

NOTES

A CHILD'S EXPERTISE: ESTABLISHING STATUTORY PROTECTION FOR INTERSEXED CHILDREN WHO REJECT THEIR GENDER OF ASSIGNMENT

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Intersexed children are born with genitalia and/or reproductive organs that do not look like those of most biological males or females. Doctors and parents usually assign an intersexed child a gender at birth or during early childhood. Occasionally, an individual will reject his or her gender of assignment and will want to take on a different gender role. Some clinicians and intersex advocates instruct parents to accept an intersexed child's expressions of gender identity and to support the child's gender role change. There is a risk, however, that parents may resist or prevent a child's gender transition due to their own discomfort with the idea or based on a physician's recommendation. A statutory framework that allowed intersexed minors to complete a "social gender transition," coupled with a provision equating parental interference with this transition with actionable neglect, would protect intersexed children's autonomy and prevent the trauma that can result from a forced existence in a gender role with which a child does not identify. The proposed framework would likely survive a constitutional challenge by the parents of an intersexed child because the harm caused by the parental decision to interfere with a child's gender expression removes such interference from the realm of constitutionally protected parental decisionmaking.

INTRODUCTION

When Carl was born, his parents sent out a written announcement inviting friends and family to celebrate the birth of their little girl.¹ Carl's genitals, however, were sufficiently "ambiguous" in appearance to instill confusion and uncertainty in his doctors and parents, so Carl was subsequently raised as a boy.² As a child, Carl preferred the company and clothing of other girls; his father responded

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¹ The details of Carl's story come from Katherine A. Mason, *The Unkindest Cut: Intersexuals Launch a Movement to Stop Doctors from 'Assigning' Sex with a Scalpel*, NEW HAVEN ADVOC., Mar. 29, 2001, at 10.

² *Id.* at 10.

by trying to coax Carl into playing baseball and basketball.³ When Carl asked his parents what was wrong with him, they told him it had something to do with his birth but would say no more.⁴

When Carl reached puberty, his parents began taking him on frequent trips to the doctor's office, where he was told to take pills and was injected with something that Carl now believes was testosterone.⁵ Still struggling as an adult with the feeling of being female, Carl again attempted to question his parents.⁶ They admitted that at his birth doctors had originally identified Carl as female (something they could not deny once Carl found the birth announcement), but told him, "Everything was done to make sure you were a boy."⁷ They again refused to discuss it any further.⁸

Now, after serving in the military, Carl lifts weights, works construction, and has a girlfriend, but says, "Don't be fooled by all of this. I'm overcompensating. This isn't me. But this is what I have to do."⁹ Hesitant to have surgery or transition to a female gender role because it would require him to move and change jobs, Carl ultimately wishes his parents had foregone treatment and let him determine his own gender identity.¹⁰

Because Carl's sex was not immediately apparent at birth, his parents and doctors assigned him to a gender.¹¹ Like many parents of intersexed children, Carl's parents probably allowed doctors to surgically alter Carl's genitals. Rarely, but occasionally, an intersexed individual will come to identify, in childhood or as an adult, with a gender other than the one to which he or she was assigned. As Carl's story demonstrates, whether or not a child makes a "social gender transi-

³ *Id.* at 13.

⁴ *Id.*

⁵ *Id.* at 10.

⁶ *Id.* at 13.

⁷ *Id.* at 10.

⁸ *Id.*

⁹ *Id.*

¹⁰ See *id.* at 10 (stating that decision was made "without his best interests in mind").

¹¹ In this Note, I do not use the terms "sex" and "gender" synonymously: "Sex refers to whether a person is male or female based largely on anatomical factors such as external genitalia. Gender refers to the characteristics associated with masculinity and femininity." Patience W. Crozier, *Forcing Boys to Be Boys: The Persecution of Gender Non-Conforming Youth*, 21 B.C. THIRD WORLD L.J. 123, 125-26 (2001) (reviewing CHRISTINA HOFF SOMMERS, *THE WAR AGAINST BOYS* (2000)) (citations omitted); see also ANNE FAUSTO-STERLING, *SEXING THE BODY: GENDER POLITICS AND THE CONSTRUCTION OF SEXUALITY* 250-51 (2000) (explaining sociologist Judith Lorber's subdivisions of gender); CONSORTIUM ON THE MGMT. OF DISORDERS OF SEX DEV., *HANDBOOK FOR PARENTS* 13-14 (2006) [hereinafter *HANDBOOK FOR PARENTS*], available at <http://www.dsdguidelines.org/files/parents.pdf> (explaining differences among "gender," "gender role," "gender identity," and "sex").

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tion”¹² in order to live publicly as the gender with which he or she most identifies can depend largely upon parental support of the child’s gender expression. A child with supportive parents may find the transition a complex but rewarding process, while another child may be blocked not only from transitioning, but from expressing *any* gender nonconforming behavior whatsoever. When parents do not attempt to “correct” gender-variant behavior, the child is less likely to experience the feelings of shame and rejection reported by many intersexed individuals.

This Note proposes the creation of a law allowing intersexed children who reject their gender of assignment to adopt a different gender role, even in the face of parental opposition. Specifically, it proposes a statute that allows minors to obtain assistance in choosing and completing a social gender transition and recognizes parental interference with that transition as neglect. Although some might object that this process infringes upon the right of parents to direct and control their children’s upbringing, I contend that the intersex situation merits exception to the general pattern of judicial deference to parental authority.

The rearing of an intersexed child is fundamentally different from the situations in which courts usually defer to parental decisions. First, the parents’ own discomfort with intersex, compounded by the medical profession’s general insistence that intersex is a “social emergency” requiring swift “correction” and unflinching enforcement of the child’s gender of assignment, might prevent parents from acting in their child’s best interests.¹³ Also, by giving an intersexed child a gender of assignment at birth, the child’s parents take a step that, though likely made with good intentions and the best available information, is essentially a prediction.¹⁴ Given that gender identity can

¹² This term, used by intersex education and advocacy groups, *see infra* note 99, was originally used in literature on transgenderism to describe “gender presentation,” often including name and style of dress. *See, e.g.,* HARRY BENJAMIN INT’L GENDER DYSPHORIA ASS’N, STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS 17 (6th rev. 2001) [hereinafter STANDARDS OF CARE], available at <http://www.hbigda.org/Documents2/socv6.pdf>. I use it in a similar manner. A social gender transition for an intersexed individual does not require medical or surgical intervention, for my use of the term does not include the use of “blockers,” hormones used to delay the onset of puberty in cases where it could be psychologically devastating.” Patricia Leigh Brown, *Supporting Boys or Girls When the Line Isn’t Clear*, N.Y. TIMES, Dec. 2, 2006, at A1 (reporting controversy over use of blockers due to some doctors’ belief “that only at puberty does an individual fully appreciate their gender identity”). Of course, an individual may choose to undergo hormonal therapy or surgical procedures later in life. Though the term “social gender transition” can be used in both the intersex and transgender contexts, the arguments in this Note refer to the intersex context, unless otherwise specified.

¹³ *See infra* Part I.B.

¹⁴ *See infra* notes 46–47 and accompanying text.

often establish itself during childhood,¹⁵ the child is the one who can best understand his or her gender identity. These factors strongly undermine the traditional rationale¹⁶ for judicial deference to parents. Finally, parental decisions to reject—or even punish—a child’s expression of gender identity cause harm¹⁷ and therefore fall outside the realm of constitutionally protected parental decisionmaking.¹⁸

One preliminary comment is in order: Although a child need not be intersexed to identify as a gender different from the one assigned at birth, I have chosen to focus on intersexed children for several reasons. First, intersexed children may be more likely than other children to reject their gender of assignment,¹⁹ so they may be more likely to find themselves in the predicament that I describe in this Note.²⁰ Second, many view early assignment surgery as a violation of an intersexed child’s autonomy.²¹ The statutory solution that I propose is an attempt to respect children’s autonomy in a way that may not have been done earlier in their lives. Finally, although there is extensive debate about the appropriateness of early assignment surgery,²² few have examined the issues that could arise as an intersexed child grows.²³ This Note is intended in part to encourage research and

¹⁵ See PEGGY T. COHEN-KETTENIS & FRIEDMAN PFAFFLIN, *TRANSGENDERISM AND INTERSEXUALITY IN CHILDHOOD AND ADOLESCENCE* 8 (2003) (citing studies that identify “gender consistency” developing at ages three to seven); FAUSTO-STERLING, *supra* note 11, at 249 (establishing age four as age at which “gender constancy” begins to develop); Anne Vitale, *The Gender Variant Phenomenon: A Developmental Review*, Jan. 27, 2003, <http://www.avitale.com/developmentalreview.htm> (reporting that children usually identify themselves as boy or girl by age three). *But see* Ieuan A. Hughes et al., *Consensus Statement on Management of Intersex Disorders*, 91 *ARCHIVES DISEASE CHILDHOOD* 554, 557 (2006) (“Gender identity development begins before the age of 3 years, but the earliest age at which it can be reliably assessed remains unclear.” (emphasis added) (citations omitted)), also published as Peter A. Lee et al., *Consensus Statement on Management of Intersex Disorders*, 118 *PEDIATRICS* e488, e492 (2006).

¹⁶ See *infra* Part III.A.

¹⁷ See *infra* notes 102–04 and accompanying text.

¹⁸ See *infra* Part III.B.2.

¹⁹ See *infra* note 95.

²⁰ Nevertheless, it may be possible to apply the statutory framework I envision to a child who was not born intersexed. It could possibly even protect parents who support a transgender child’s desire to adopt a new gender role. See Noa Ben-Asher, *Essay, Paradoxes of Health and Equality: When a Boy Becomes a Girl*, 16 *YALE J.L. & FEMINISM* 275, 275–76 (2004) (chronicling story of biologically male child who was removed from parents’ custody after parents attempted, at child’s request, to enroll child in school as female).

