

Legal Aspects of Gender Assignment
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I. Introduction

Whenever a baby is born, the first question the parents and the wider community ask is: Is it a boy or a girl? Yet in as many as 1 in 1,000 births, this question - born of a desire to celebrate a new life - is not an easy one to answer due to the fact that the outward genital appearance of the baby is ambiguous.¹ In these moments, the anxiety of parents, obstetricians and the inquiring family and friends is unbearable. Indeed, the American Academy of Pediatrics has recently declared that “the birth of a child with ambiguous genitalia constitutes a *social emergency*.”² Not a medical emergency, or even a tragedy for the family, but a social emergency. To be unable to answer this seemingly innocuous, unobtrusive, uncomplicatedly dimorphic question belies an underlying truth about the intersexed baby: the viability of human subjectivity presupposes that subject possessing a coherent and unambiguous sexual identity - in this view of human subjectivity, we all have a stake.

Since the late 1950s it has been common medical practice to address these moments of extreme parental and medical anxiety by resort to surgery. Indeed, the medical community regards the intersex infant as a problem to be “managed” through surgical techniques that “normalize” the ambiguous genitalia.

There is a broad range of legal issues that bear upon the decisions that parents of children with ambiguous genitalia are urged to make on behalf of, and to further the interests of their children. In this chapter I will address two central themes: i) when and why it matters legally that

¹ See Ann Fausto-Sterling, *The Five Sexes, Revisited*, *The Sciences* July/August 2000 at 19, 20.

² American Academy of Pediatrics Policy Statement, *Evaluation of the Newborn With Developmental Anomalies of the External Genitalia*, 106 *Pediatrics* 138 (July 2000)(emphasis supplied).

a person have an unambiguous sexual identity; and ii) why we should question this standard medical practice of “normalizing” babies with “cosmetically offensive” genital anatomy, with a particular focus on how we might understand the overwhelming pull to normalize these children as traceable to a kind of gender-based bias or set of stereotypes that we have come to disfavor in other cultural, legal and medical contexts. Given that other contributors to this volume are far more qualified to describe the range of intersex conditions that may result in an infant being born with ambiguous genitalia, I will refrain from doing so here.³

While the incidence of intersexuality is not a new phenomenon, surgical interventions to “cure” this crisis of sexual identity have evolved since the 1950s, in large measure as a result of the profoundly influential work of John Money. Money was responsible for a profound shift in our understandings of the relationship of sex to gender when, in the mid-1950s,⁴ he reported that he had taken an otherwise perfectly formed boy who had suffered a botched circumcision, and after genital surgery, successfully transformed his identity to that of a girl. Out of these tragic events, Money maintained that we could conclude that i) individuals are psychosexually neutral at birth, ii) healthy psychosexual development is dependent upon the appearance of the genitals; and iii) with a combination of surgery within 18 months of birth, proper gender-based counseling, and later hormonal treatment, a child could be “assigned” any gender successfully.⁵

³ What follows is a very quick summary of the range of conditions that are labeled “intersex.” In the legal literature, Julie Greenberg has taken much time and care to enumerate the details and prevalence of various intersex conditions in Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 *Ariz.L.Rev.* 265, 278-292 (1999); see also Melvin M. Frumback & Gelix A. Conte, *Disorder of Sex Differentiation*, in Williams *Textbook of Endocrinology* 1303, 1331 (J.D. Wilson et al. eds., 9th ed. 1998).

⁴ See John Money et al., *An Examination of Some Basic Sexual Concepts: The Evidence of Human Hermaphroditism*, 97 *Bull. Johns Hopkins Hosp.* 301-319 (1955).

⁵ This case is referred to in the literature as the “John/Joan” case. JOHN MONEY AND ANKE E. EHRHARDT, *MAN & WOMAN, BOY & GIRL* (1972); Milton Diamond and Keith Sigmundson, *Sex Reassignment at Birth: Long-Term Review and Clinical Implications*, 151 *Archives of Pediatrics and Adolescent Medicine* 151 (1997); and Ann Fausto-Sterling, *The Five*

While Money's famous John/Joan case did not relate directly to the treatment of intersex babies, its foundational premise, that gender identity formation took place after birth and was malleable, formed the basis upon which a standard of care for children born with ambiguous genitalia developed.⁶ In April 1996, the American Academy of Pediatrics issued the following policy with respect to the treatment of children with ambiguous genitalia, reflecting what had become the conventional wisdom for almost 40 years:

Research on children with ambiguous genitalia has shown that sexual identity is a function of social learning through differential responses to multiple individuals in the environment. For example, children whose genetic sexes are not clearly reflected in external genitalia (ie, hermaphroditism) can be raised successfully as members of either sex if the process begins before the age of 2 years. Therefore, a person's sexual body image is largely a function of socialization.⁷

Not until quite recently has this standard been called into question. In 1997 Dr. Milton Diamond published a shocking article in which he disclosed a secret Money had been hiding from the world: the John/Joan case had not been a success.⁸ Quite the contrary, his female gender identity never took hold, and at 14 he refused further treatments and resumed his life as a man. Money's claim that gender identity is completely responsive to professional manipulation was brought into question by Diamond's 1997 publication, nevertheless, surgical intervention to

Sexes, Revisited, supra note 1 at 20-21.

⁶ Alice Domurat Dreger, "Ambiguous Sex" – or Ambivalent Medicine? *Ethical Issues in the Treatment of Intersexuality*, Hastings Center Report, May-June 1998 at 24, 25.

⁷ American Academy of Pediatrics, *Timing of Elective Surgery on the Genitalia of Male Children with Particular Reference to the Risks, Benefits, and Psychological Effects of Surgery and Anesthesia*, 97 *Pediatrics* 590 (1996) (citations omitted).

⁸ Diamond and Sigmundson, supra note 5; Hazel Glenn Beh and Milton Diamond, *An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?*, 7 *Mich.J.Gender & Law* 1, 5-12 (2000).

“normalize” infants with ambiguous genitalia continue, albeit against an increasing scepticism regarding its justifications and efficacy by both medical professionals and intersexed advocates themselves.

Surgical, and later hormonal intervention to address and resolve this “social emergency” is typically justified on the grounds that going through life with ambiguous, or anomalous genitalia would be a psychosocial nightmare for any individual, and they would be unable to form a successful or coherent gender identity, and would suffer painful ridicule and ostracization from society. Further, ambiguous or “cosmetically unattractive” genitalia are understood to impair parental bonding with and affection for the infant.⁹

Surely there is a range of clitoral and penile size that does not trigger such parental anxiety and clinical intervention when faced with the question, is it a boy or a girl? Typically, clinicians consider a clitoris too big if it exceeds one centimeter in length,¹⁰ and urge reductive surgery to make it more “feminine and delicate.”¹¹ Penises are considered too small if the stretched length is less than 2.5 centimeters.¹² Adolescent ability to urinate standing up, and adult penile capacity for vaginal penetration during heterosexual intercourse are the physio-social activities in which the successful or “adequate” penis is measured. Thus, regardless of

⁹ SUZANNE KESSLER, LESSONS FROM THE INTERSEXED 52-64 (1998); John Money, *Sex Errors of the Body and Related Syndromes: A Guide to Counseling Children, Adolescents and Their Families* 82-83 (2d ed. 1994).

