COMMENTS

Intersexed and Injured: How *M.C. v. Aaronson* Breaks Federal Ground in Protecting Intersex Children from Unnecessary Genital-Normalization Surgeries

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I. INTRODUCTION

M.C. was born with ovotesticular difference/disorder of sex development (ovotesticular DSD), an intersex[1] condition deemed "true

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1. "Intersex" refers to a congenital condition in which a person is born with genitalia that cannot be identified as clearly male or female. The gonads and external genitalia may be incongruent with typical definitions of the male or female sexes, or the external organs may exhibit attributes of both a penis and clitoris, or the person may exhibit a mosaic XX-XY DNA. "Intersex" is more of a social construct than a biological actuality. Because what characteristics identify an organ as being clearly male or female is governed by society's expectations, this arbitrary system of binary norms places intersex persons in an intermediate, or even nonsex,

hermaphroditism."[2] Being a ward of the state, M.C. was in the care of the South Carolina Department of Social Services (SCDSS). At only sixteen months old, M.C. was subjected to a medically unnecessary and nonemergency surgery to "correct" the intersex condition and to assign a clear sex.[3] M.C. was left with female genitalia. Despite being rendered sexually female by the surgery, M.C. came to identify as a male. When he was an eight-year-old self-identifying boy, M.C.'s parents filed suit on his behalf against the physicians and others for violating his constitutional rights by subjecting him to the medically unnecessary surgery that left him permanently unable to reproduce as a male and caused a permanent impairment of sexual function.[4] The suit alleges in two counts that the medically unnecessary genital-normalization surgery amounted to violations of M.C.'s Fourteenth Amendment substantive due process rights to bodily integrity, procreation, privacy, and liberty and his Fourteenth Amendment procedural due process rights to the same because no predeprivation hearing was held.[5] This is the first federal case of its kind since genital-normalization surgeries began in the 1950s.[6] Part II of this Comment explores the pending case of *M.C. v. Aaronson*[7] and how the court could offer protection for many children from invasive, irreversible, and unnecessary genital-normalization surgeries.

Unfortunately, M.C.'s plight is an illustration of a common occurrence in America today. Exact approximations on the prevalence of intersex conditions are difficult to calculate due to the inherent difficulty in diagnosis and the fact that the definition of "intersex" is not stringent enough to know which conditions and disorders should actually be

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assignment. *What Is Intersex?*, INTERSEX SOC'Y N. AM., http://www.isna.org/faq/what_is_intersex (last visited Nov. 16, 2014).

2. Complaint at 12, M.C. v. Aaronson, No. 2:13-cv-01303-DCN (D.S.C. 2013). The term "hermaphrodite" has been used interchangeably with "intersex" and comes from the name Hermaphroditus, the two-sexed son of Aphrodite and Hermes in Greek mythology, as told in Ovid's *Metamorphoses*, Book IV. The term "intersex" is preferable to "hermaphrodite," as the latter implies the equal and full functioning of both male and female sex organs, which is not the usual case in intersex conditions. *See Is a Person Who Is Intersex a Hermaphrodite?*, INTERSEX SOC'Y N. AM., http://www.isna.org/faq/hermaphrodite (last visited Nov. 16, 2014). For the purposes of this Comment, the term "intersex" will be used.

3. M.C. v. Aaronson, S. POVERTY L. CENTER, http://www.splcenter.org/get-informed/case-docket/mc-v-aaronson (last visited Nov. 16, 2014).

4. Complaint, *supra* note 2, at 16.

5. *Id.* at 20, 22.

6. *AIC's Groundbreaking Lawsuit Accuses South Carolina, Doctors, and Hospitals of Performing Unnecessary Surgery on Infant*, ADVOCS. FOR INFORMED CHOICE, http://aiclegal.org/programs/project-integrity/.