²¹ See *infra* note 49.

²² See *infra* Part I.B.

²³ In 2006, University of California, Berkeley School of Law Equal Justice Works Fellow Anne Tamar-Mattis founded the Institute for Intersex Children and the Law (IICL), see Equal Justice Works, *Fellowships Profile*, Anne Tamar-Mattis, <http://info.equaljusticeworks.org/fellowships/profiles/fellowprofile.asp?fguid=2006043> (last visited Mar. 9, 2007), an organization designed to “undertake a coordinated strategy of legal advocacy for the rights of children with intersex conditions.” Inst. for Intersex Children & the Law,

debate in other areas.²⁴

Part I provides a brief overview of the various intersex conditions and describes the problems inherent in the traditional protocol for rearing intersexed children. Part II proposes a statutory framework that would vest intersexed minors with the authority to consent to assistance in choosing and completing a social gender transition. Part III demonstrates that the proposed statute would survive a constitutional challenge made by the parents of an intersexed child.

I

BACKGROUND ON INTERSEX²⁵ AND CLASHING TREATMENT PARADIGMS

Estimates of the frequency of intersex conditions vary according to the definition of “intersex” employed, but it is safe to say that there

<http://iiclaw.org> (last visited Mar. 9, 2007). At the time of publication of this Note, I am unaware of any efforts by the IICL or other organizations to address the legal rights of older intersexed children to undergo gender transitions, though Tamar-Mattis has proposed a system of judicial approval of decisions to perform genital surgery on intersexed infants and young children. See Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersexed Infants*, 21 BERKELEY J. GENDER L. & JUST. 59, 94–98 (2006) (explaining mechanism of judicial approval of parental consent to organ donation by children and sterilization of mentally handicapped persons and proposing extension of system to early genital surgery for intersexed infants and young children).

²⁴ Professor Elizabeth Reilly has proposed increasing the autonomy of intersexed children to declare their own gender identities by eradicating the “sex” category on the standard birth certificate form and placing it in the “information for medical and health purposes only” section. Elizabeth Reilly, *Radical Tweak—Relocating the Power to Assign Sex: From Enforcer of Differentiation to Facilitator of Inclusiveness: Revising the Response to Intersexuality*, 12 CARDOZO J.L. & GENDER 297 (2005). Reilly predicts that this change would cause a corresponding shift in the cultural attitude toward gender identity: “[Sex a]ssignment, once it is recognized as tentative, can be acknowledged as a potentially wrong guess. Parents can respond to the manifestations of sex identity in their child, rearing the child with a tentative sex identity while awaiting the input from the child.” *Id.* at 329. Further investigation and innovation in this area is necessary for at least two reasons, however. First, Reilly’s birth certificate proposal has not been adopted. In fact, New York City’s Board of Health recently withdrew a proposal “that would have allowed people to alter the sex on their birth certificates without sex-change surgery.” Damien Cave, *No Change in Definition of Gender*, N.Y. TIMES, Dec. 6, 2006, at B1. Second, the proposal does not address the potential problem of parents who insist that the identity they chose for their child is the “right” one and refuse to acknowledge that the child identifies differently.

²⁵ A clarification of the terminology used in this Note is in order. In the last year, a group of intersex advocates and physicians has begun using the term “disorders of sex development” (DSD) when discussing the treatment of intersexed children. Hughes et al., *supra* note 15, at 554. The consensus group explained that “[t]erms such as intersex [and others] . . . are perceived as potentially pejorative by patients, and can be confusing to practitioners and parents alike.” *Id.* (citations omitted). The group defines DSD as “congenital conditions in which development of chromosomal, gonadal, or anatomical sex is atypical.” *Id.* The related Consortium on the Management of Disorders of Sex Development has also adopted the term. *E.g.*, HANDBOOK FOR PARENTS, *supra* note 11,

are currently thousands of children in the United States with some form of intersexuality.²⁶ The treatment protocol for intersexed individuals often includes early surgical intervention and an environment of secrecy.²⁷ Though some doctors are pushing for change, many still adhere to the old paradigm despite the strong arguments against it.²⁸ Preliminary research suggests that an intersexed individual will occasionally reject his or her gender of assignment.²⁹ There is, however, a dearth of long term studies of intersexed children, and even less is known about parental reactions to a child's expression of gender identity. Still, the evidence that does exist suggests that parental interference with or punishment of a child's gender expression can cause the child real harm.

A. *Intersex Conditions: Origins and Frequency*

Defining "intersex" is almost as difficult as agreeing on how to deal with it. The standard dictionary definition—"one having characteristics of both sexes"—is unsatisfactorily vague.³⁰ Defining intersex in terms of "ambiguous genitalia" is also problematic, as this definition rests upon disputed normative questions about what genital struc-

at 1. This nomenclature, however, has provoked a backlash from doctors, intersexed individuals, and advocates who argue that the term pathologizes, and therefore stigmatizes, intersexuality. See, e.g., Hazel Glenn Beh & Milton Diamond, Electronic Letter to the Editor, *Variations of Sex Development Instead of Disorders of Sex Development*, ARCHIVES DISEASE CHILDHOOD ONLINE, July 27, 2006, <http://adc.bmj.com/cgi/eletters/91/7/554#2460> ("[T]he consensus statement remains wedded to the notion that variations in sex development constitute 'disorders' or 'something wrong' that should be medically or surgically managed."). The Intersex Society of North America (ISNA), a proponent of the use of the term DSD, maintains that the term is not meant to replace "intersex," does not stigmatize, and in fact serves the instrumental function of "mak[ing] our message of patient-centered care much more accessible to parents and doctors." ISNA's Blog, <http://www.isna.org/node/1066> (May 24, 2006, 09:02); see also Posting of Sherri Groveman Morris to ISNA's Blog, <http://www.isna.org/node/1067> (May 24, 2006, 09:06) ("It would be a mistake to advocate that 'intersex' be replaced with 'DSD' within [the community of adults 'who define themselves using the term "intersex"'], in the same way that people with a variety of different conditions identify themselves using terms which may vary from the terms employed by their health care providers."). In an effort to use a term that both sides agree is acceptable in most circumstances, I use "intersex" except when referring to sources that explicitly use "disorders of sex development" or "DSD." See, e.g., *infra* note 76.

²⁶ See *infra* Part I.A.

²⁷ See *infra* Part I.B.1.

²⁸ See *infra* text accompanying notes 80–82.

²⁹ See *infra* notes 89–93 and accompanying text.

³⁰ Robert M. Blizzard, *Intersex Issues: A Series of Continuing Conundrums*, 110 PEDIATRICS 616, 616 (2002) (noting inadequacy of definitions of "intersex" in major dictionaries).

tures are clearly male or female.³¹ The American Academy of Pediatrics has concluded that intersex conditions originate in the early stages of pregnancy.³² In addition, some young children who sustain extensive genital injuries have been reassigned to the female sex, and others born with what their doctors or parents considered “oversized”³³ clitorises have undergone surgical clitoral reduction.³⁴

Estimates of the frequency of intersex conditions vary depending on the definition of intersex employed. One frequently cited statistic is that one of every two thousand children is born with an intersex condition.³⁵ Other scholars, however, cite different frequencies based on different definitions of the term.³⁶ While the precise frequency of

³¹ See Alice Domurat Dreger, “*Ambiguous Sex*”—or *Ambivalent Medicine?* *Ethical Issues in the Treatment of Intersexuality*, HASTINGS CENTER REP., May/June 1998, at 24, 26 (noting that phrase “ambiguous genitalia” begs question of “what should count as ‘ambiguous’”).

³² See Comm. on Genetics, Am. Acad. of Pediatrics, *Evaluation of the Newborn with Developmental Anomalies of the External Genitalia*, 106 PEDIATRICS 138, 138 (2000) (describing intersex conditions as result of “an abnormality along the male [hormonal] pathway that interferes with complete masculinization or, in the case of a genetic female, some virilizing influence that acts on the developing embryo”). Doctors often identify newborns with intersex conditions through physical inspection, but some conditions are not detectable until later in life or after chromosomal testing. Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics & the Law*, 11 ANNALS HEALTH L. 195, 196 (2002). For a comprehensive description of particular intersex conditions, see Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265, 278–92 (1999).

³³ Again, by Dreger’s reasoning, this begs the question of what qualifies a clitoris as “oversized,” besides doctors’ and parents’ preconceptions. See Dreger, *supra* note 31, at 26 (stating that some doctors identify as ambiguous “big” clitorises, which they consider “cosmetically ‘unacceptable’”); see also Alice Domurat Dreger & Cheryl Chase, *A Mother’s Care: An Interview with “Sue” and “Margaret,”* in INTERSEX IN THE AGE OF ETHICS 83, 85 (Alice Domurat Dreger ed., 1999) (discussing doctor saying he had never seen medical problems result from “big clitorises”).

³⁴ E.g., Greenberg, *supra* note 32, at 290 (“[S]ome individuals have had their penises removed at a young age because they were mistakenly identified as females and the penis was considered an oversized clitoris that required reduction.”).

³⁵ See, e.g., Hermer, *supra* note 32, at 195; see also Christine Gorman & Wendy Cole, *Between the Sexes*, TIME, Mar. 1, 2004, at 54, 55 (citing 2000 study estimating number of intersex births at 0.2–2% of live births); Louise D. Palmer, *Hermaphrodite Activists Urge Medical Reforms, Doctors Rethink Practice of Choosing Sex for Baby*, TIMES-PICAYUNE (New Orleans), Dec. 12, 1999, at A28 (“Five children a day are born in the United States with some form of intersexuality, according to pediatric urologists and endocrinologists.”).