¹⁰ Ian A. Aaronson, *Sexual Differentiation and Intersexuality*, in *Clinical Pediatric Urology* 977, 1005 -07 (P. Kelalis et al. eds. 1992); Kessler, *supra*, note 9 at 43.

¹¹ Dreger, *supra* note 6 at 28, quoting Kurt Newman, Judson Randolph, et al., *The Surgical Management of Infants and Children with Ambiguous Genitalia*, 215 *Annals of Surgery* 644, 651, 647 (1992).

¹² Cynthia H. Meyers-Seifer and Nancy J. Charest, *Diagnosis and Management of Patients with Ambiguous Genitalia*, 16 *Seminars in Perinatology* 332 (1992). The American Academy of Pediatrics observes that “[i]n full term newborns the stretched penile length should measure at least 2 cm.” American Academy of Pediatrics, *Evaluation of the Newborn with Developmental Anomalies of the External Genitalia*, *supra* note 2 at 140.

chromosomal or other factors, in many cases if the child's phallus (clitoris in a girl and penis in a boy) is greater than 1 centimeter and less than 2.5 centimeters in size, the clinical recommendation will most likely be that the phallus be surgically reduced in size and the child be reared as a girl. Should a vagina need to be constructed, colon or other similar tissue is ordinarily deployed for this purpose.

With this background information about the diagnosis and treatment protocols for intersex conditions in infants, I will discuss two particular aspects of the legal treatment of intersexuality and treatment.¹³ First I will elaborate the principle areas of law in which sexual dimorphism, if not ambiguity, is most at stake, and then I will critique those stakes in the hopes of better understanding them.

II. When and Why it Matters Legally That a Person Have an Unambiguous Sexual Identity

We all know that a person's unambiguous sexual identity matters a great deal socially, but in what ways does the law concern itself with classifying humans into two binary sexual groups, male and female? In virtually every context in which a person's sexual identity carries legal significance, however, courts have struggled with choosing the criteria upon which to define what makes a person male or female, drawing from the same complement of available criteria deployed by medical professionals: chromosomal sex, gonadal sex, internal morphologic sex, external morphologic sex, hormonal sex, phenotypic sex, assigned sex, and sexual identity.¹⁴ The legal contexts in which a person's unambiguous sexual identity matters should be of interest to medical professionals working in this area, as most courts look to medical experts first in

¹³ My discussion of intersexuality or intersex conditions does not aspire to be comprehensive in nature, but rather seeks to contribute insights that build on the excellent work of others such as Julie Greenberg, supra note 3, and Beh & Diamond, supra note 8.

¹⁴ MONEY, SEX ERRORS, supra note 9 at 4.

trying to resolve difficult problems of categorization. Indeed, law and science operate hand in glove in these sorts of cases, in a way that belies a kind of epistemological interdependence of interest to both legal and scientific actors in this area.

There is a wide variety of contexts in which a stable sexual identity, dimorphically defined, is legally relevant. These contexts include:

- ▶ birth certificates - in US change of mistakes is easier to do than change of sex. Sweden, Netherlands, Czech Republic, Greece, Italy, Switzerland and Finland allow change of official documents after sex-change.
- ▶ marriage
- ▶ military service and pension rights
- ▶ liability under sex crime statutes
- ▶ parenthood/adoption
- ▶ eligibility for sex-based discrimination claims
- ▶ passports
- ▶ driver's licenses
- ▶ single sex school assignment
- ▶ insurance actuarial tables
- ▶ prison assignment
- ▶ athletics

Others have spent considerable time inventoring the significance of sexual classifications in these and other contexts,¹⁵ thus for present purposes I will provide an analysis of the implications of genital surgeries for a fundamental aspect of human life: marriage. Marriage is

¹⁵ See e.g. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 Ariz.L.Rev. 265 (1999).

treated in most cultures and legal systems as a fundamental right of personhood,¹⁶ and thus were there implications for marriageability that flowed from the medical treatment of infants born with ambiguous genitalia, surely they should play a role in parental decision-making in this area.

Only one case has dealt with the marital status of an intersex person. In the 1979 Australian case, *In Marriage of C. and D. (falsely called C.)*,¹⁷ the husband, a true hermaphrodite had XX chromosomes and a combination of male and female genitalia, and had undergone various surgeries to “masculinize” his body during the course of the marriage. After 12 years of marriage, his wife prevailed in her action to have the marriage annulled on the ground that the marriage was never valid. The court found, in the end, that the husband was neither male nor female, thereby invalidating the marriage, but implicitly holding that he could not marry anyone.

Marriage is generally understood as a legal institution created to recognize the sexual and domestic union of a man and a woman. While a bundle of non-U.S. jurisdictions permit same-sex marriage,¹⁸ all U.S. states allow only different sex couples to marry. That restriction notwithstanding, no jurisdiction, to my knowledge, tests applicants for marriage licenses to be sure that they are of different sexes.

Curiously, most states that limit marriage to different sex couples do not define male or female. This has been left to the courts, largely in cases in which one or both spouse is transgendered. In these cases, the courts have struggled with choosing among the various scientific definitions of sexual identity listed above. No clear consensus has evolved as to which

¹⁶ See e.g. *Boddie v. Connecticut*, 401 U.S. 371, 376 (1971); *Loving v. Virginia*, 388 U.S. 1, 12 (1967).

¹⁷ (1979) 35 F.L.R. 340, 28 A.L.R. 524, 526 (Austl.).

¹⁸ Denmark (including Greenland), Norway, Sweden, The Netherlands, Hungary, Germany and Iceland are among the nations that have permitted same sex marriage.

criterion meets the legal standard of maleness or femaleness for the purposes of marriage.¹⁹

Yet, in all of the transgendered marriage cases, the sex of the transgendered party was not ambiguous at birth, rather the person chose to undergo a range of surgical and hormonal interventions to change from one stable sexual identity to another. The issue of sexual identity, for the purpose of marriage, for intersexed people presents a set of challenges that do not arise for transgendered spouses. Indeed, a recent Texas court of appeals opinion that addressed the right of a post-operative male to female transsexual person to marry a man, acknowledged the fact that the legal resolution of this issue depended upon the congruence of biological sex criteria at birth, and that the court's conclusion would not extend to "those individuals whose sex may be ambiguous."²⁰

Most states have justified a requirement that valid marriages be between a man and a woman on the ground that the marital relationship exists for the purpose of heterosexual relations with the goal of producing offspring.²¹ This justification persists, notwithstanding the fact that many couples cannot or choose not to have their own biological children, and typically infertility

¹⁹ Surely one of most interesting cases in which a court was forced to "choose" a legal criterion to determine a person's sex for the purpose of marriage, and did so with great dis-ease, is *Corbett v. Corbett*, 1971 P. 83, 105 (1970). I discuss this case at some length in Katherine M. Franke, *The Central Mistake of Sex Discrimination Law: The Disaggregation of Sex from Gender*, 144 U.Penn.L.Rev. 1, 41-51 (1995). Texas courts have recently been faced with resolving the rights of transgendered people to marry. In *Littleton v. Prange*, 9 S.W. 2d 223 (Tex.Ct.App. 1999), a Texas appellate court held that a post operative male-to-female transsexual person could not enter into a valid marriage with a man since a person's legal sex is fixed at birth. See also cases discussed in Greenberg, *Defining Male and Female*, *supra* note 3 at 296-308; and Katrina C. Rose, *The Transsexual and the Damage Done: The Fourth Court of Appeals Opens Pandora's Box by Closing the Door on Transsexuals' Right to Marry*, 9 Law and Sexuality: A Review of Lesbian, Gay, Bisexual, and Transgender Legal Issues 1 (1999-2000).