7. Complaint, *supra* note 2.

included in a census of intersex persons.[8] However, it has been estimated that between 1 in 1,500 and 1 in 2,000 children are born with an intersex condition.[9] Furthermore, it is estimated that 1 or 2 in every 1,000 persons born receive genital-normalization surgeries to more clearly identify them as distinctly male or female.[10]

These surgeries raise serious questions regarding informed consent, medical malpractice, and constitutional rights. As many intersex conditions are not medical emergencies, many genital-normalization surgeries are not medically necessary. Medical malpractice considerations arise when physicians fail to inform parents that such surgeries are unnecessary and may be delayed until the child has identified his or her own gender, or also when physicians fail to articulate the inherent dangers of sterilization and loss of sexual function that these surgeries can pose. Constitutional issues arise when genital-normalization surgeries result in irreversible damage to sexual function and reproductive ability. The informed consent and constitutional issues are further explored in Part III of this Comment. Finally, Part IV will examine how moratoriums on infantile genital-normalization procedures should not only be sought against states with custody of children as in *M.C. v. Aaronson*, but will demonstrate that such restrictions should be placed on parents as well in order to protect the child's constitutional interests.

II. *M.C. V. AARONSON*

M.C. was born prematurely and was discovered to have "ambiguous genitals"[11] and was hospitalized for two months.[12] Shortly after birth, the biological parents were investigated for being unfit, and they later relinquished their parental rights.[13] M.C. thus became a ward of the state of South Carolina in the custody of the SCDSS.[14] While in foster care,

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8. *Genomic Resources Center: Gender and Genetics*, WORLD HEALTH ORG., http://www.who.int/genomics/gender/en/index1.html (last visited Jan. 15, 2015).

9. Samantha S. Uslan, *What Parents Don't Know: Informed Consent, Marriage, and Genital-Normalizing Surgery on Intersex Children*, 85 IND. L.J. 301, 304 (2010).

10. *How Common Is Intersex?*, INTERSEX SOC'Y N. AM., http://www.isna.org/faq/frequency (last visited Jan. 14, 2015).

11. *See* Complaint, *supra* note 2. M.C. was born with a well-developed phallus and elevated testosterone, but with one gonad resembling an ovary, and one resembling a testis and also a "scrotalized labia." M.C. was officially diagnosed with ovotesticular DSD. This type of intersex condition was not harmful to M.C.'s health or well-being and did not pose a medical emergency.

12. *Id.* at 11.

13. *Id.*

14. *Id.*

SCDSS still retained the power to authorize medical treatment for M.C.[15] Within the first year of life, M.C.'s sex was difficult to determine, sometimes being referred to as male and sometimes as female.[16] Subsequent medical tests diagnosed M.C. with ovotesticular DSD, a form of "true hermaphroditism" in which M.C. was born with both ovary and testis tissue.[17] This congenital birth condition posed no risk of harm to M.C.'s health or well-being.[18] Following this diagnosis, one of the named defendants, a physician employed by a state university hospital entrusted to the care of M.C., made the decision to call for a "surgical correction" to assign a distinct sex for M.C.[19] After referral to other named defendants also employed by the same hospital, an endocrinologist and a surgeon, their observations determined that M.C. could be reared as either male or female, and potential gender identity could not be determined at that time.[20] The surgery could have been postponed until M.C. was of the age to identify his own gender and decide which "corrective" surgeries, if any, he wanted to undergo. Nonetheless, a decision was made when M.C. was sixteen months old to subject him to corrective surgery to make his body appear female.[21] The majority of M.C.'s phallus was removed in a "reduction clitoroplasty," and M.C.'s one true testicle was removed along with any testicular tissue from the ovotesticular gonad.[22] This removed any and all male sex organs from M.C.'s body, rendering his sexual anatomy distinctly female.

M.C. was eventually adopted and grew up to exhibit a male gender. "His interests, manner and play, and refusal to be identified as a girl indicate that M.C.'s gender has developed as male."[23] M.C. identifies as a boy and lives as a boy with the support of his family, primary pediatrician, religious community, and school. However, M.C.'s gender has developed in contrast to his assigned sex from the genital-normalization surgery, and he is unable to reproduce as a male. The painful surgery has robbed M.C. of a decision he ultimately could have made, and should have been allowed to make. At eight years old, M.C.'s parents filed suit in state court and the United States District Court for the District of South Carolina Charleston Division on his behalf against the physicians, the

15. *Id.*
16. *Id.* at 12.
17. *Id.*
18. *Id.* at 16.
19. *Id.* at 13.
20. *Id.* at 14.
21. *Id.* at 15.
22. *Id.* at 20.
23. *Id.* at 19.