³⁶ Doctor Leonard Sax, for example, interprets “intersex” as encompassing only certain hormonal syndromes and estimates the incidence at only 0.018%. Leonard Sax, *How Common Is Intersex? A Response to Anne Fausto-Sterling*, 39 J. SEX RES. 174, 174 (2002). On the other hand, Anne Fausto-Sterling has estimated the frequency of intersex at 1.7%, based on a broader definition of the condition. *Id.* at 174–75 (citing FAUSTO-STERLING, *supra* note 11, at 51 (noting that 1.7% figure “should be taken as an order-of-magnitude estimate rather than a precise count.”)). The Intersex Society of North America asserts that individuals “whose bodies differ from standard male or female” constitute one in one hundred births. Intersex Society of North America, *How Common Is Intersex?*, <http://www.intersex.org/>

intersex births is disputed, given that there are on average over four million live births each year in the United States,³⁷ even conservative definitions of intersex suggest that the population includes thousands of individuals whose bodies have been labeled “abnormal” by doctors—and by many laypeople, as well.

B. *The Traditional Western Response to Intersex*

1. *The Treatment Protocol*

Johns Hopkins University researcher John Money’s theory of gender development provided the initial framework for the treatment of intersexed children.³⁸ Money identified ten separate “variables of sex”³⁹ and posited that “errors” in these variables can lead to various genital “anomalies.”⁴⁰ His response to variant sex organs was quick and surgical: The child’s doctors and parents must quickly choose a gender of assignment, and the child’s genitals must be surgically altered so that he or she could develop as a “clearly sexed individual[]” and avoid the stigma of sexual ambiguity.⁴¹ Money’s treatment model thus assumes that gender identity is not predetermined by hormones but is instead the product of socialization during childrearing.

Today, many doctors still view the birth of an intersexed child as a “social emergency”⁴² because of the perceived risk that the child’s “ambiguous” genitalia will prevent proper parent-child bonding,⁴³

www.isna.org/faq/frequency (last visited Mar. 9, 2007) (citing Melanie Blackless et al., *How Sexually Dimorphic Are We? Review and Synthesis*, 12 AM. J. HUM. BIOLOGY 151, 151–66 (2000)).

³⁷ Nat’l Vital Stat. Sys., Ctrs. for Disease Control & Prevention, *Births, Marriages, Divorces, and Deaths: Provisional Data for October 2005*, NAT’L VITAL STAT. REP., May 10, 2006, at 1, available at http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_17.pdf (estimating 4,138,000 live births between October 2004 and October 2005).

³⁸ Kate Haas, *Who Will Make Room for the Intersexed?*, 30 AM. J.L. & MED. 41, 45 (2004) (“Genital reconstruction surgery became standard practice in the United States through the efforts of John Money, a Johns Hopkins University professor.” (citations omitted)).

³⁹ They are: (1) genetic or chromosomal sex; (2) gonadal sex; (3) fetal hormonal sex; (4) internal morphologic sex; (5) external morphologic sex; (6) hypothalamic sex; (7) sex of assignment and rearing; (8) pubertal hormonal sex; (9) gender identity and role; and (10) procreative sex impairments. JOHN MONEY, *SEX ERRORS OF THE BODY AND RELATED SYNDROMES* 4 (2d ed. 1994) (quoting JOHN MONEY, *SEX ERRORS OF THE BODY* 11 (1st ed. 1968) (earlier edition of same book)).

⁴⁰ *Id.* at 4–5.

⁴¹ SHARON E. PREVES, *INTERSEX AND IDENTITY: THE CONTESTED SELF* 53 (2003) (describing Money’s research).

⁴² Comm. on Genetics, *supra* note 32, at 138.

⁴³ See Am. Acad. 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, 590 (1996) (noting that “congenital birth defects

cause the child to have a negative body image,⁴⁴ and impede the child from being accepted by his or her peers.⁴⁵ To avoid this fate, a newborn child identified as having visually “ambiguous” genitals undergoes an emergency medical evaluation.⁴⁶ Doctors will usually recommend a gender of assignment and will often suggest genital surgery.⁴⁷ Doctors frequently instruct parents to disclose as little as possible to the child as he or she grows, for “any doubt may undermine development of a gender identity concordant with the assigned sex of rearing.”⁴⁸

2. *Problems with Early Surgery*

Early assignment surgery occurs without the consent of the child and thus violates the general presumption—unquestioned in the context of adults and older minors—that every individual has the right to determine what happens to his or her body.⁴⁹ It also imposes an inva-

. . . may influence the mother’s attitude toward the child,” and warning that delaying surgery “has the disadvantage of potentially prolonging the child’s ‘defective’ status and crystallizing any disruption in family relationships that the child’s condition may have produced”).

⁴⁴ See *id.* (“A child with an external birth defect . . . is at risk of developing distortions of body image that reflect other people’s subtly communicated evaluations of the child’s body.”).

⁴⁵ Responding to opponents of reassignment surgery during infancy, pediatric urologist Kenneth Glassberg asks, “How will playmates and classmates react, and what effect will this have on psychosocial development, especially during adolescence when body image is problematic even for children with normal sexual development? . . . Should [surgical patients] have been condemned to growing up as what would inevitably be considered freaks by their classmates?” Kenneth I. Glassberg, Editorial, *Gender Identity and the Pediatric Urologist*, 161 *J. UROLOGY* 1308, 1308–09 (1999).

⁴⁶ Bruce E. Wilson & William G. Reiner, *Management of Intersex: A Shifting Paradigm*, 9 *J. CLINICAL ETHICS* 360, 362 (1998).

⁴⁷ *Id.* at 363.

⁴⁸ *Id.*; see also Alice Dreger, Intersex Society of North America, *Shifting the Paradigm of Intersex Treatment*, <http://www.isna.org/pdf/compare.pdf> (last visited Mar. 8, 2007) (comparing “concealment-centered” and “patient-centered” models of intersex treatment).

⁴⁹ Wilson & Reiner, *supra* note 46, at 364 (noting that assignment surgery implicates “the right of the individual to determine what happens to his or her body”); see also Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 *HARV. J.L. & GENDER* 51, 96 (2006) (“[T]he legal claim for freedom from early intersex surgery can be viewed as a claim for individual negative liberty of *non-interference* with one’s body.”). One author has argued that the right “to define one’s own concept of existence,” most recently identified by the Supreme Court in *Lawrence v. Texas*, 539 U.S. 558 (2003), “speaks directly to the efforts of intersex people to wrest control over the fate of their sex anatomy from concerned parents and physicians.” Chai R. Feldblum, *The Right to Define One’s Own Concept of Existence: What Lawrence Can Mean for Intersex and Transgender People*, 7 *GEO. J. GENDER & L.* 115, 115–16 (2006). Writers have also described early surgery as “ignoring the child’s right to an open future” because surgery can infringe, for example, upon the child’s right to marry and reproduce. 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 &*

sive and often irreversible “solution” on intersexed children, when the problem may actually stem from a cultural fixation on gender binarism⁵⁰ and sex and gender stereotypes. What is actually sexual “variability” is branded “ambiguity” or abnormality.⁵¹ Thus intersexed infants’ genitals are altered mainly because they do not conform to dominant conceptions of what it means to be male (having a penis that allows standing urination and vaginal penetration) or female (having a “normal”-sized clitoris and a vagina that will permit penetration).⁵² Genitals (and children) who do not conform to these norms are seen as “pathological,” not because they are actually diseased, but because they do not fit within a socially constructed gender framework.⁵³ Surgery is thus an easy fix for the cultural “problem” of intersex, allowing doctors and parents to evade the more difficult task of persuading society “to accept the genitals.”⁵⁴

Sociocultural objections aside, the results of assignment surgery have not undergone systematic evaluation, rendering its legitimacy as standard medical practice dubious. Surgeons have been performing sex assignment surgeries on children for decades, but there are pain-

L. 1, 57–58 (2000); *see also* Haas, *supra* note 38, at 59–60 (noting that some sex assignment procedures require removal of gonads, and that, having been assigned to one sex, child may be restricted in future by statutes prohibiting same-sex marriage).

⁵⁰ *See* Crozier, *supra* note 11, at 126 (“In a system that presumes the binary nature of sex and gender, the two genders complement each other in a manner that compels heterosexuality. Men properly perform their gender role by having sex with women and vice versa.” (citations omitted)).

⁵¹ SUZANNE J. KESSLER, *LESSONS FROM THE INTERSEXED* 8 (1998) (differentiating these terms in that “something needs to be done about ‘ambiguity,’ but it is less obvious what (if anything) needs to be done about ‘variability’”).

⁵² Robert A. Crouch, *Betwixt and Between: The Past and Future of Intersexuality*, 9 J. CLINICAL ETHICS 372, 374–75 (1998). In other words, “the reaction to the intersexed child reveals less about *intersexuality* than it does about a social and medical *discomfort with intersexuality*.” *Id.*; *see also* KESSLER, *supra* note 51, at 21–28 (discussing how physicians deal with gender ambiguity and what social factors drive gender assignment decisions).

⁵³ FAUSTO-STERLING, *supra* note 11, at 75–76; Crouch, *supra* note 52, at 378; Nancy Ehrenreich & Mark Barr, *Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of “Cultural Practices,”* 40 HARV. C.R.-C.L. L. REV. 71, 77 (2005) (arguing that medical treatment of intersexuality is guided by “patriarchal” and “heteronormative” attitudes).

⁵⁴ KESSLER, *supra* note 51, at 35. At least one scholar, however, argues that this more difficult task is not one which doctors can realistically ask of parents:

[A] physician cannot, in good conscience, assure the parents of an intersex infant that they ought not to choose cosmetic or sex assignment surgery for their child, on the ground that the unaltered child, along with his/her intersexual forebears and brethren, will (over time) alter our present sex and gender systems to make space for those who do not conform to the present norms.