²⁰ *Littleton v. Prange*, 9 S.W. 2d 223, 232 (Tex.Ct.App. 1999).

²¹ See e.g. *B. v. B.*, 355 N.Y.S.2d 712, 717 (N.Y.Sup.Ct. 1974); *Melia v. Melia*, 226 A.2d 745, 747 (N.J.Super.Ch. 1967)("Conditions which, by modern understanding, abort the human and social objects of marriage are essentially incompatible with the public purposes of marriage. First among these purposes is procreation of the human race, as the fruit of a consensual, libidinal and instinctual relationship.")

is not a ground for divorce or annulment, unless the husband or wife had fraudulently misrepresented the interest in or capacity to bear children.²²

Apart from conceiving offspring, consummation remains an important aspect of a valid marriage, indeed in many jurisdictions an unconsummated marriage is more amenable to annulment than one in which consummation has taken place for, as a New Jersey court noted, “the community have [sic] not yet acquired the specially grave and weighty interest” in the non-consummated union.²³ Many jurisdictions will invalidate a marriage if a party is unable to consummate the marriage, although the majority rule is to recognize this impediment to marital formation only where the incapacity to consummate is not disclosed prior to the marriage.²⁴ Thus, a woman born with a foreshortened vagina due to Androgen Insensitivity Syndrome, or a man with a micropenis may, in some jurisdictions be structurally incapable of consummating a marriage, and were this condition not disclosed prior to the marriage, the marriage may be found invalid.

The legal significance of impotence may be of particular concern to persons with ambiguous genitalia as well. By and large, a marriage may be annulled where one or both parties

²² See e.g. *Handley v. Handley*, 3 Cal. Rptr. 910 (Cal. Ct. App. 1960). As a New York court wrote, “[w]here nothing is said prior to the marriage by a spouse on the subject of children, it is presumed that he or she intends to enter the marriage contract with all the implications, including a willingness to have children.” *Gerwitz v. Gerwitz*, 66 N.Y.S.2d 327, 329 (1945).

²³ See *Houlahan v. Horzepa*, 46 N.J. Super. 583, 588 (1957), cited approvingly, *Lopez v. Lopez*, 245 A.2d 771,773 (N.J.Super.Ch. 1968); see also Baldwin’s Ohio Revised Code Title 31 § 3105.31 (2001) Grounds for Annulment (Marriage may be annulled by reason of nonconsummation).

²⁴ See e.g. Colorado Revised Statutes § 14-10-111(1)(b) (“The district court shall enter its decree declaring the invalidity of a marriage entered into under the following circumstances ... A party lacked the physical capacity to consummate the marriage by sexual intercourse, and the other party did not at the time the marriage was solemnized know of the incapacity.”); Uniform Marriage and Divorce Act §§ 208(a)(2)(“The court shall enter its decree declaring the invalidity of a marriage entered into under the following circumstances ... a party lacks the physical capacity to consummate the marriage by sexual intercourse, and at the time the marriage was solemnized the other party did not know of the incapacity.”)

are found to be impotent.²⁵ Impotency is typically defined as the permanent incapacity for sexual intercourse.²⁶ Male impotence is most frequently understood as an incapacity to gain an erection, penetrate the female's vagina and achieve ejaculation. A male with a small penis, who can, most assuredly, both give and receive genital pleasure,²⁷ may very well be found to be permanently and legally impotent in jurisdictions that narrowly define copulation as a certain normative form of intercourse.

So too, will intersexed females likely face legal impediments to marriage based on a construction of female impotence. Interestingly enough, the majority of annulment and/or divorce petitions involving claims of spousal impotence are based upon the wife's, not the husband's, impotence. Of these cases, many involve women whose vaginas are too short to accommodate full penile penetration.²⁸ No doubt, many of these cases involve women with AIS, indeed the court in *Singer v. Singer* all but said so when it described the wife as having an "infantile vulva and uterus, and that the organs of the [wife] were of insufficient size to permit penetration ... the [wife's] trouble is, in all probability, congenital in nature."²⁹

Another significant number of cases involving female impotence relate to women for whom intercourse is too painful.³⁰ Some clinicians who favor infant surgeries to normalize

²⁵ See e.g. *Manbeck v. Manbeck*, 489 A.2d 748, 751 (Super.Ct.Pa. 1985).

²⁶ See Black's Law Dictionary 756 (6th ed. 1990). The term should not be confused with "sterility," which does not imply sexual dysfunction, but rather the inability to reproduce. *Id.* at 1414. See also Homer H. Clark, Jr. *The Law of Domestic Relations in the United States* 2d ed. § 2.13 (1987).

²⁷ Not surprisingly, there are many on-line sources to assist small-penised men in getting and giving pleasure. See e.g. Dr. Josie's Advice Column at: <http://www.tantra.com/qa/q74.html>.

²⁸ See e.g. *Singer v. Singer*, 74 A.2d 622 (N.J. Super.Ch. 1950).

²⁹ *Id.* at 624.

³⁰ See Clark, *The Law of Domestic Relations in the United States*, supra note 26 at § 2.13 n. 14; 52 Am.Jur. 2d *Marriage* § 25 (20002)("the inability need be only for normal copulation; an ability to have partial, imperfect, unnatural, or painful copulation will not render a person

ambiguous or abnormal genitalia, recommend vaginoplasty, or surgery to lengthen an intersexed infants vagina, so as to permit “normal coital functions” in adulthood. Yet a recent study has shown that most girls who had undergone vaginoplasty surgery in their first 12 months of life, still needed additional surgeries well into adolescence in order to have their vaginas sufficiently functional for the purposes of intercourse.³¹ The researchers, noting that there appears to be little benefit to vaginoplasty so early in life, wondered out loud: “why don’t we leave that until they are old enough to be involved in the decision?”³²

Another aspect of marriage is relevant in considering whether to order genital surgery for intersexed infants. Very often surgery designed to “normalize” or “femininize” an infant’s abnormally large clitoris or abnormally small penis, results in scarring that diminishes, if not entirely eliminates, genital sensation and the capacity for arousal and orgasm. A recent study revealed that one in four women born with ambiguous genitalia and whose clitoris was operated on, were unable to achieve an orgasm. Furthermore, vaginas surgically created from colon tissue do not have the sensitivity, elasticity and lubricating qualities of a typical vagina.³³ If a man with a “normal” penis were not able to achieve arousal, erection and ejaculation, that man would be considered legally impotent, but how is the law to measure female impotence when it presents in

potent and the marriage valid, as this term is used in law.”). An interesting set of cases test the boundary between women who find sex painful and those who find it “unpleasant.” Coital disappointment is not regarded as a ground upon which a marriage can be annulled. See e.g. *Phillpott v. Phillpott*, 285 So.2d 570, 571 (La.App. 4th Cir. 1970) ('disappointment in sex isn't cause for a divorce').