SCDSS, and others, alleging violations of M.C.'s Fourteenth Amendment substantive and procedural due process rights as deprivations of his protected interests in procreation, bodily integrity, privacy, and liberty.

A. Substantive Due Process Claims

Count I of the complaint alleges that because the genital-normalization surgery was not necessary and has resulted in possible sterility, an inability to reproduce as a male, and possible mental anguish, M.C. was deprived of his right to make his own decision as to his anatomy.[24] The unwarranted surgical procedure amounts to an intentional invasion of M.C.'s "due process rights to bodily integrity, privacy, procreation, and liberty in violation of the Fourteenth Amendment."[25] As the procedure has foreclosed any ability to reproduce as a male, and has possibly rendered him sterile, M.C.'s constitutionally protected substantive due process rights have been deprived without his consent.

B. Procedural Due Process Claims

Count II of the complaint alleges that M.C.'s procedural due process rights under the Fourteenth Amendment have been violated because the resulting harm from the genital-normalization surgery occurred without any attempt by defendants to obtain a predeprivation hearing to determine M.C.'s interests.[26] A predeprivation hearing would have satisfied the procedural due process requirements of the Fourteenth Amendment because M.C.'s interests would have been judicially determined and weighed before being deprived. Although the physicians knew that M.C. would suffer permanent impairment of sexual function, would never be able to procreate as a male, and that a possible risk of complete sterility was present, they did not seek such a review, thereby violating M.C.'s procedural due process rights.

C. Defendant's Motion To Dismiss Denied

Shortly after the filing of the complaint, the defendants' claimed qualified immunity and filed a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), alleging that plaintiffs "fail[ed] to state a claim upon which relief [could] be granted."[27] Defendants claimed qualified immunity because they were employed by a state-run hospital. In the

24. *Id.* at 20-21.
25. *Id.* at 21.
26. *Id.* at 22-23.
27. FED. R. CIV. P. 12(b)(6).

order denying defendants' motion to dismiss, the district court relied on the United States Supreme Court's interpretation of qualified immunity in the case of *Harlow v. Fitzgerald*. In *Harlow*, the Court held that qualified immunity shields government officials from civil liability when they perform discretionary actions insofar as they do not "violate clearly established statutory or constitutional rights of which a reasonable person would have known."[28] The district court further articulated reasoning from the holding in *Evans v. Chalmers*, in which the United States Court of Appeals for the Fourth Circuit held that qualified immunity could be overcome if the plaintiff "(1) allege[s] a violation of a right (2) clearly established at the time of the violation."[29]

The district court in M.C.'s case turned to the question of whether M.C.'s rights were clearly established at the time of the alleged injury-causing event, the genital-normalization surgery.[30] This may appear as a legitimate inquiry by the defendants, as no federal case has been made to establish injury to substantive due process rights by a genital-normalization surgery. However, the court relied on U.S. Supreme Court precedent in deciding that sterilization violates a fundamental right to procreation.[31] Thus, qualified immunity could not be found to apply in regards to this deprived right.

As to plaintiffs' allegation of a violated procedural due process right, the defendants argued that there had been no procedural due process violation because there was no substantive right being deprived which required a hearing and that the SCDSS (M.C.'s then-guardian) consented to the surgery. The district court rejected these arguments because (1) it had already determined that a substantive due process right of procreation had been deprived, and (2) the nature of the right and the lack of a sufficient government interest in the deprivation of that right did not allow consent sufficient enough to satisfy the procedural due process requirements.[32]

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28. Harlow v. Fitzgerald, 457 U.S. 800, 818 (2006).

29. Evans v. Chalmers, 703 F.3d 636, 646 (4th Cir. 2012).

30. Order Denying Defendants' Motion To Dismiss at 7, M.C. v. Aaronson, No. 2:13-cv-01303-DCN (D.S.C. 2013).

31. The district court relied on settled United States Supreme Court precedent in holding that qualified immunity did not apply because M.C.'s right to procreate was deprived by the surgery rendering him sterile. *E.g.*, Skinner v. Oklahoma, 316 U.S. 535 (1942) ("Procreation [is] fundamental to the very existence and survival of the race."); Carey v. Population Servs., Int'l, 431 U.S. 678, 684-85 (1977) ("The decision whether or not to beget or bear a child is at the very heart of [a] cluster of constitutionally protected choices.").