Hermer, *supra* note 32, at 228.

fully few studies assessing the long term effects of the procedures.⁵⁵ Evidence of healthy psychosocial development in intersexed children who have *not* had surgery further calls into question the necessity and wisdom of the procedures.⁵⁶

Using the evidence available, opponents of early assignment surgery have cast serious doubt upon the traditional treatment paradigm. First, doctors who seek to give children “normal” genitalia often ignore the negative physical and psychological effects of the surgeries. Several scholars, and many intersexed individuals who have undergone assignment surgery,⁵⁷ note the negative physical side effects of the surgery, which can continue from childhood through adulthood.⁵⁸

⁵⁵ See, e.g., Kishka-Kamari Ford, “First, Do No Harm”—*The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants*, 19 YALE L. & POL’Y REV. 469, 482 (2001) (noting lack of scientific basis for use of genital surgery on infants and lack of follow-up data on benefits of surgery).

⁵⁶ CONSORTIUM ON THE MGMT. OF DISORDERS OF SEX DEV., CLINICAL GUIDELINES FOR THE MANAGEMENT OF DISORDERS OF SEX DEVELOPMENT IN CHILDHOOD 28 (2006) [hereinafter CLINICAL GUIDELINES] (citing case studies and personal narratives documenting healthy psychological, physical, and sexual development of children raised without surgery).

⁵⁷ Many intersexed individuals have contributed their personal stories to the debate surrounding the rearing of intersexed children. E.g., INTERSEX IN THE AGE OF ETHICS, *supra* note 33, at 69–81, 91–100, 110–13 (containing chapters written by intersexed individuals, chronicling their experiences with sex assignment surgery or, in one case, lack thereof); PREVES, *supra* note 41 (discussing results of sociological study in which author interviewed adult intersexed persons about their experiences); Morgan Holmes, *Rethinking the Meaning and Management of Intersexuality*, 5 SEXUALITIES 159, 169–70, 172 (2002) (citing personal communications with intersexed persons and their families regarding reactions to surgical treatment). In addition, the last decade has seen the rise of support and advocacy groups organized and led by intersexuals and their allies. See, e.g., Intersex Society of North America, What’s the History Behind the Intersex Rights Movement?, <http://www.isna.org/faq/history> (last visited Mar. 9, 2007).

⁵⁸ Many people who undergo clitoral surgery, for example, experience long term sexual difficulties, including the inability to achieve orgasm. See Catherine L. Minto et al., *The Effect of Clitoral Surgery on Sexual Outcome in Individuals Who Have Intersex Conditions with Ambiguous Genitalia: A Cross-Sectional Study*, 361 LANCET 1252, 1252–53 (2003) (discussing study finding that intersexed adults who undergo clitoral surgery are significantly more likely to experience non-sensuality and inability to achieve orgasm); see also Sarah M. Creighton et al., *Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood*, 358 LANCET 124, 124 (2001) (reporting that forty-three of forty-four subjects who had undergone “feminising genital surgery” required “further treatment to the genitalia for cosmesis, tampon use, or intercourse,” and concluding that “[c]osmetic genital surgery in infancy needs to be reassessed in the light of these results”). But see Froukje M.E. Slijper, Commentary, *Clitoral Surgery and Sexual Outcome in Intersex Conditions*, 361 LANCET 1236, 1236 (2003) (“Sexual shyness could make it difficult for women with an intersex condition to enjoy their sexuality. . . . [This does] not mean that they lack the ability to reach an orgasm by self-stimulation.”).

Other people must undergo painful vaginal dilations multiple times a day. See KESSLER, *supra* note 51, at 49 (describing “pressure dilation” as “the insertion of a solid plastic dilator into the vagina for fifteen minutes twice a day for months or years”).

Thus, doctors who recommend assignment surgery often sacrifice long term functionality for “short-term cosmetic appearance.”⁵⁹

In addition to the negative physical repercussions that can result from sex assignment surgery, the secrecy inherent in the treatment paradigm can leave psychological scars as well: Cheryl Chase, director of the Intersex Society of North America (ISNA), reports that “[t]he primary source of harm described by former patients is not surgery per se, but the underlying attitude that intersexuality is so shameful that it must be erased before the child can have any say in what will be done to his or her body.”⁶⁰ Additionally, many intersexed persons report feelings of shame and humiliation as a result of repeated invasive physical examinations and the vaginal dilation procedure.⁶¹

The above considerations have led intersex activists, as well as one municipal government agency, to conclude that early assignment surgery constitutes a human rights violation. Building off of the characterization of sex assignment surgery as a surgical solution to a cul-

Bladder and urinary tract problems can also occur. *See, e.g.*, Sven Nicholson, *Take Charge! A Guide to Home Auto-Catheterization*, in INTERSEX IN THE AGE OF ETHICS, *supra* note 33, at 201–08 (describing post-surgery urinary tract infections and chronic need for painful catheterization to dilate bladder).

⁵⁹ Wilson & Reiner, *supra* note 46, at 364; *see also* KESSLER, *supra* note 51, at 98 (suggesting that surgeons’ preoccupation with genital appearance influences parents to “focus]] disproportionately on how the genitals look rather than on what the child might be experiencing or how her genitals might function in the future”).

⁶⁰ Cheryl Chase, *Surgical Progress Is Not the Answer to Intersexuality*, 9 J. CLINICAL ETHICS 385, 385 (1998); *see also* Edmund G. Howe, *Intersexuality: What Should Careproviders Do Now*, 9 J. CLINICAL ETHICS 337, 337–38 (1998) (“Many of those who have had surgery . . . report that surgery made them feel ashamed, as if there were something profoundly wrong with them.”); Wilson & Reiner, *supra* note 46, at 364 (“[S]ilence can create significant feelings of shame. After all, what could be so wrong with a child that his/her own parents won’t discuss it with him/her?”).

⁶¹ *See, e.g.*, KESSLER, *supra* note 51, at 49, 63 (noting that dilation procedure can impose “psychological burden” on both children and parents, who must often perform it on children too young to do it themselves); Sherri A. Groveman, *The Hanukkah Bush: Ethical Implications in the Clinical Management of Intersex*, 9 J. CLINICAL ETHICS 356, 358 (1998) (“My trauma was needlessly compounded by my doctor’s stony silence while examining me, and his asking me to lie naked on an examining table so that teams of interns and residents could inspect my genitals.”). The ISNA has even likened intersex treatment procedures to child sexual abuse (CSA):

[C]hildren with intersex conditions are subjected to repeated genital traumas which are kept secret both within the family and in the culture surrounding it. . . . These children experience their treatment as a form of sexual abuse, and view their parents as having betrayed them by colluding with the medical professionals who injured them. As in CSA, the psychological sequelae of these treatments include depression, suicidal attempts, failure to form intimate bonds, sexual dysfunction, body image disturbance and dissociative patterns.

Tamara Alexander, *The Medical Management of Intersexed Children: An Analogue for Childhood Sexual Abuse*, 1997, <http://www.isna.org/articles/analog> (citations omitted).

tural dilemma, the ISNA has drawn an analogy between the surgeries and female genital mutilation.⁶² In April 2005, the Human Rights Commission of the City and County of San Francisco held a public hearing to investigate “the medical ‘normalization’ of intersexed people.”⁶³ After receiving testimony from doctors, legal and ethical scholars, and parents and children living with intersex conditions, the Commission concluded that “[n]ormalizing’ interventions done without the patient’s informed consent are inherent human rights abuses.”⁶⁴

3. *Problems with Other Aspects of the Paradigm*

Other, more fundamental, aspects of the traditional treatment paradigm are equally troubling, for they can contribute to a dysfunctional parent-child dynamic. Doctors’ explanations (or lack of explanations) of intersex can have a profound effect on the parents’ attitude toward the child and his or her future gender identity: They can instill fear in parents and lead them to believe that their primary task will be monitoring and steering the child to make sure he or she grows up to be “normal.” For example, a doctor’s description of the situation as an “emergency” can lead parents who see their child as “perfect” to suddenly think that something is fundamentally wrong.⁶⁵ Therefore, although doctors often advocate for surgery as a means of facilitating bonding between parents and child,⁶⁶ the attitude toward intersex instilled by the treatment paradigm may actually taint the family dynamic. Fifty percent of the parents of intersexed children in

⁶² See generally Ehrenreich & Barr, *supra* note 53 (describing parallels between intersex surgery and “female genital cutting” (FGC)). “Leaders of the anti-FGC movement, however, have explicitly refused to embrace the intersex cause.” *Id.* at 74.

⁶³ MARCUS DE MARÍA ARANA, HUMAN RIGHTS COMM’N OF THE CITY & COUNTY OF S.F., A HUMAN RIGHTS INVESTIGATION INTO THE MEDICAL “NORMALIZATION” OF INTERSEX PEOPLE (2005).

⁶⁴ *Id.* at 17. The Commission also released, inter alia, the following findings:

“Normalizing” interventions deprive intersex people of the opportunity to express their own identity and to experience their own intact physiology. . . .

“Normalizing” interventions performed to alleviate a parent’s social discomfort about their [sic] child’s intersex anatomy violate the patient’s human rights. . . . “Normalizing” medical interventions performed on an intersex child to address the discomfort of doctors, relatives, and anyone other than the consenting patient is [sic] a violation of the child’s human rights.

Id. at 17–18.

⁶⁵ J. David Hester, *Rhetoric of the Medical Management of Intersexed Children*, *GEN- DERS*, 2003, ¶ 31, http://www.genders.org/g38/g38_hester.html (citing KESSLER, *supra* note 51, at 93–94).