³¹ Lisa Melton, *New Perspectives on the Management of Intersex*, *The Lancet*, June 30, 2001 at 2110. This article reports on one of the first follow-up studies of children on whom genital surgeries were performed in infancy. Hazel Glenn Beh and Milton Diamond have noted that early surgical intervention in cases of genital ambiguity became standard medical practice prior to the rigorous, or for that matter, any studies of treatment outcomes. Beh and Diamond, *supra* note 8 at 16.

³² Lisa Melton, *New Perspectives on the Management of Intersex*, *supra* note 31.

³³ See Dreger, *supra* note 6 at 29.

manners other than an inability to be penetrated successfully by a penis? Is female pleasure a requirement for a successful marriage? Should it be?

While these questions, surely, inaugurate a new and quite complicated conversation about the significance of women's sexual pleasure in marriage,³⁴ a more narrow technical question presents itself for present purposes: is the post-surgical intersex female adult who has no genital or clitoral sensation impotent as that concept is used in domestic relations law? That is to say, when surgeons and parents consider whether to perform such surgeries on intersexed infants, should they consider the fact that they may be rendering their daughters permanently impotent, and thereby rendering their marriages voidable and/or subject to annulment?³⁵

This issue, albeit not in the intersex context, was faced by the Supreme Court of Georgia in *S. v. S.*³⁶ Here the husband brought suit to annul the marriage due to his wife's impotence. Since the age of 14, the wife had been completely paralyzed from her navel area down. The husband knew of this condition when he married her, but claimed in his action to annul the marriage that due to her paralysis, "she experienced no feeling when the act [intercourse] was being performed ...[and] that she was incapable during the act of intercourse of having an orgasm

³⁴ An issue I began to take up in Katherine M. Franke, *Theorizing Yes: An Essay on Feminism, Law & Desire*, 101 Columbia L.Rev. 181 (2001).

³⁵ See 4 Am.Jur.2d *Annulment of Marriage, Generally* §27 (1995):

Impotency, that is, the inability to have sexual intercourse, is frequently held to render the marriage voidable, and, consequently, provides grounds for annulment, if the impotency existed at the time of the marriage and the condition is incurable. Impotency occurring after marriage is not in itself ground for annulment.

Misrepresentation or concealment as to physical impotency to consummate the marriage may constitute ground for exercise of jurisdiction to annul the marriage. That is, in order for incapacity for sexual intercourse to be a ground for annulment, the condition must have been unknown at the time of the marriage to the party seeking the annulment. (citations omitted).

³⁶ 211 Ga. 365 (1955).

or crisis of sexual excitement.”³⁷ This set of facts did not raise, the court acknowledged, the more typical scenario whereby the wife’s impotence was alleged to amount to genital deformity, or a condition that rendered intercourse impossible or unpleasant.³⁸ Rather, the facts presented the court with a question that made it quite uncomfortable: was “an orgasm by the female [] necessary to the complete act of sexual intercourse.”³⁹

Having found the medical literature wanting in providing a definition of female impotence, the court explicitly refused to decide the question of “what constitutes impotency in a female capable of having sexual relations but incapable of experiencing orgasm.”⁴⁰ The court’s desire to duck the issue was far from subtle:

The medical authorities being in disagreement as to this matter, we, as non-experts, should not rush in where those competent to judge fear to tread ... ‘Upon a question of sexual intercourse the experience and sagacity of the jurors might very well be trusted to run the general logic of the case.’⁴¹

Thus the Georgia Supreme Court deferred to the trial court’s decision to refuse to annul the marriage on the ground of the wife’s impotence. As such, the wife won a claim to alimony, but in order to do so, the Georgia courts, albeit passively, had to find that the wife’s sexual pleasure was not “necessary to the complete act of sexual intercourse.”

So too, the law’s construction of coital and reproductive capacity echoes the view of the medical community. In providing policy guidance to medical professionals who are faced with

³⁷ *Id.* at 366.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.* at 368.

⁴¹ *Id.* (citations omitted).

“managing” the infant with ambiguous genitalia, the American Pediatric Association instructs that the decision as to the appropriate sex of rearing of a baby born should be resolved i) in favor of raising the baby as a girl if she is most likely fertile,⁴² yet ii) “the size of the phallus and its potential to develop into a sexually functional penis are of *paramount importance* when one is considering male sex of rearing.”⁴³ As other commentators have noted,⁴⁴ the privileging of reproductive capacity for females and coital capacity for males reproduces larger, questionable, gender norms of femininity and masculinity. They appear here passing as science, or as legal conclusions driven by scientific facts. I will return to them in the next part of this chapter.

III. The Legal Significance of the Legal Significance of Dimorphic Sex

Notwithstanding the U.S. culture of rights,⁴⁵ and the degree to which a jurisprudence has developed around the claims of virtually every group that could call itself an oppressed minority, the law has almost entirely ignored the rights of individuals who have undergone genital and other intersex-related surgeries and medical treatments in order to disambiguate their sexual identity. While biological sex seems to matter so much to the law, the law fails to recognize a right to autonomy and physical integrity that would allow persons with a range of intersex conditions, including those that manifest themselves in anomalous or ambiguous genitalia, to decide this fundamental aspect of personhood and human flourishing for themselves. In what follows, I will consider two ways to approach the claims of intersex persons who seek redress for

⁴² This is the case most often in female infants with CAH, congenital adrenal hyperplasia, which can cause an enlarged or “virilized” clitoris.

⁴³ American Academy of Pediatrics Policy Statement, *Evaluation of the Newborn With Developmental Anomalies of the External Genitalia*, supra note 2 at 4 (emphasis supplied).

⁴⁴ See e.g. Dreger, supra note 6 at 28-29.

⁴⁵ See e.g. MARY ANN GLENDON, *RIGHTS TALK* (1991); A CULTURE OF RIGHTS (Michael J. Lacey & Knud Haakonssen eds., 1991).

surgeries and other medical interventions that they would not have chosen for themselves.

a. The Deafness Analogy

Deafness presents itself as a useful analogy in thinking through a protocol that views the “problem” of infants born with ambiguous genitalia as one that demands a medicalized response. Children born with ambiguous genitalia and children born deaf present enormous challenges to parents to cope with this unexpected anomaly. Both deafness and ambiguous gender stand to bear heavily upon the child’s fundamental identity, and both conditions are ones which, all other things being equal, parents would prefer to “fix” if given the opportunity. Indeed, we see with both conditions, strong parental preferences to normalize the infant, even if doing so is likely to produce known negative consequences.⁴⁶

For most hearing parents, the birth of a deaf child is a moment of enormous loss and sadness that provokes a strong desire to undertake a range of ameliorative interventions to minimize the child’s hearing impairment, so as to make a “normal” life possible. Hearing parents of deaf children often speak of an enormous sense of grief upon learning of their child’s deafness, almost as if they have lost a part of the healthy child they thought they’d had. Years of training in lip-reading and speech therapy classes so as to assist the child in communicating “normally” are undertaken by the overwhelming majority of deaf children with hearing parents. These parents, without the aid of counseling, regard their child as having been born with a tragic