32. Order Denying Defendants' Motion To Dismiss, *supra* note 30.

The district court then addressed the issue of whether a clearly established right was violated.[33] As the court had already determined that M.C. had a clearly established right to procreation at the time of the surgery, it further held that, based on the facts set forth in the complaint, M.C.'s right to procreation had been violated by the surgery.[34] Defendant's motion to dismiss was thereby denied.

D. The Importance of M.C. v. Aaronson *and Its Possible Implications for Future Intersex Protections*

While this case has yet to reach the trial stage to be adjudicated on the merits, it is a major hallmark for intersex rights in American jurisprudence. Never before has a federal court held that a possible violation of a fundamental right may result from a genital-normalization surgery. Assuming the validity of plaintiffs' facts in the complaint, the district court clearly articulated in the order denying defendants' motion to dismiss that M.C.'s sex assignment surgery resulted in a violation of M.C.'s fundamental right to procreation by rendering him incapable of reproducing. By denying defendants' motion to dismiss, the court recognizes the *possibility* that intersex children may have their fundamental rights protected when it comes to genital-normalization surgeries. If this case is decided in M.C.'s favor in the future, it will signal that genital-normalization surgeries on intersex infants may amount to infringements of the fundamental rights of procreation, bodily integrity, privacy, and liberty that all infants are innately born with in the United States.

III. THE ISSUES SURROUNDING GENITAL-NORMALIZATION SURGERIES ON INTERSEX INFANTS

Genital-normalization surgeries on infants raise serious issues regarding informed consent, possible infringement of infants' fundamental rights, and the social ramifications to follow the assignment of a sex by physicians.

A. Informed Consent

In common law, there is an understanding that parents may generally consent to and authorize most medical procedures for their

33. *Id.*
34. *Id.* at 12-13.

infant children.[35] Assuming parents may provide consent for their infant children to submit to surgical procedures, it is the duty of the physician to obtain *informed* consent from the parents before any operations be undertaken. This is the standard in cases of nonemergencies.[36] While informed consent is a professionally defined concept that varies by locale,[37] physicians are under a fiduciary duty to their patients and must typically provide material information that a reasonable physician would provide.[38] Physicians need not only disclose the reasonable relevant risks involved with a certain line of treatment, but also must disclose the alternatives, including nontreatment.[39] In this way, the doctrine of informed consent seeks to protect patient autonomy while at the same time shielding physicians from an onslaught of lawsuits from procedures to which patients consented.

In order to receive informed consent, a physician seeking to, or asked to, perform a genital-normalization surgery on an intersex infant must disclose all relevant information regarding the procedure, including its alternatives. A clearly relevant piece of information would be whether the intersex condition is classified as a medical emergency warranting genital-normalization surgery. In the current medical field, intersex conditions are often wrongfully treated as medical emergencies.[40] Most intersex conditions do not pose an immediate risk of harm to the infant's health and may be postponed until the child is of age to make his or her own decision.[41] By treating a medical nonemergency as an emergency, a physician may mislead an intersex infant's guardian into consenting to genital-normalization procedures that would make informed consent lacking.

Furthermore, genital-normalization surgeries carry a risk of sterility postoperation.[42] As was illustrated in *M.C. v. Aaronson*, intersex children

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35. Elizabeth J. Sher, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157, 168 (1983); *see also* Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 158 (2000) ("Indeed, no court has ever granted a patient younger than fourteen the right to consent.").

36. RESTATEMENT (SECOND) OF TORTS § 892d (1979).

37. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 916 (1994).

38. *Id.*

39. *Id.* at 921.

40. 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, 44 (2000).