⁶⁶ See *supra* note 43 and accompanying text.

one study were “not able to work through the trials and tribulations their child’s lack of gender clarity entailed.”⁶⁷

Surprisingly, even though doctors often speak in dire terms of the supposed trauma that can befall an intersexed child whose genitals are not surgically altered, the parents of intersexed children often receive no contact information for counselors or support groups from their child’s physicians.⁶⁸ To the contrary, parents are commonly counseled not to disclose the child’s condition even to family members or friends because of the stigma associated with intersex.⁶⁹ Ultimately, parents often receive little more than the aggressive reassurance that the problem has been “corrected” and the child will become a “normal” boy or girl,⁷⁰ as long as the parents remain committed to the gender of rearing and do not question the doctors’ actions.⁷¹

C. *The Development of a Competing Paradigm and Persistence of the Old Model*

In recent years, some physicians have made sex assignment more deliberative, waiting to perform surgery except where medically necessary and providing parents with more accurate information about the child’s condition.⁷² In fact, some doctors advocate a complete moratorium on surgery before the child is old enough to give consent.⁷³ Crucially, moratorium advocates do *not* advocate the rearing of “genderless” children.⁷⁴ Instead, they agree that parents should select a gender of assignment for the child based on an assessment of

⁶⁷ Howe, *supra* note 60, at 339 (citing Froukje M.E. Slijper et al., *Long-Term Psychological Evaluation of Intersex Children*, 27 ARCHIVES SEXUAL BEHAV. 125, 132 (1998)).

⁶⁸ Ellen K. Feder, *Doctor’s Orders: Parents and Intersexed Children*, in THE SUBJECT OF CARE: FEMINIST PERSPECTIVES ON DEPENDENCY 294, 294 (Eva Feder Kittay & Ellen K. Feder eds., 2003).

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Cf. id.* at 300–01 (noting that, in case study of mother of intersexed children, “[w]hen she seeks advice to address the consequences of the earlier recommendations, she is given to understand that her questions . . . are improper”).

⁷² Hermer, *supra* note 32, at 227.

⁷³ See Wilson & Reiner, *supra* note 46, at 365 (relating view that early urogenital surgery should be avoided and gonads left in place until patient is capable of consent). Moratorium advocates would make an exception when surgery is necessary to protect the child’s health. *Id.*

⁷⁴ April Herndon, Why Doesn’t ISNA Want to Eradicate Gender? (Feb. 17, 2006), http://www.isna.org/faq/not_eradicating_gender; see also Cheryl Chase, *Rethinking Treatment for Ambiguous Genitalia*, 25 PEDIATRIC NURSING 451, 453 (1999) (suggesting that under new treatment paradigm “[n]ewborn intersexed children would be diagnosed and labeled boy or girl”).

“how the patient will develop and prefer to live postpuberty, when he or she becomes most sexually active.”⁷⁵

But moratorium advocates also propose a comprehensive revision of the entire treatment paradigm. They advocate a plan that focuses on educating families about intersex and preserving important decisions about sex and gender identity for the child to make as he or she matures. Thus, both child and parent should be given all available information about the particular intersex condition.⁷⁶ The new treatment paradigm stresses the importance of psychological support and counseling for both the child and the parents.⁷⁷ It also recognizes that, though the medical team has made its best guess about the optimal gender of assignment, the child may choose to change gender as he or she develops.⁷⁸

Though a group of physicians has recently united to oppose the old paradigm,⁷⁹ and more doctors and commentators have begun to incorporate family counseling into their treatment protocols,⁸⁰ treatment still falls short of the ideal in many cases.⁸¹ Some doctors still tout sex assignment surgery during infancy as the best solution, maintaining that, although data are lacking about the benefits of early sur-

⁷⁵ Milton Diamond & H. Keith Sigmundson, *Management of Intersexuality: Guidelines for Dealing with Persons with Ambiguous Genitalia*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1046, 1047 (1997). Moratorium advocates also argue that doctors should avoid prolonged steroid hormone therapy and, if gonad removal is necessary, delay it until after puberty. *Id.*; see also Wilson & Reiner, *supra* note 46, at 365 (advocating leaving gonads intact except when malignant).

⁷⁶ See HANDBOOK FOR PARENTS, *supra* note 11, at 9–10 (“[T]he best thing you can do for your child is to be open and honest with him or her about his or her [disorder of sex development].” (emphasis removed)); Wilson & Reiner, *supra* note 46, at 365–66 (noting that attempts to suppress “gender confusion” seem to risk greater confusion and conflict in adult life); Dreger, *supra* note 48 (suggesting that intersexed persons have right to know about their conditions).

⁷⁷ Doctors are advised to suggest intersex support groups and to offer advice on dealing with people who react negatively to the child. Diamond & Sigmundson, *supra* note 75, at 1048. The family should also receive long term counseling, including individual sessions for the child. *Id.*; see also HANDBOOK FOR PARENTS, *supra* note 11, at 27–28.

⁷⁸ See *infra* Part I.D.

⁷⁹ The Consensus Statement, Hughes et al., *supra* note 15, published in the medical journals *Archives of Disease in Childhood* and *Pediatrics*, was signed by “50 international experts, primarily doctors but including [intersex advocate Cheryl] Chase.” Elizabeth Weil, *What if It's (Sort of) a Boy and (Sort of) a Girl?*, N.Y. TIMES, Sept. 24, 2006, § 6 (Magazine), at 48, 50–51. Notably, the Consensus Statement “doesn’t directly tell doctors not to operate [on intersexed infants] but does state that no good scientific studies prove infant cosmetic genital surgery improves quality of life.” *Id.* at 51.

⁸⁰ See Comm. on Genetics, *supra* note 32, at 141–42 (encouraging participation of psychologists and counselors with experience in intersex issues). The American Academy of Pediatrics now also suggests referring families to support groups. *Id.* at 142.

⁸¹ See Tamar-Mattis, *supra* note 23, at 78 (“[T]he creation of new standards of care is not binding on medical providers, and it can take many years for medical practice to change in accordance with new information.”).

gery, data about the benefits of delaying surgery or not performing it at all are equally scant.⁸² Because there is no clearly “right” answer, they argue, parents should be able to choose the path for their child that makes the most sense to them. The solution to problems with the old surgical paradigm is therefore to give parents more information about its risks and benefits, instead of banning surgeries altogether.⁸³ Arguments about the physical and familial fallout of the protocol often simply go unaddressed. Given that the surgical solution has occupied a position of prominence for decades, “[f]rom the parents’ perspective, the argument for surgery is almost impervious to reason.”⁸⁴ It is therefore unlikely that calls for a new treatment protocol will result in the immediate cessation of surgeries during infancy or in a change in the attitude that it is possible to inculcate gender identity through repeated behavioral enforcement.⁸⁵

D. Rejection of the Gender of Assignment

In 1997, John Money’s theory that gender is entirely a product of socialization was strongly and publicly called into doubt. Money’s most famous patient was David Reimer—called “John” in the medical literature—who suffered a severe penile injury in infancy.⁸⁶ Doctors surgically altered Reimer’s genitalia, and his parents agreed to raise him as a girl (“Joan”).⁸⁷ For several years, Money followed Reimer’s progress, and in 1975, when Reimer was ten, Money reported that the reassignment had been a complete success.⁸⁸ In the mid-1990s, however, interviews with Money’s “success story” revealed that the upbringing as “Joan” had failed: After sixteen years marked by the

⁸² E.g., Glassberg, *supra* note 45, at 1308.

⁸³ See, e.g., Sara A. Aliabadi, *You Make Me Feel Like a Natural Woman: Allowing Parents to Consent to Early Gender Assignment Surgeries for Their Intersexed Infants*; Hermer, *supra* note 32, at 223, 236 (rejecting proposals for moratorium on surgeries and arguing that full disclosure and therapeutic support can adequately improve parental decisionmaking); 11 WM. & MARY J. WOMEN & L. 427, 441–42 (2005) (same).

⁸⁴ Weil, *supra* note 79, at 51 (reporting that “[o]ne doctor . . . put her chances of persuading parents not to choose surgery for their intersex children at ‘honestly, zero’”).

⁸⁵ See Tamar-Mattis, *supra* note 23, at 78 (“The pace of change is too slow for many in the intersex community who are calling for an immediate moratorium on genital-normalizing surgery. Many legal scholars are troubled as well by the medical community’s slow response to this serious issue.”).

⁸⁶ Sara A. Aliabadi, *Gender Assignment Surgery for Intersexed Infants: How the Substantive Due Process Right to Privacy Both Supports and Opposes a Moratorium*, 12 VA. J. SOC. POL’Y & L. 170, 174 (2004).

⁸⁷ *Id.* at 174–75.

⁸⁸ John Money, *Ablatio Penis: Normal Male Infant Sex-Reassigned as a Girl*, 4 ARCHIVES SEXUAL BEHAV. 65, 71 (1975).

intuitive sense that he was a boy and intermittent suicidal thoughts, Reimer had decided to live as a male.⁸⁹

The revelation of the true outcome of the John/Joan case has led several medical professionals to research the frequency with which intersexed children come to identify with a gender that differs from their gender of assignment. Several studies report rejection of the gender of assignment by intersexed individuals,⁹⁰ suggesting that “there may be a neurobiologic component to many gender identities” that Money had overlooked.⁹¹ Other researchers note that the likelihood that an intersexed person will identify with a gender different from the gender of assignment may vary among different intersex conditions,⁹² but they caution that gender identity is not merely the

⁸⁹ See Milton Diamond & H. Keith Sigmundson, *Sex Reassignment at Birth: Long-Term Review and Clinical Implications*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 298 (1997) (reporting results of interviews with “John,” his wife, and his mother); see also Kenneth Kipnis and Milton Diamond, *Pediatric Ethics and the Surgical Assignment of Sex*, 9 J. CLINICAL ETHICS 398, 398–402 (1998) (detailing progression of John/Joan case study). After the results of Diamond and Sigmundson’s research were released, John Colapinto published a detailed account of David Reimer’s life based on extensive interviews with Reimer himself. See generally JOHN COLAPINTO, *AS NATURE MADE HIM: THE BOY WHO WAS RAISED AS A GIRL* (2000). In May 2004, David Reimer committed suicide. Aliabadi, *supra* note 86, at 176.