⁴⁶ The calculus clinicians and parents use in making this difficult decision, even where they have been fully informed of the potential, if not likely, physical and psychic consequences, bears a similarity to what George Annas labeled “monster ethics.” Annas suggested that one way to approach the difficult ethical problem of killing one conjoined twin in order to save the other, is resort to a kind of reasoning premised on the notion that conjoined twins are so grotesque that any procedures to normalize them, even if they risk killing one of the twins, is morally justified by the monstrosity of the underlying condition. See George J. Annas, *Siamese Twins: Killing One to Save the Other*, 1 Hastings Center Report 27 (1987). Annas did not endorse this form of moral reasoning about the problem, but merely suggested it as a way to reason about such a difficult ethical problem. Alice Dreger suggests an analogy between the conjoined twins case and the intersex case in Dreger, supra note 6 at 33.

infirmity, and they regard themselves facing a terrible “social and medical emergency.” Hearing parents “frequently beset by guilt, grief, and anxiety, are largely ignorant of the deaf community, commonly accept the infirmity model uncritically, and consequently turn for help to the related social institutions, such as medicine, audiology, and special education.”⁴⁷

Deaf children of deaf parents, on the other hand, are unlikely to regard their child’s deafness as neither a tragedy nor an emergency. These children are more often taught sign language as their first language and educated in deaf classes where signing is the norm and reading comprehension is stressed over the extremely difficult task of learning to lip read and acquiring fluency in spoken language.⁴⁸

Mainstreaming, or normalizing, deaf children is a very controversial concept, and one about which virtually every hearing impaired person has strong feelings. Deaf people frequently speak of two types of deaf identity: deaf and Deaf. The lowercase *deaf* referring to the audiological condition of not hearing, and the uppercase *Deaf* referring to an identity, a community, a discrete and insular minority comprised of members who share not a disability, but a language and a culture.⁴⁹ Many hearing parents resist “giving over” their hearing impaired child to Deaf schools and educators that stress signing over English as the primary language of communication, as they fear that they will lose their ability to communicate with their own child, and, what is more, fear losing their child to another community.

Some members of the Deaf community analogize deafness to an identity characteristic

⁴⁷ HARLAN LANE, *THE MASK OF BENEVOLENCE* 207 (1992).

⁴⁸ My sign language teacher once said to me: “You want to know how hard it is to learn how to lip read? Imagine an English speaking person learning to speak Chinese by watching someone speak Chinese through a glass wall.” Even the best lip readers get about a half of what the speaker is saying.

⁴⁹ See CAROL PADDEN AND TOM HUMPHRIES, *DEAF IN AMERICA: VOICES FROM A CULTURE* 2 (1988).

such as ethnicity or race. “ Whenever people with disabilities are surveyed by the Louis Harris organization, as they have been frequently since 1986, it turns out that pluralities, sometimes majorities, of respondents perceive disability status as akin to minority status and feel some commonality with people who have the same, or different impairments.”⁵⁰ Indeed, the Americans with Disabilities Act defines disabled people, including those who are deaf, as “a discrete and insular minority” borrowing this language from the U.S. Supreme Court’s treatment of racial identity.⁵¹ To think this way about the relationship between identity and impairment is to frame the identity question in a form such as: “would I still be me, if I had been hearing?”⁵² The ADA and modern Deaf cultural and political movements have transformed our thinking about deafness from an impairment that diminishes or spoils a person’s identity in such a way that renders their humanity partial, at best, to a characteristic of human identity similar to ethnicity or race that one should celebrate.⁵³ Like movements for racial equality, the Deaf rights

⁵⁰ Adrienne Asch, *Critical Race Theory, Feminism, and Disability: Reflections on Social Justice and Personal Identity*, 62 Ohio St. L.J. 391, 415 (2001), *citing*, Stuart Leichenko et al., Louis Harris and Associates, *The ICD Survey of Disabled Americans: Bringing Disabled Americans into the Mainstream* 9-10 (1986).

⁵¹ [I]ndividuals with disabilities are a discrete and insular minority who have been . . . subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society . . . resulting from . . . assumptions not truly indicative of the . . . ability of such individuals to participate in, and contribute to, society.” Americans with Disabilities Act, 42 U.S.C. §§ 12111(a)(7) (1994).

⁵² Kwame Anthony Appiah has asked this question as a way to distinguish sexual from racial identity. See, Anthony Appiah, “*But Would That Still Be Me?*” *Notes on Gender, “Race,” Ethnicity, as Sources of “Identity,”* 87 J. Phil. 493, 497 (1990).

⁵³ For further reading on the relationship between disability and identity, see PAUL C. HIGGINS, *MAKING DISABILITY : EXPLORING THE SOCIAL TRANSFORMATION OF HUMAN VARIATION* (1992); SIMI LINTON, *CLAIMING DISABILITY: KNOWLEDGE AND IDENTITY* 12 (1998) (“While retaining the term disability, despite its medical origins, a premise of most of the literature in disability studies is that disability is best understood as a marker of identity. As such, it has been used to build a coalition of people with significant impairments, people with behavioral or anatomical characteristics marked as deviant, and people who have or are suspected of having conditions, such as AIDS or emotional illness, that make them targets of discrimination.”).

movement has sought a change in the significance of deafness from pity to pride.

Of course, not all people who are deaf consider themselves part of a Deaf community.⁵⁴ They regard deafness not as “who I am” but as “a condition I have.” Surely there is no right answer to these sorts of questions, however the relationship between deafness, culture, identity, infirmity and “normal” are instructive in thinking about how to approach the set of decisions that are triggered when an infant is born with ambiguous genitalia. So too, they are helpful in thinking through the ways in which we construct human happiness as falling within a particularly narrowly prescribed standard deviation away from a conception of “normal” human ability and identity. Finally, analogizing ambiguous gender to deafness is instructive in considering the ways in which these deviations from “normal” are regarded as *nature gone awry*. Under such an account, human anomaly, produced by a nature “screwing up,” is to be solved or at least ameliorated by natural scientific means so as to restore a “normal” natural order. Yet that natural norm is, of course, the product of cultural construction.

The cultural struggle over how to understand deafness, as people with an infirmity or as a cultural and linguistic minority, has been made more intense by the availability of a device called a cochlear implant. These devices, implanted surgically into the skull of a hearing impaired person, carry an auditory signal that does not reproduce actual hearing, but rather vibrates in the inner ear and assists in lip reading. The protocol for eligibility for a cochlear implant directs that the younger the child who receives the implant, the better the results are likely to be. The cochlear implant has the effect, however, of destroying whatever residual hearing the person had.

Deaf (with a capital D) activists are vehemently opposed to the use of cochlear implants.⁵⁵

⁵⁴ See e.g. Bonnie P. Tucker, *Deafness—Disability or Subculture: The Emerging Conflict*, 3 Cornell J.L. & Pub. Pol'y 265 (1994).