41. *Id.*

42. *Endocrinologists Respond to UN Statement on Genital-Normalizing Surgery*, ADVOCS. FOR INFORMED CHOICE (Nov. 11, 2013), http://aiclegal.org/endocrinologists-respond-to-un-statement-on-genital-normalizing-surgery/.

may lose the ability to reproduce as one sex or be rendered completely sterile by the removal of vital sex organs.[43] This risk is significant because it involves an infant's fundamental right to procreate. Arguably, if a physician were to fail to disclose this information, informed consent could not be obtained.

Perhaps more startling is the significant risk of an improper sex assignment, as was the case with M.C. Many intersex infants that undergo genital-normalization procedures are assigned one sex but develop psychologically to identify with a gender not associated with their assigned sex.[44] Such gender dysphoria often results in mental anguish, a legitimate injury suffered by many intersex children that were improperly assigned. Such a risk would need to be articulated by the physician in order to obtain informed consent.

However, the current medical field operates under the assumption that an intersex child should be assigned to one sex under the binary male-female system currently expected by society; consequently, physicians resort to normalization procedures to place a child into one of these binaries. The hasty surgical approach is the dominant approach to intersex conditions in infants and is one that entails rampant failures to obtain full and truly informed consent.

B. Battery

Failure to obtain informed consent for medical treatment rendered has long been held to constitute battery under the common law.[45] In *Mohr v. Williams*, a plaintiff successfully established a cause of action for battery when she consented to have surgery performed on one ear but the physician decided while she was under anesthesia to perform surgery on the other ear.[46] The Supreme Court of Minnesota held that because consent was not given to perform surgery on the other ear, the defendant physician had committed a battery. Furthermore, an unlawful intent to commit the battery was not needed to establish a cause of action.[47] The

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43. Order Denying Defendants' Motion To Dismiss, *supra* note 30. M.C.'s penis was removed, along with a healthy testicle and all testicular tissue from the ovotestis, rendering him phenotypically female. However, M.C. also lacked a uterus and was therefore unable to procreate as a female. These circumstances left M.C. virtually sterile.

44. Jamie Alis Hardy, *Sex, Lies, and Surgery: The Role of Informed Consent in Sex Assignment and Normalization Surgeries Performed on Intersex Minors*, MICH. ST. U. C.L. 2 (2007), http://digitalcommons.law.msu.edu/king/92; *see also* Darra L. Clark Hofman, *Male, Female, and Other: How Science, Medicine and Law Treat the Intersexed, and the Implications for Sex-Dependent Law*, 21 TUL. J.L. & SEXUALITY 1, 11 (2012).

45. Mohr v. Williams, 104 N.W. 12 (Minn. 1905).

46. *Id.*

47. *Id.* at 16.

court held: "The case [was] unlike a criminal prosecution for assault and battery, for there an unlawful intent must be shown. But that rule does not apply to a civil action, to maintain which it is sufficient to show that the assault complained of was wrongful and unlawful."[48] Thus, physicians may be found liable for battery even without intent to injure a patient if informed consent is not received.

However, consent need not be obtained in cases of emergency.[49] The emergency exception to the doctrine of informed consent applies in states of emergency where it is impracticable to receive consent from the patient and treatment is needed to protect the health or life of the patient.[50] Operating under this standard, it is unlikely that a physician could make a convincing claim of an emergency exception to the informed consent doctrine when most intersex conditions have been found to be nonemergencies. It follows that, in the absence of true emergencies, a physician would still need to articulate the risks imposed by genital-normalization surgeries to the legal guardians of the intersex child in order to obtain informed consent and to prevent from committing medical battery.

C. Constitutional Concerns and Social Ramifications

When an intersex infant is subjected to genital-normalization surgery, red flags immediately are raised in concern over whether the child's fundamental rights are being violated. Of particular concern are the fundamental rights to bodily integrity and procreation. Because genital-normalization surgeries cause irreparable and even injurious changes to intersex children's anatomies, even sometimes leaving them sterile, the child's reserved interests in bodily autonomy and procreation are affected. The interests of bodily integrity and procreation overlap, because an exercise of the right of procreation is considered one of the protected exercises within the right of bodily integrity.