⁹⁰ See, e.g., Louis Gooren & Peggy T. Cohen-Kettenis, *Development of Male Gender Identity/Role and a Sexual Orientation Toward Women in a 46,XY Subject with an Incomplete Form of the Androgen Insensitivity Syndrome*, 20 ARCHIVES SEXUAL BEHAV. 459, 461–69 (1991) (assessing history of intersexed individual raised as girl who changed to male gender role at age thirty); Bernard Ochoa, *Trauma of the External Genitalia in Children: Amputation of the Penis and Emasculation*, 160 J. UROLOGY 1116, 1116 (1998) (reporting that boy surgically assigned and raised as female following penile emasculation at age six months “refused to continue hormonal medication and requested reassignment as a boy”); Chanika Phornphutkul et al., *Gender Self-Reassignment in an XY Adolescent Female Born with Ambiguous Genitalia*, 106 PEDIATRICS 135, 135–36 (2000) (giving case history of child born XY with micropenis who was assigned to female gender but “reassigned himself as male during adolescence”); William George Reiner, *Case Study: Sex Reassignment in a Teenage Girl*, 35 J. AM. ACAD. CHILD ADOLESCENT PSYCH. 799, 799–800 (1996) (reporting case history of intersexed child raised as girl who declared himself male at age fourteen). But see Susan J. Bradley et al., *Experiment of Nurture: Ablatio Penis at 2 Months, Sex Reassignment at 7 Months, and a Psychosexual Follow-up in Young Adulthood*, 102 PEDIATRICS e9, e10 (1998), available at <http://pediatrics.aappublications.org/cgi/reprint/102/1/e9> (“[O]ur case suggests that it is possible for a female gender identity to differentiate in a biologically ‘normal’ genetic male.”).

⁹¹ Wilson & Reiner, *supra* note 46, at 364.

⁹² Heino F.L. Meyer-Bahlburg, *Introduction: Gender Dysphoria and Gender Change in Persons with Intersexuality*, 34 ARCHIVES SEXUAL BEHAV. 371, 372 (2005) [hereinafter Meyer-Bahlburg, *Introduction*] (“[T]here are very marked variations between syndromes in the prevalence of patients who are not satisfied with their assigned gender and undergo gender change.”). Compare Peggy T. Cohen-Kettenis, *Gender Change in 46,XY Persons with 5 α -Reductase-2 Deficiency and 17 β -Hydroxysteroid Dehydrogenase-3 Deficiency*, 34 ARCHIVES SEXUAL BEHAV. 399, 399, 407 (2005) (noting that change of gender identity in individuals with certain enzyme deficiencies is “considerable and certainly higher than in other intersex conditions”), and Heino F.L. Meyer-Bahlburg, *Gender Identity Outcome in*

product of prenatal hormonal exposure.⁹³ Clinicians often note that more research in this area is necessary.⁹⁴

Based on the results of these studies, individuals and groups such as the ISNA have described the rejection of gender of assignment by an intersexed child as rare, but occasional.⁹⁵ There is little formal research on whether families can easily accept a child's desire for social gender transition,⁹⁶ but there are indications that "[t]hough the child (and oftentimes his or her peers) will likely find the social transition a relief, the parents will often find it a substantial source of distress."⁹⁷

Female-Raised 46,XY Persons with Penile Agenesis, Cloacal Exstrophy of the Bladder, or Penile Ablation, 34 ARCHIVES SEXUAL BEHAV. 423, 423 (2005) [hereinafter Meyer-Bahlburg, *Gender Identity Outcome*] ("The findings clearly indicate an increased risk of later patient-initiated gender re-assignment to male after female assignment in infancy or early childhood, but are nevertheless incompatible with the notion of a full determination of core gender identity by prenatal androgens."), and William G. Reiner & John P. Gearhart, *Discordant Sexual Identity in Some Genetic Males with Cloacal Exstrophy Assigned to Female Sex at Birth*, 350 NEW ENG. J. MED. 333, 333 (2004) (reporting that eight of fourteen subjects assigned to female sex "declared themselves male" during course of study), with Arianne B. Dessens et al., *Gender Dysphoria and Gender Change in Chromosomal Females with Congenital Adrenal Hyperplasia*, 34 ARCHIVES SEXUAL BEHAV. 389, 393 (2005) (reporting that of 250 individuals with congenital adrenal hyperplasia who were raised female, 5.2% experienced gender dysphoria, but only 1.6% underwent gender change later in life), and Tom Mazur, *Gender Dysphoria and Gender Change in Androgen Insensitivity or Micropenis*, 34 ARCHIVES SEXUAL BEHAV. 411, 411 (2005) (concluding that "self-initiated gender reassignment was rare" in sample of individuals with complete or partial androgen insensitivity syndrome or micropenis).

⁹³ E.g., Meyer-Bahlburg, *Gender Identity Outcome*, *supra* note 92, at 432.

⁹⁴ E.g., Meyer-Bahlburg, *Introduction*, *supra* note 92, at 372 (noting "the unsatisfactory state of the scientific evidence on gender development in [persons with intersex conditions], particularly in terms of the quality of the psychological assessments").

⁹⁵ The *Clinical Guidelines for the Management of Disorders of Sex Development in Childhood*, published by the ISNA, notes that this occurs in "a small number of cases" but does not give an exact figure. CLINICAL GUIDELINES, *supra* note 56, at 23. In another recent publication, the group states that "it is statistically very unlikely [that a] child will change the gender to which he or she was assigned." HANDBOOK FOR PARENTS, *supra* note 11, at 16. It acknowledges, however, that "[r]arely but occasionally a child will consistently express a gender identity other than the one he or she was assigned." *Id.* at 57; see also Dessens et al., *supra* note 92, at 393 (reporting that, although majority of persons with certain hormonal syndrome raised female "identify themselves as females and live in their assigned gender," "[t]he number of females who desired a gender change is larger than expected, given the baseline prevalence of female to male transsexualism in the general population of chromosomal females" (citations omitted)); Dreger, *supra* note 48 ("Any child may decide later in life to change their gender assignment; but children with intersex conditions have significantly higher rates of gender transition than the general population, with or without treatment.").

⁹⁶ Wilson & Reiner, *supra* note 46, at 367. Indeed, commentators have noted the lack of formal research on any aspect of the experience of raising an intersexed child. E.g., Feder, *supra* note 68, at 294.

⁹⁷ CLINICAL GUIDELINES, *supra* note 56, at 23 (citations omitted).

Intersex activists advise parents not to focus on whether a child's behavior conforms to the usual expectations of his or her gender, and instead to support the child's expressions of gender identity.⁹⁸ If the child consistently identifies with a gender other than that of assignment, the parents should consult a mental health professional who can help oversee the child's gender transition.⁹⁹ Ideally, this flexible approach will be used in most cases, but it requires many parents to disregard the prevalent medical advice that unwavering commitment to the gender of assignment is the only way to produce a "normal" and healthy child.¹⁰⁰

There are indications that some parents actively prevent children from expressing a gender identity different from that of assignment. For example, one study mentions in passing that two subjects, assigned to be female in infancy, "have persistently and spontaneously declared their sexual identity as males since the age of nine years," but that "[t]hey live as females because their parents have rejected their declarations."¹⁰¹ Additionally, the personal histories of many intersexed people indicate that some parents go to extreme measures—including physical punishment—to keep their children in the gender roles to which they have been assigned.¹⁰² Many also report suffering severe psychological trauma as a result of their parents' and doctors' actions, with some, like David Reimer,¹⁰³ considering suicide.¹⁰⁴

⁹⁸ HANDBOOK FOR PARENTS, *supra* note 11, at 15–16, 55 ("It isn't your job to try to 'make' your child fit a particular gender identity. Your child will express to you what is right for him or her.").

⁹⁹ *Id.* at 58 ("If you think your child is going to transition gender assignments, then the gender transition should be managed by a health professional experienced in this area . . .").

¹⁰⁰ See *supra* notes 70–71 and accompanying text.

¹⁰¹ Reiner & Gearhart, *supra* note 92, at 338 (noting also that both subjects continue to take estrogen, though "both state that they would prefer to receive testosterone").

¹⁰² For example, the San Francisco Human Rights Commission Report recounts the story of Lynell Stephani Long: "Despite being given male hormones, her body seemed to feminize, which pleased Ms. Long, who had a female gender identity. Yet, if her mother caught her engaging in feminine activities, she was beaten. So, Ms. Long learned quickly to hide her gender identity to keep her mother's favor." MARÍA ARANA, *supra* note 63, at 43. Ms. Long reported that when her mother overheard her say that she did not know if she was a boy or a girl, "she whipped me and told me I was an embarrassment to her." *Id.* Another individual reported "being sent to therapy at 15 to be taught 'how to be a girl.'" *Id.* at 42 (recounting testimony of Eli Hobbs).

¹⁰³ See Aliabadi, *supra* note 86, at 176 (reporting David Reimer's suicide).

¹⁰⁴ MARÍA ARANA, *supra* note 63, at 42 (reporting Mr. Hobbs's feelings of "hopelessness and humiliation" during childhood and noting that Hobbs "spent years in drug and alcohol dependency trying to deal with his childhood trauma"); *id.* at 43 (noting that Ms. Long reported "years of feeling suicidal"); *id.* at 45 (reporting Fr. Spencer St. John's testimony that his forced rearing as female under direction of his father and doctors generated suicidal thoughts).