⁵⁵ The National Association of the Deaf has taken a position opposing the use of cochlear implants in children. See

They believe that it amounts to a form of child abuse, forcing young children to undergo a serious and risky surgical procedure borne of the parents' discomfort with their child's difference and their desire to "normalize" them to the greatest extent possible. They analogize the cochlear implant to surgeries to lighten a child's skin, and go so far as to call it a device to accomplish cultural genocide.⁵⁶

Without weighing in on one side or the other of this debate for the moment, it is interesting to contrast the advice that the American Society of Pediatrics gives to parents of hearing impaired children with respect to the cochlear implant with the way the American Academy of Pediatrics frames the "social emergency" presented by a child with ambiguous genitalia.

In the *Guide to Your Child's Symptoms: Hearing Loss* the American Society of Pediatrics advises that "[w]herever possible, hearing-impaired children should be educated with those who hear and speak normally ... The cochlear implant, an electronic replacement for the inner ear, is a new treatment for severe hearing loss. This treatment remains controversial."⁵⁷ They say nothing about the wisdom of pursuing a cochlear implant for hearing impaired children, they merely mention it and note its controversial nature. This is to be contrasted with the strongly normative language accompanying the ASP's discussion of children born with ambiguous genitalia - a condition which is less public but, to them, presumptively more traumatic than profound hearing loss. Perhaps of greatest interest is the degree to which the ASP is hesitant to recommend the cochlear implant due to its experimental nature, while the AAP is

<http://www.nad.org/infocenter/newsroom/positions/CochlearImplants.html>. A number of on-line sources provide a forum for deaf people to discuss the ethics and practicality of cochlear implants. See e.g. <http://www.awesome-ears.com/contro.html>.

⁵⁶ See e.g. HARLAN LANE, *THE MASK OF BENEVOLENCE* 216-238.

⁵⁷ American Society of Pediatrics, *Guide to Your Child's Symptoms: Hearing Loss* (2001).

much more willing to suggest genital surgeries despite the fact there have been virtually no follow up studies to determine long term effects of these procedures.⁵⁸ What justifies the differential treatment of these two experimental treatments? Why are these two professional organizations voicing more hesitancy with respect to surgical interventions to ameliorate hearing loss than with interventions to disambiguate genital anomalies, when both procedures lack adequate follow-up study, promise far less than a “cure” for the impairment, and hold out the prospect of additional surgical procedures during the course of the child’s life to address complications or other foreseeable medical needs?

The differences in tone, and willingness to recommend clearly experimental treatments in these two cases suggests some interesting and difficult questions for the clinician who recommends genital surgeries: Is a person with ambiguous genitalia disabled under the Americans with Disabilities Act? Or even more controversially: could surgical procedures to disambiguate genitalia that have the effect of eliminating genital sensation render an intersexed person disabled under the ADA? If the ability to achieve orgasm is a major life activity under the ADA, surely this might be the case. Is surgery to “normalize” these infants a form of discrimination, or reasonable amelioration, if not accommodation?

The deafness analogy suggests some difficult questions for law to grapple with when it comes to the claims of intersex people: should intersex people be considered a minority group like deaf people, gay people, transgendered people, racial minorities, or women? If so, the medical “management” of ambiguous genitalia could be subject to the scrutiny of civil rights laws that prohibit certain forms of discrimination. The pull to identity politics as a means by which to address class-based mistreatment brings me to the next issue of relevance to the treatment of infants with ambiguous genitalia: whether there are any issues of sex discrimination

⁵⁸ See Beh and Diamond, supra note 8 at 20.

at stake in current medical practice.

b. Are the Dominant Treatments Recommended for Intersex Infants a Form of Sex Discrimination?

The most obvious way in which issue of sex based discrimination present itself in connection with disambiguating infant genital surgeries is analogizing it to female genital mutilation. This argument has been made elsewhere,⁵⁹ and I need not rehearse it here in its full form. But in both cases, the justification for these surgeries is cultural - when we don't endorse the cultural justifications of these treatments we call it FGM, when we feel the child would be better adjusted as an adult with unambiguous genitals, we call it appropriate genital surgery. Most professional discussions of the need for disambiguating genital surgeries focus on three primary concerns that would militate in favor of thereof: i) psychosocial sexual development of the child, ii) capacity for normal sexual function , and iii) dis-ease experienced by the parents and childcare provider of a child with ambiguous genitalia.⁶⁰ Yet, in expressing it's strong condemnation of FGM, the American Academy of Pediatrics sought to explain why the practice is valued in the communities in which it is prevalent:

they believe that [the surgery] will promote their daughter's integration into their culture ... and thereby guarantee her desirability as a marriage partner.⁶¹

How can one differentiate the cultural/social preferences articulated in the one case from the

⁵⁹ See Greenberg, supra note 3 at ; Beh and Diamond, supra note 8 at ; Dreger, supra note 6 at 33-34.

⁶⁰ See American Academy of Pediatrics Policy Statement, *Evaluation of the Newborn With Developmental Anomalies of the External Genitalia*, supra note 2. Of course, the potential for malignant degeneration in a retained gonad or other potentially serious health consequences that might flow from the intersex condition impose normatively different concerns for the parent and clinician.

⁶¹ American Academy of Pediatrics, *Female Genital Mutilation*, 102 Pediatrics 153 (1998).

other? Despite parents' requests to perform the prohibited genital surgeries, the AAP strongly recommends against doing it as it "violates the rights of infants and children to good health and well-being, part of the universal standard of basic human rights."⁶² Surely the "alteration of the genitalia of female infants"⁶³ strongly condemned by the AAP in one context is very difficult to square with their endorsement of the practice in another.

Consider the following case, which forces us to take this critique even more seriously than we might have *ab initio*: an Afghanistani boy was brought to the U.S. last year when he began menstruating as an adolescent. His parents came from a country in which boy children are highly prized, and girl children are highly undesirable. They brought him here, without telling him why, so that they could surgically remove his ovaries and breasts. Indeed, he was never told about why he had this surgery done. This boy, possibly a person with XX chromosomes and a "virilized" clitoris due to CAH or progestin-induced virilization,⁶⁴ returned to Afghanistan (prior to the recent events that give this story additional meaning) having undergone radical surgery, without his consent, so as to satisfy his parents' cultural preferences for a male heir. Surely we would condemn such a surgery as a manifestation of the worst kind of sex-biased cultural norms. Just as we have a norm against sex selection in accessing abortion-related services, so too we would condemn sex selection so late in life.

The surgeries that are undertaken on behalf of and in the interests of infants born with ambiguous genitalia, raise related, but not precisely the same, issues regarding how sex differences are asymmetrically valued in U.S. culture. The protocols ask two fundamental questions in determining how to assign sex to infants with ambiguous genitalia: First, is the XX

⁶² *Id.*

⁶³ *Id.*

⁶⁴ See Greenberg, supra note 3 at 288-89.

child with a phallus greater than 2 centimeters potentially fertile? If so, make her a girl. Second, how large is the phallus of all other children with ambiguous genitalia (too large or too small phallus, ambiguous scrotum/labia, etc)? The determining factor for many is the “adequacy” of the penis - if it appears that it will be insufficient for urinating while standing, and adequate vaginal penetration during heterosexual intercourse, then the child should be raised as a girl. That is to say, being raised as a female is where failed males end up.