Bodily integrity is considered a fundamental right of a person to be secure in their being. As early as 1891, the U.S. Supreme Court held, "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others . . . ."[51] The right to bodily integrity was further developed by the U.S. Supreme Court in a series of privacy rights cases in the second half

48. *Id.*
49. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).
50. Chambers v. Nottebaum, 96 So.2d 716, 718 (Fla. Dist. Ct. App. 1957).
51. Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

of the twentieth century.[52] As a right to privacy was established through landmark precedent, the privacy right paved the way for an articulation that a person has the right to decide what to do with their own body.[53] This right was more clearly defined in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, in which the U.S. Supreme Court held that a woman's right to obtain a previability abortion as set out in *Roe* should be maintained without undue interference by the State.[54] The Court's insistence that the right to control one's body be protected from undue interference by others shows a developed principle of a right to bodily integrity that has evolved from the right to privacy.

The right to procreation is viewed as an exercise of the right to bodily integrity and is considered as "one of the basic civil rights of man."[55] In *Skinner v. Oklahoma*, the U.S. Supreme Court invalidated an Oklahoma statute that allowed for sterilization of certain types of criminal offenders.[56] In doing so, the Court established the right of procreation as "fundamental to the very existence and survival of the race."[57] The Court tangentially expounded on this principle in *Griswold v. Connecticut* by holding that a right of privacy exists between married couples in a case which ultimately allowed for married couples to be afforded access to contraception.[58] In so holding, the Court actually held that a right to *not* beget a child was an interest protected in the privacy rights of married couples. This decision was further extended to unmarried individuals in *Eisenstadt v. Baird*.[59] Taking the right to procreate identified in *Skinner* and the rights to not beget children from *Griswold* and *Eisenstadt*, the Court has established a fundamental right to procreation protected by the Fourteenth Amendment of the United States Constitution.

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52. *See generally* Griswold v. Connecticut, 381 U.S. 479 (1965) (showing that a right to privacy is a penumbral emanation from enumerated rights in the Bill of Rights to the United States Constitution); Roe v. Wade, 410 U.S. 113 (1973) (holding that a woman's choice in terminating a pregnancy is a protected interest under the right of privacy articulated in *Griswold*).

53. Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 270-71 (1990). In Cruzan, the Court traced the history of the right to bodily integrity from the introduction of the right to privacy. With a right of privacy established, a person also has the right to refuse lifesaving medical treatment. This protects the person's autonomy in the decisions regarding their body. Interestingly, this right to refuse treatment also was found to emanate from the doctrine of informed consent: if a person has a right to consent to treatment, then it follows that they have a right to not consent to treatment.

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

55. Skinner v. Oklahoma, 316 U.S. 535, 540 (1942).

56. *Id.*

57. *Id.*

58. *See* Griswold v. Connecticut, 381 U.S. 479 (1965).

59. Eisenstadt v. Baird, 405 U.S. 438 (1972).

Genital-normalization surgeries affect both the right to bodily integrity and the right to procreation. As parents are allowed to submit their intersex infants to genital-normalization, irreversible and oftentimes injurious changes are made to the infant's anatomy without any consent from the child. This is even more troubling when coupled with the fact that physicians, oftentimes relying on outdated ideas that an intersex condition is an emergency and deleterious to the child's health, actually misinform parents before they consent to their intersex child undergoing such surgeries.

Furthermore, genital-normalization surgeries pose a substantial risk of infringing on the intersex child's reserved fundamental right to procreate. Such procedures carry risks of sterilization by the removal of healthy reproductive organs as well as the risk of loss of sexual function and ability to experience sexual pleasure. As illustrated in the case of *M.C. v. Aaronson*, it is established fact that such procedures may render a child completely sterile, thereby foreclosing the right to procreation before the child could ever exercise it.

Apart from concerns of constitutional rights, gender-normalization surgeries also carry implications for the child's place in society later in life. For instance, if an intersex child is assigned a female sex by surgical operation, then that child will face different societal challenges than if the child was assigned a male sex. In the United States, a gender-wage gap still exists with women earning seventy-seven cents for every dollar a man earns.[60] Biological females are prohibited from being ordained in certain religious sects.[61] And if still fertile, intersex children surgically assigned a female sex may have to live with the challenges of access to reproductive justice, such as adequate access to contraception, healthcare, and abortion—challenges that by their very nature do not affect men in the same way. Clearly, assignment of a sex will affect the intersex child in ways that are not entirely governed by the common law. Sexual assignments affect the way intersex children will be treated under the expectations of society based on genitalia, not only gender expression.