Statutory protection of an intersexed child's expression of his or her gender identity could help to prevent the harm described above. A legislative solution must consider the medical, ethical, and cultural dimensions of intersex and should seek to minimize harm to children and preserve their autonomy. In the following Part, I offer a legislative proposal that attempts to address each of these dimensions.

II

ALLOWING INTERSEXED CHILDREN TO EXPRESS GENDER IDENTITY: ONE STATUTORY POSSIBILITY

A solution to the dilemma of intersexed children who reject their assigned gender but whose parents prevent their transition may already have its components in other aspects of juvenile law. In particular, the law circumvents the traditional deference to parental consent in discrete contexts by allowing minors to consent to certain types of medical treatment.¹⁰⁵ Extending this framework to cover intersexed minors wishing to change genders would give them the authority to control a critical aspect of their identity.

This alone, however, might not fully protect the interests of an intersexed minor whose parents object to his or her intended social gender transition. A statutory provision that equates active parental interference with this transition with neglect could provide the necessary "teeth" to the consent provision, helping to ensure that parents who disapprove of their child's decision will, at the very least, not thwart it. This Part explains the basic components of most minor consent statutes and of many neglect laws and demonstrates how they could be adapted to this context.

A. *Prong 1: A Minor Consent Statute*

1. *General Definition and Purpose*

Minor consent statutes represent a limited departure from the principle that parents are empowered to make decisions on behalf of their children.¹⁰⁶ These laws fall into two general categories: statutes based on the *status* of the minor,¹⁰⁷ and statutes based on the *services*

¹⁰⁵ See *infra* Part III.B.3.

¹⁰⁶ See Part III, *infra*, for a discussion of the tradition of state deference to parental decisionmaking.

¹⁰⁷ Abigail English & Madlyn Morreale, *A Legal and Policy Framework for Adolescent Health Care: Past, Present, and Future*, 1 HOUS. J. HEALTH L. & POL'Y 63, 81 (2001) (giving examples of statutes covering "mature minors; legally emancipated minors; married minors; minors in the armed forces; minors living apart from their parents; minors over a certain age; high school graduates; pregnant minors; and minor parents"). For more infor-

the minor is seeking.¹⁰⁸ Laws in the second category, also called “condition specific consent provisions,”¹⁰⁹ “treat[] minors as adults for the [limited] purpose of consenting to particular kinds of treatments,”¹¹⁰ such as treatment for drug or alcohol abuse or sex-related health care.¹¹¹ The impetus for these statutes is typically a recognition that decisions like these implicate sensitive issues that can cause otherwise healthy family communication channels to break down, a problem that might cause minors to delay or to forego seeking much needed treatment.¹¹² Allowing minors to consent thus affords them the option of receiving treatment on a confidential basis. Minor consent statutes also vary across several other parameters: For example, some laws set a minimum age at which a minor can give consent, and others include an explicit requirement that the minor provide *informed* consent.¹¹³ The statutes also vary as to “whether notification of parents is *required, permitted, or prohibited* without the consent of the minor.”¹¹⁴

2. Application to the Intersex Context

a. “Treatment” Defined

It may be possible to draft a law allowing intersexed minors to seek and consent to professional assistance in choosing and completing a social gender transition.¹¹⁵ As an initial matter, it is impor-

mation on these laws, see ABIGAIL ENGLISH ET AL., *CTR. FOR CONTINUING EDUC. IN ADOLESCENT HEALTH, STATE MINOR CONSENT STATUTES* (1995).

¹⁰⁸ English & Morreale, *supra* note 107, at 81.

¹⁰⁹ Walter J. Wadlington, *Consent to Medical Care for Minors: The Legal Framework*, in *CHILDREN'S COMPETENCE TO CONSENT* 57, 61 (Gary B. Melton et al. eds., 1983).

¹¹⁰ Am. Bar Ass'n, Glossary of Terms, <http://www.abanet.org/publiced/youth/sia> (follow “Glossary” hyperlink) (last visited Mar. 7, 2007).

¹¹¹ English & Morreale, *supra* note 107, at 81–82. Other treatments often covered by this type of law include “emergency care; . . . diagnosis or treatment of reportable, infectious, contagious, or communicable diseases; HIV/AIDS testing and/or treatment; . . . collection of medical evidence or treatment for sexual assault; or outpatient mental health services.” *Id.*

¹¹² Wadlington, *supra* note 109, at 61–62; *see also* Walter Wadlington, *Medical Decision Making for and by Children: Tensions Between Parent, State, and Child*, 1994 U. ILL. L. REV. 311, 324 (explaining that minor consent laws apply in situations where, “[i]f minors could not personally consent to treatment, they might not obtain medical care—to the detriment of themselves, their families, and society”).

¹¹³ English & Morreale, *supra* note 107, at 82.

¹¹⁴ *Id.* (emphasis added).

¹¹⁵ As discussed in note 12, *supra*, a social gender transition enables an intersexed minor to change the outward presentation of his or her gender identity.

Drafting a statute that bases the ability to consent not on the minor's status as an intersexed child but on the services the minor seeks makes sense, for, unlike legally emancipated or married minors, *see supra* note 107, intersexed minors are typically under the same degree of parental control and supervision as the majority of minors. Using a treat-

tant to clarify that while I occasionally refer to these services as “treatment,” I am not implying that an intersexed minor wishing to change his or her gender is in any way physically or mentally ill.¹¹⁶ This terminology only reflects the fact, recognized by groups like the ISNA,¹¹⁷ that an intersexed child considering a gender transition will benefit from the support and assistance of people with expertise in intersex matters. Therefore, the “treatment” I envision would allow an intersexed minor to discuss his or her gender identity with a therapist or counselor with training in intersex issues,¹¹⁸ decide whether a social gender transition is the best option, and receive assistance in completing the transition.

ment-based law instead of a status-based law also has a significant instrumental function: It would be impossible to use neglect law as an enforcement mechanism, *see infra* Part II.B, if intersexed minors were declared “mature minors.” *Cf. In re E.G.*, 549 N.E.2d 322, 328 (Ill. 1989) (noting that finding of neglect is improper if child has mature minor status).

¹¹⁶ As Doctors Beh and Diamond have noted in their opposition to the term “disorders of sex development,” “medical labels have a power that transcends medical treatment. . . . [T]he labels assigned to persons born today with sexual characteristics outside statistical norms can become static symbols of their inferiority that they might shoulder for a lifetime.” Beh & Diamond, *supra* note 25. Intersexed minors may exhibit some negative psychological symptoms if they feel that they are caught in a gender role with which they do not identify. For example, “[a] child who feels he or she is labeled incorrectly may feel misunderstood or confused.” HANDBOOK FOR PARENTS, *supra* note 11, at 58; *see also* Alexander, *supra* note 61 (identifying “psychological sequelae” that can result from surgical treatment of intersex). But this alone does not amount to having a mental illness.

In contrast, the Diagnostic & Statistical Manual of Mental Disorders (DSM-IV-TR) identifies Gender Identity Disorder (GID) as predicated on “[a] strong and persistent cross-gender identification.” AM. PSYCHOL. ASS’N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 581 (4th ed., text rev., 2001). The general form of GID does not apply to individuals with a physical intersex condition, but a variant—“Gender Identity Disorder Not Otherwise Specified”—does. *Id.* at 581–82. However, at least one psychologist specializing in gender identity issues argues that discomfort with one’s assigned gender is not a sign of mental illness per se, and that “a child’s own insistence regarding gender expression ought to be taken at its obvious face value, that is, as an indication that the child has at least in part the gender identity of the sex opposite to that assign[ed] at birth.” Anne Vitale, Notes on Gender Role Transition: Rethinking the Gender Identity Disorder Terminology in the Diagnostic Manual of Mental Disorders IV, Apr. 7, 2005, <http://www.avitale.com/hbigdataalkplus2005.htm>. Others have advocated rethinking the GID definition altogether, arguing, among other things, that it punishes people for not conforming to gender stereotypes by labeling them mentally ill. *See* Elvia R. Arriola, *The Penalties for Puppy Love: Institutionalized Violence Against Gay, Lesbian, and Transgendered Youth*, 1 J. GENDER, RACE & JUST. 429, 463–65 (1998).

¹¹⁷ *See supra* note 99 and accompanying text.

¹¹⁸ If the child is involved in a long term treatment program, *see supra* note 77 and accompanying text, he or she could consult with his or her regular therapist. In the case of a child who does not regularly consult with a therapist and seeks assistance from, for example, a school counselor, the counselor could enlist the help of someone with expertise in intersex issues.

b. Competence to Consent

The legal system generally assumes that minors are not competent to make important decisions for themselves, and it therefore authorizes parents to make decisions on their behalf.¹¹⁹ Minor consent laws are an exception to this pattern. These laws reflect legislatures' willingness to regard a minor as competent to consent to certain medical treatments, unless it is evident that the minor lacks "an understanding and appreciation of the nature and consequences of treatment alternatives."¹²⁰

The proposed statutory framework would presume that intersexed minors are competent to consent to both preliminary counseling and to assistance with a social gender transition, as long as they demonstrate an understanding of the nature and consequences of their treatment options.¹²¹ As a protective mechanism, however, this presumption would be rebuttable: A finding of valid consent to transition may be improper, for example, if the care provider determines that the child's declaration of a different gender identity is inconsistent,¹²² or if the child suffers from a separate condition that is cur-

¹¹⁹ See, e.g., Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 704 (1993) ("Most children, even in adolescence, simply are not able to make sound judgments . . . including their need for medical care or treatment. Parents can and must make those judgments." (quoting *Parham v. J.R.*, 442 U.S. 584, 603 (1979))); Wadlington, *supra* note 112, at 314 (noting historical presumption of children's incompetence in medical decisionmaking and contract law).

¹²⁰ Redding, *supra* note 119, at 711.