In this sense, maleness is the privileged category, femaleness is the residual category. This, of course, is due to the fact that we ask quite a great deal of the penis, yet have minimal expectations of female genitalia - mere receptiveness to penile penetration. As Alice Dreger writes so elegantly, “it is relatively easy to construct an insensitive hole.”⁶⁵

Beyond a concern about how male and female bodies are valued, many of the underlying justifications for disambiguating genitalia, and for medically managing a congruence of sexual bodies and gendered identities, raise issues of concern to modern sex discrimination jurisprudence.

A short summary of the Supreme Court’s sex equality jurisprudence is necessary to appreciate the legal attention that genital surgeries may garner. Time and again, the Supreme Court has interpreted sex discrimination prohibitions to apply to men and women who do not conform to traditional norms with respect to how the different sexes are “supposed to” look or behave. In case after case the Court has held that federal law prohibits disparate treatment of men or women on the basis of stereotypic assumptions about who is or should be the breadwinner in the family, who is or should be the primary caretaker for children, and how a person should dress in conformance with gender norms that dictate feminine dress for women and masculine dress for men.

⁶⁵ Dreger, supra note 6 at 29.

Starting in 1973, the Court began to question the legitimacy of policies grounded in sexual stereotypes regarding the proper roles, abilities and positions of women and men in the home and in public. Numerous cases established the Court’s view that the legal wrong of sex discrimination lay in the problem of the illegitimacy of decisions based upon gender stereotypes.⁶⁶ In these cases, the Court established a rule that it was unfair to judge the qualifications, merits or traits of an individual based upon gross generalizations or stereotypes about the class—male or female—to which that person belonged. This was the case even if the application of those generalizations might hold true for some or many members of the class, and the use of the generalization was, therefore, a relatively efficient or administratively convenient way of allocating resources, or resolving disputes.⁶⁷ According to the Court, the abilities and

⁶⁶ See, e.g., Caban v. Mohammed, 441 U.S. 380, 394 (1979) (reasoning that maternal and paternal roles are not invariably different in importance and holding that the Equal Protection Clause was violated by the sex-based distinction between unmarried mothers and unmarried fathers in New York domestic relations law); Orr v. Orr, 440 U.S. 268, 279 (1979) (holding that gender-based alimony statute violated equal protection and could not be validated on basis of state’s preference for allocation of family responsibilities in which wife plays a dependent role); Califano v. Goldfarb, 430 U.S. 199, 217 (1977) (holding that Social Security Act’s gender-based distinction between widows and widowers violated due process and equal protection and discriminated against covered female wage earners); Schlesinger v. Ballard, 419 U.S. 498, 507 (1975) (disparate treatment of men and women in Naval promotion schedules does not reflect “archaic and overbroad generalizations” about the relative abilities of men and women); Stanton v. Stanton, 421 U.S. 7, 17 (1975) (statutory distinction between males and females, which resulted in appellee’s liability for child support for a daughter only to age 18 but for a son to age 21, found unconstitutional); Weinberger, 420 U.S. at 645 (Social Security Act provision that granted survivors’ benefits to widows, but not widowers, was grounded in the impermissible gender-based generalization that men are more likely than women to be the primary supporters of their spouses and children); Kahn v. Shevin, 416 U.S. 351, 352 (1974) (challenge to Florida statute giving widows but not widowers a \$500 exemption from property taxation); Frontiero v. Richardson, 411 U.S. 677, 690–91 (1973) (striking down statutes that granted automatic presumption that wives of male uniformed service members were economically dependent upon their husbands for purposes of obtaining increased quarters allowances and medical, and dental benefits, but that spouses of female members were not so dependent); Reed v. Reed, 404 U.S. 71, 77 (1971) (invalidating Idaho probate statute which granted preference to males over equally qualified females in the administration of estates).

⁶⁷ See City of Los Angeles, Dep’t of Water & Power v. Manhart, 435 U.S. 702, 708 (1978) (“Even a true generalization about the class is an insufficient reason for disqualifying an individual to whom the generalization does not apply.”); Reed, 404 U.S. at 76 (“To give a

needs of each person must be assessed on an individualized basis, not by resort to group-based generalizations or stereotypes.

For instance, the Court relied on a critique of stereotyping in Califano,⁶⁸ when a widower challenged a Social Security rule that extended survivors' benefits to widows but not widowers on the assumption that widowers, as a rule, were not likely to have been dependent upon their wives, whereas it was fair to assume that widows have been so dependent upon their former husbands. The statute was held unconstitutional because it was "supported by no more substantial justification than 'archaic and overbroad' generalizations . . . or 'old notions,' . . . such as 'assumptions as to dependency,' . . . that are more consistent with 'the role-typing society has long imposed. . . .'"⁶⁹

Similarly, in Mississippi University for Women v. Hogan⁷⁰ the Court struck down the admissions policies of a state-run nursing school that refused to admit men on the ground that such a policy perpetuates "the stereotyped view of nursing as an exclusively woman's job."⁷¹

The Supreme Court's modern sex discrimination jurisprudence has primarily taken aim at two forms of sex stereotyping: policies and practices that reward conformance to certain overbroad and unfounded class-based assumptions about the relative strengths and weaknesses of men and women, and policies and practices that punish men and women for their failure to conform to stereotypic expectations about who men and women are or should be. Thus, by 1978

mandatory preference to members of either sex over members of the other, merely [on the grounds of administrative convenience] is to make the very kind of arbitrary legislative choice forbidden by the Equal Protection Clause. . . .").

⁶⁸ Califano, 430 U.S. at 199–206.

⁶⁹ Id. at 207 (citations omitted).

⁷⁰ Mississippi Univ. for Women v. Hogan, 458 U.S. 718 (1982).

⁷¹ Hogan, 458 U.S. at 729.

the Court was comfortable concluding that “[i]t is now well recognized that employment decisions cannot be predicated on mere ‘stereotyped’ impressions about the characteristics of males or females.”⁷²

The Court’s stereotyping jurisprudence reached its most mature stage in Price Waterhouse v. Hopkins,⁷³ in which Ann Hopkins was denied partnership at a prominent accounting firm because the firm’s male partners considered her to be too masculine. She was told she should “walk more femininely, talk more femininely, dress more femininely, wear make-up, have her hair styled, and wear jewelry.”⁷⁴ In fact, Price Waterhouse’s partners placed Hopkins in an impossible double bind: “[a]n employer who objects to aggressiveness in women but whose positions require this trait places women in an intolerable and impermissible catch 22.”⁷⁵ Thus the Court held that “[i]n the specific context of sex stereotyping, an employer who acts on the basis of a belief that a woman cannot be aggressive, or that she must not be, has acted on the basis of gender.”⁷⁶ Here, as in the Court’s earlier sex discrimination cases, sex stereotyping lay at the core of the discriminatory wrong: “we are beyond the day when an employer could evaluate employees by assuming or insisting that they matched the stereotype associated with their group. . . .”⁷⁷

While U.S. courts have never addressed the issue of whether disambiguating genital surgeries constitute a form of gender-based discrimination, it is not terribly difficult to extrapolate from their current jurisprudence to this problem. Gender norms or stereotypes offend

⁷² City of Los Angeles Dep’t of Water & Power v. Manhart, 435 U.S. 702, 707 (1978).