IV. RECOMMENDATIONS

Legal mechanisms must be put in place to protect intersex infants not only from genital-normalization surgeries performed by the state, but

60. *Pay Equity & Discrimination*, INST. FOR WOMEN'S POL'Y RES., http://www.iwpr.org/initiatives/pay-equity-and-discrimination (last visited Feb. 23, 2015).

61. *US Denominations and Their Stances on Women in Leadership*, CHRISTIANS FOR BIBLICAL EQUITY, http://www2.cbeinternational.org/new/E-Journal/2007/07spring/denominations%20first%20installment—FINAL.pdf (last visited Feb. 23, 2015).

also from genital-normalization surgeries their parents consent to having them undergo. Under the current legal structure, parents of intersex children can consent to have their child undergo a genital-normalization surgery.[62] To support this practice, the U.S. Supreme Court has recognized a protected liberty interest under the Fourteenth Amendment for parents to decide in how they wish to rear their children.[63] However, the right to make decisions in the upbringing of a child has its limits.[64] For instance, a parent cannot voluntarily subject their child to a sterilization procedure without judicial oversight.[65] Because genital-normalization procedures on intersex infants carry a substantial risk of sterilization, it logically follows that judicial oversight should be utilized whenever a parent voluntarily seeks to submit their child to such operations.[66] Intersex activists even further advocate for a complete legislative moratorium on genital-normalization surgeries on legally incompetent children.[67] Parental rights and calls for legislation aside, there may be a possible remedy in state tort law to prevent intersex infants from being subjected to unnecessary genital-normalization procedures.

Because the U.S. Supreme Court has clearly established that parents' liberty interests in childrearing are not tantamount to a child's fundamental rights, it is reasonable to argue that with medical procedures such as these that pose substantial risks to a child's fundamental rights, a parent should not be allowed to give consent on behalf of the child to the procedure. Because most intersex conditions are not medical emergencies and do not pose risks of harm to the health or life of the child, and because important fundamental rights are threatened, these dangerous procedures should only be consented to by the child itself. How this change in power to consent from parent to child would occur could be achieved in state court litigation based on these arguments, a push for state medical boards to amend their ethics codes to reflect the

62. Hofman, *supra* note 44, at 11.

63. Meyer v. Nebraska, 262 U.S. 390 (1923) (invalidating a statute which criminalized the teaching of languages other than English to children and holding that persons retain a liberty interest in upbringing children); Pierce v. Soc'y of the Sisters, 268 U.S. 510 (1925) (holding that a law which required children to attend public nonreligious schools violated parents' liberty interest in directing the upbringing of their children).

64. Prince v. Massachusetts, 321 U.S. 158 (1944) (holding that the parental rights are not without limitation and that the state as parens patriae may restrict parental control in childrearing).

65. Uslan, *supra* note 9, at 310.

66. Hofman, *supra* note 44, at 11.

67. *E.g.*, Uslan, *supra* note 9.

autonomy of intersex children and their reserved right to consent, or, perhaps more idealistically, tort reform.

If the right to consent to genital-normalization surgeries is relegated from parent to child, then this poses a peculiar and perfect dilemma: infants cannot legally consent to medical treatment.[68] Thus, physicians who are requested to perform such surgeries by the parents of an intersex child will be rendered incapable of receiving informed consent to the genital-normalization surgery until the child is of a competent age to decide for him- or herself. At that time, it is likely that the child will have come to self-identify with a particular gender and will decide which assignment, if any, he or she wants to undergo. This is not to say that genital-normalization surgeries would always be entirely up to the legally incompetent intersex child, as the emergency exception to the informed consent doctrine clearly indicates. In cases of true medical emergencies where a genital-normalization surgery proves necessary, a physician may reasonably perform such a procedure in the interests of protecting the health and/or life of the infant while also being shielded from civil action.

