, this author advocates that we move toward a legal model where rights are not dependent upon sex. Moves small and large are being made in this direction—many jurisdictions have eliminated the “tender years” doctrine, leading to a family court where fathers are not presumed out of best parent status because they are men.¹¹² Same-sex marriage rights were most recently approved in New York. But the fundamental premise remains the same: that there are two sexes, tied to two genders, and that these should form the basis for the relationships that we sanction and permit, the basis for extended protection of the law under the Equal Protection Clause. But, given what medicine has shown us about sex, a law that was concerned with equity would turn that assumption upside down. If we can accept an “other,” perhaps we can do away with the check-boxes all together.

V. CONCLUSION

The law stands in unique relationship to science and society—ever responsive, the law is changed by and changes both. As our scientific understanding of sex, gender, and the intersexed increases, improves, and grows in complexity, so too must our social and legal understanding of sex, gender, and the intersexed. Kate Haas titled her article on the challenges of protecting intersexed infants from sex-assignment, “Who Will Make Room for the Intersexed?” The room the intersexed need must be created on every level—they must be recognized medically, socially, and perhaps most importantly, legally. Our concept of gender and sex must progress beyond the immutable, oppositional male-female binary, much as our concept of race has progressed beyond an immutable, oppositional black-white binary. When we embrace and legally protect the “other” in gender and sex, the room we make for the intersexed will, eventually, become room that we make for ourselves.

112. See *Ketola v. Ketola*, 636 So. 2d 850, 851-52 (Fla. Dist. Ct. App. 1994).