⁷³ Price Waterhouse v. Hopkins, 490 U.S. 228 (1989).

⁷⁴ *Id.* at 235 (internal quotations omitted).

⁷⁵ *Id.* at 251.

⁷⁶ *Id.* at 250.

⁷⁷ *Id.* at 251.

rules against discrimination when they are used to enforce or reinforce social customs or rules about what types of people men should be and what types of people women should be. That is, they seek to dismantle social practices that punish men who aren't masculine and women who aren't feminine,⁷⁸ or extol social costs for people who fail to live up to gender role-based expectations.⁷⁹

The social emergency that is faced when an infant is born with ambiguous genitalia is predicated on the notion that nature intends the following human repertoire: people with XY chromosomes, penises and testes have a male sexual identity and have a masculine affect; whereas, people with XX chromosomes, vaginas and ovaries have a female sexual identity, and have a feminine affect. Disambiguating genital surgery seeks to surgically construct human bodies in such a way that they conform to this set of natural congruities. Yet the implicit causal relationship between chromosomes and affect that underwrites these social subjectivities collides with gender equality jurisprudence that seeks to dismantle the social mechanisms by which these expectations are enforced. Discrimination against gender-non-conforming people is merely a parallel manifestation of the socio-medical expectation that presupposes human happiness and successful identity formation on the alignment of these three aspects of our sexed lives: body, self knowledge and affect. Sex discrimination laws rest upon a notion that not all women are, nor should they be, feminine, and that not all men are, nor should they be, masculine. It is the coercion of congruence between bodies, identities and behavior that the law seeks to interrupt.

All of these notions of sexual coherence are present in Milton Diamond's work debunking the so-called successful gender reassignment of John/Joan. Virtually all of the

⁷⁸ For instance, women, not men, are nurturing and are best suited to careers in nursing, while men are best suited to physical labor such as construction work.

⁷⁹ Women should perform unpaid labor in the home, men paid labor in the market, for instance.

evidence that Diamond marshals to demonstrate how John/Joan's sex reassignment was a failure turns on sex-role stereotyping and gender-based orthodoxies about how boys "naturally" are, and how girls "naturally" are.

Girl's toys, clothes, and activities were repeatedly proffered to Joan and most often rejected. Throughout childhood Joan preferred boy's activities and games: she had little interest in dolls, sewing, or girl's activities. Ignoring the toys she was given, she would play with her brother's toys. She preferred to tinker with gadgets and tools, dress up in men's clothing, and take things apart to see what made them tick. She was regarded as a tomboy with an interest in playing soldier. Joan did not shun rough and tumble sports or avoid fights.⁸⁰

Diamond also recounts a story of how Joan was taken shopping with her mother in order to buy an umbrella, but Joan preferred to buy a gun instead. This story unwittingly mirrors a gendered rule of the military, an institution in which deep cultural needs for and investments in real differences between men and women animate military subjects as "real men". Curiously enough, umbrellas have played a role in gendered syntax: "Army and Marine Corps men are not allowed to use umbrellas while in uniform, although women in all the services are. Why the difference? ... [U]mbrella use by men was vetoed because senior officers thought the practice 'too wimpy.'"⁸¹ Thus, Joan's eschewal of umbrellas in favor of guns provided persuasive evidence of his true male identity - a natural identity that could not be altered with the intervention of surgery and hormones.

The anxiety that parents and clinicians experience when presented with the pressing

⁸⁰ Milton Diamond and Keith Sigmundson, *Sex Reassignment at Birth: Long-Term Review and Clinical Implications*, 151 *Archives of Pediatrics and Adolescent Medicine* 151, 299 (1997).

⁸¹ CHRISTINE L. WILLIAMS, *GENDER DIFFERENCES AT WORK: WOMEN AND MEN IN NONTRADITIONAL OCCUPATIONS* 47-48 (1989).

question whether the baby is a boy or a girl derives, in some significant part, from overwhelming cultural background norms that frame possible acceptable answers. These background norms include the following: i) sexual dimorphism; ii) strong preferences, enforced through complex and numerous social institutions, that insist that boys have certain body parts, possess certain self-identities, and perform in masculine ways, and that girls have certain body parts, possess certain self-identities, and perform in feminine ways; and iii) a notion that our organs announce their meaning: vagina announces “girl,” and penis announces “boy,” and that sexual difference is a natural, pre-cultural fact.

Yet we all know that human bodies are not sexually dimorphic, rather humans impose this cognitive order on the spectrum of human bodies as a part of making human identity coherent. Thus, we see the explicit rules set forth in the AAP Policy Statement on deciding the sex of children born with ambiguous genitalia.

What is more, gender is not something that nature came up with, and that manifests itself in clear, unambiguous signs that are read by the birth attendant and announced at the birth of the baby. Rather, “contrary to dominant beliefs, notions of gender are logically prior to, and necessary for, the existence of concepts of sexual difference.”⁸² Sex organs do not demand dimorphic categorization, rather we have certain demands of them - demands related to size, shape and capacity to perform that are grounded in social and cultural gender norms. These constitutive gender norms, at bottom, are part and parcel of the norms and stereotypes that sex discrimination laws are designed to undermine. The same social orthodoxies that punished Ann Hopkins for being too masculine are at work in the notion that a child cannot accomplish the successful transition into adulthood without dimorphically coherent genitalia that matches the child’s sexual identity and gendered behavior or affect. The day is quickly approaching when

⁸² Jane Flax, *Taking Multiplicity Seriously*, 32 *Contemp. Psychoanalysis* 577, 585 (1996).

these sorts of challenges to disambiguating genital surgeries will be brought by adults who underwent these procedures as infants.

Indeed, this day has already arrived in Columbia, where in May of 1999 the Columbian Constitutional Court severely limited the ability of parents to consent to disambiguating surgery for their children born with ambiguous genitalia. Relying on several grounds that echo the concerns discussed above, the court found that intersexed people constituted a minority entitled to protection against discrimination, that all children have a right to free development of their personality and autonomy, and that that right imposes certain constraints on their parents to substitute their own judgment about “normalizing” surgeries. Indeed, the Court was worried about the children being discriminated against by their own parents.⁸³-

IV. Conclusion

The decision to disambiguate the genitals of an intersexed infant is one which implicates a broad range of legal rights, responsibilities, and categorizations that surely should be considered when clinicians and parents consider such surgical and other interventions on behalf of a minor child. As yet, law has played a minor role in the treatment of infants born with ambiguous genitalia, but this legal disinterest will not be long-lasting as intersexed adults have begun to raise questions about the wisdom of these surgeries. This chapter is designed to flag several of the legal concerns that parents and clinicians in this area should begin to entertain as treatment options are considered.

⁸³ Sentencia SU-337/99 Principio De Publicidad Del Proceso-armonización Con La Intimidación Del Menor Y Su Familia/sentencia De Revision De Tutela May 12, 1999.