If this model were in place, another problem could also occur. If parents of an intersex child requested a physician to perform a genital-normalization surgery, and the physician performs the procedure, the physician will have administered treatment without informed consent because the infant would still be too young to legally exercise that consent. If this were the case, medical battery may have occurred for which the physician may be liable in a civil suit for damages. But this produces another conundrum: who would file suit? The infant is legally incompetent and a statute of limitations for civil battery would most likely run before the infant matures cognitively enough to initiate a suit. The parents, who requested the surgery, are unlikely to file suit. So how can this model survive blatant violations? The state itself could exercise its power under the doctrine of *parens patriae*[69] to represent the child's interests in a civil suit. In this way, the legally incompetent infant may have his or her fundamental rights to bodily integrity and procreation protected while reserving a right to give informed consent upon maturation.

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68. Schlam & Wood, *supra* note 35, at 158.

69. *See* BLACK'S LAW DICTIONARY (9th ed. 2009) (stating that *parens patriae* [Latin for "parent of his or her country"] is a doctrine by which a government may initiate a lawsuit on behalf of one of its citizens).

V. CONCLUSION

As M.C.'s case illustrates, the medical community treats intersex conditions as subjectively abnormal medical emergencies deserving of immediate "corrective" genital-normalization surgeries, oftentimes substituting the physician's desire for precise and binary sexual assignments for the infant's innate fundamental rights in being let alone. Even more clearly, M.C.'s plight demonstrates how such surgical procedures can rob an intersex infant of reserved protected interests in bodily integrity and procreation that have been deemed fundamental by U.S. Supreme Court precedent.

Genital-normalization surgeries raise serious tort, constitutional, and social considerations due to them being typically medically unnecessary. While all reasonable material information regarding a procedure and its alternatives must be communicated to a patient in order for a physician to obtain informed consent, the medical community nonetheless inadequately informs patients and parents by relying on outdated information in telling parents of intersex children that the child's condition is a medical emergency. This inadequacy is compounded by a refusal to articulate the risks of sexual impairment, sterility, and gender dysphoria that often accompany such procedures. This really amounts to medical battery, but under current medical consensus, the consent would have been fully informed.

Nonetheless, the child's fundamental right to bodily integrity may be compromised by performing such invasive and medically unnecessary procedures. Also, the potential for sterility places in jeopardy the child's reserved right to procreate that the United States Supreme Court has deemed to be fundamental. Furthermore, the assignment of a sex without the child's consent predestines the child to certain challenges in society, because biological men and women are treated very differently in a variety of contexts.

For these genital-normalization surgeries to prove less egregious, proper informed consent would need to be received from parents of intersex children. While parents are currently empowered to consent their children to many types of medical treatments, the current model of informed consent is more misinformed. Notice of risks of sexual impairment, gender dysphoria, and sterilization would help to satisfy the doctrine of informed consent before subjecting healthy intersex children to "corrective" surgeries.

M.C.'s case is a hallmark for intersex rights, because it is the first federal case thus far to recognize that the risks and injuries concomitant

with such surgeries may constitute violations of intersex infants' fundamental rights to procreation and bodily integrity. While the case is filed against a state actor, it opens the door for more conversation into protecting children from private actors including their own parents or legal guardians.

While intersex activists advocate from mere accurately informed consent to outright legislative bans on nonemergency genital-normalization surgeries, other possibilities exist in curbing these practices to protect children. By arguing for a shift of informed consent from parent to child in cases of intersex children, the child would reserve an interest in physical autonomy that could not be violated except for true medical emergencies. This shift of power of consent from parent to child could be brought on by litigation based on the theory that a child's fundamental rights are tantamount to a parent's, by petitions to state medical boards to define informed consent as being reserved in the intersex child in cases of nonemergencies, or even by tort reform. If a child reserved the power of informed consent, physicians would be unable to perform nonemergency genital-normalization surgeries until the child is legally competent, probably in tandem with the child's gender identity development. Violations of such a standard could be actionable by a state acting in its *parens patriae* capacity to protect the interests of the child.

While the denial of the defendants' motion to dismiss in M.C.'s case is a celebratory moment for intersex activists, there is still much more that could be done to protect intersex children. As the science grows and conversations continue, both society's and the medical community's opinions hopefully will evolve to understand that *everybody* deserves respect.