¹²¹ Again, some states set an age floor that serves as a proxy for competence to consent. See *supra* note 113 and accompanying text; Redding, *supra* note 119, at 712 ("Age of consent laws . . . simply stipulate a certain age requirement, usually twelve to fifteen, for minors to give legal consent."). Merely setting a minimum age requirement for consent would be inappropriate in this context, however, for it would ignore the fact that gender identity can develop at different ages for different children. See *supra* note 15.

¹²² Psychologists do not interpret every instance of (stereotypically) "girlish" behavior by an intersexed child raised male or "boyish" behavior by one raised female as an indication that the child wants or needs to transition. See HANDBOOK FOR PARENTS, *supra* note 11, at 57 (reassuring parents that "[a]lmost all children occasionally show interests that seem to be typical to the 'opposite sex'"). However, "occasionally" a child's gender identification is explicit and unequivocal. *Id.* at 57-58 ("When [gender identification] happens, it is often pretty clear; a child may announce in a very strong way 'I'm a boy!' or 'I'm a girl!' and suggest a new name by which he or she wants to be called."). Treatment should include repeated interviews with the child in order to assess the strength and frequency of the child's demand for gender transition so as not to act prematurely and improperly impose a gender change upon the child. Cf. Redding, *supra* note 119, at 747 (advising in context of mental health care that "it is worthwhile to ensure that the child's decision is not simply a transient one by asking the child about his or her choice at various points in time").

rently impeding his or her clarity of thought.¹²³ The presence of a mental illness, however, should not automatically trigger a finding that the minor is not competent to consent: “Only delusions related to treatment decisionmaking are relevant for informed consent purposes.”¹²⁴ Ultimately, this statutory framework could strike an appropriate balance between the need to respect a child’s autonomy and the need to protect the child by ensuring that gender role change will not be initiated if the child’s desire for it appears inconsistent, or if the child does not appear competent to give meaningful consent.

c. Confidentiality

Minor consent laws often cover situations in which the minor seeks to resolve a problem by receiving a finite amount of treatment—for example, terminating a pregnancy or treating a sexually transmitted disease. Once the treatment ends, the parents will likely be unable to determine that anything is different.¹²⁵ In these situations, implementing an absolute confidentiality requirement is relatively simple and serves an important purpose.¹²⁶

In contrast, a social gender transition involves a permanent and public change to multiple aspects of the person, including one’s outward appearance and (often) first name. This change cannot (because it is so readily apparent) and should not (because a full transition would involve living in the new gender role at home, as well) be hidden from the child’s parents. How, then, are we to balance the child’s need for privacy with the importance of parental involvement?

¹²³ Cf. Redding, *supra* note 119, at 711 (“[I]t is generally recognized that competency includes at least a factual understanding of the illness and treatment alternatives, including their risks and benefits, and the capacity for rational decisionmaking.”). Again, in the intersex context, it is critical to distinguish between feelings of distress that may result from the rejection of one’s gender of assignment and symptoms of a mental disorder that are completely independent of the child’s gender identity. When determining whether a child suffers from a mental disorder, reliance on the latter, but not the former, should be permitted. A system that circularly instructed care providers to find a child incompetent to consent to transition because the child was dissatisfied with his or her assigned gender would be both absurd and unjust.

¹²⁴ *Id.* at 749. Several courts have held that mental illness is not a *per se* indication of incompetence. *Id.* at 747 & n.313 (citing *Rogers v. Okin*, 634 F.2d 650, 658–59 (1st Cir. 1980)); *Boyd v. Bd. of Registrars of Voters*, 334 N.E.2d 629, 632 (Mass. 1975) (drawing “profound” distinction between commitment and incompetence)).

¹²⁵ I do not mean to devalue the seriousness of medical procedures like abortion or treatment for sexually transmitted diseases. Indeed, these experiences can have a profound effect on any person’s life. I only mean that they are procedures of a more limited duration than a social gender transition and are less outwardly apparent.

¹²⁶ Cf. *supra* text accompanying notes 112–13 (explaining that lack of confidentiality might deter minors from seeking treatment).

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I propose a confidentiality requirement that wanes as the child's treatment progresses. The confidentiality requirement in the early stages should be absolute: When the minor has only consulted with a psychiatrist or psychologist about his or her preliminary feelings about the transition, the care provider should be prohibited from disclosing the fact or content of these discussions to the parents without the child's consent.¹²⁷ Because a complete social gender transition would require the minor ultimately to disclose the transition to his or her parents,¹²⁸ however, the statute should permit care providers to require the minor, once he or she has decided to transition, to inform his or her parents,¹²⁹ so long as doing so would pose no threat to the minor's safety.¹³⁰

B. Prong 2: Neglect Provision for Parental Interference with Social Gender Transition

Ideally, the parents of a child who has consented to assistance with a change of gender will accept the child's decision and offer support in whatever way is recommended by the child's doctors. When parents object to and try to prevent the minor from transitioning, however, some mechanism is needed to ensure that the child can actually obtain the treatment to which he or she has consented. An appropriate statute must respond to the fact that, because children are "always in some form of custody,"¹³¹ parents can stifle their attempts

¹²⁷ Under this provision, the care provider could still suggest to the minor that he or she invite the parents to the discussions if the care provider believes it would be beneficial. The minor, however, would retain absolute authority to reject the suggestion.

¹²⁸ The transgenderism literature calls the gender transition "the real-life experience," which it defines as "[t]he act of fully adopting a new or evolving gender role or gender presentation in everyday life." *STANDARDS OF CARE*, *supra* note 12, at 17. The real-life experience requires the individual to confront "the familial, vocational, interpersonal, educational, economic, and legal consequences" of a change in gender identity. *Id.* It also "tests the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports." *Id.* at 18. A similar step would likely be equally critical in the treatment of an intersexed minor wishing to change gender.

¹²⁹ Of course, the care provider should inform the minor during preliminary discussions that transition would require disclosure of the minor's new identity to the parents, as it may become a factor in the minor's decision whether to begin the transition at that point in time.

¹³⁰ *See Ayotte v. Planned Parenthood of N. New Eng.*, 126 S. Ct. 961, 966 & n.2 (2006) (explaining longstanding validity of parental notification laws in abortion context but noting that some limits are necessary in part because of risk that parental notification would provoke violent reaction and abuse (citing *Hodgson v. Minnesota*, 497 U.S. 417 (1990))).

¹³¹ *Schall v. Martin*, 467 U.S. 253, 265 (1984).

to do almost anything.¹³² Otherwise, a minor consent law would be little more than an empty promise.

A neglect provision that targets parental interference with a social gender transition could help ensure the child's ability to consent. One might first attempt to protect intersexed children under current statutes, adopted in many states, that allow courts to find neglect when the parents fail to act in the "best interests" of the child.¹³³ Such an approach would require a court to determine whether parental refusal to recognize a child's rejection of the gender of assignment was in the child's best interests. However, this approach is problematic.¹³⁴ First, the vagueness of the term "best interests" provides too little guidance to parents and leaves room for the exercise of too much judicial discretion.¹³⁵ Determination of whether a gender change is in the child's best interests could often turn on the sympathies or biases of the judge in question. Second, the best interests statute would fail to promote the child's autonomy. It would remove the authority to make a gender transition from the child and instead require a judge to decide which gender role best suits the child.¹³⁶

¹³² Cf. Elizabeth J. Sher, Note, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157, 200–01 (1983) (noting that for "nonphysical disorders," "[a] home environment hostile to the child's treatment may prevent any improvement in the child's health").

¹³³ See, e.g., ALASKA STAT. §§ 47.10.011(9), 47.10.088(b) (2006) (allowing termination of parental rights where parent has neglected child and failed to remedy this neglect); ARIZ. REV. STAT. ANN. § 8-533(B) (1999) (allowing termination of parental rights where parent has neglected or willfully abused child); B.R.M. v. State Dep't of Human Res., 626 So. 2d 646, 647 (Ala. Civ. App. 1993) (upholding trial court decision that termination of parental rights was in best interests of children where parents were unable to care for them).

¹³⁴ For another criticism of the best interests standard in the intersex context, see Julie Cole, Androgen Insensitivity Syndrome Support Group Austl., Legal Issues, http://home.vicnet.net.au/~aissg/legal_issues.htm (last visited Mar. 9, 2007).

¹³⁵ For example, judges have used the term "best interests" to justify the removal of children from otherwise fit parents who do not conform to societal expectations. See *Painter v. Bannister*, 140 N.W.2d 152, 153–54 (Iowa 1966) (concluding that child should remain with "conventional" grandparents rather than reside with "bohemian" father); *Bottoms v. Bottoms*, 457 S.E.2d 102, 108 (Va. 1995) (upholding removal of child from custody of lesbian mother on ground that mother would not "subordinate her own desires" to needs of child). For an argument against the operation of transgender status as a per se bar against child custody, see Helen Y. Chang, *My Father Is a Woman, Oh No!: The Failure of the Courts to Uphold Individual Substantive Due Process Rights for Transgender Parents Under the Guise of the Best Interest of the Child*, 43 SANTA CLARA L. REV. 649 (2003).

¹³⁶ Even if the court determines that a change in sex or gender is in the child's best interests, it may do so for the wrong reasons. Jenni Millbank discusses the influence of cultural biases and stereotypical conceptions of sex, sexuality, and gender in an Australian case where the family court approved a mother's petition to seek reassignment surgery for her daughter (called "A" in the opinion):

In the judgment, A's sexual attraction to girls was regarded as an indication of her psychological state and 'completely male' outlook. . . . [But] A's sexual orientation could just have clearly suggested that A was not a young man, but

In contrast to the best interests approach, some state child neglect statutes define neglect in terms of the effects of parental actions on a child's well-being. In New York, for example, a "neglected child" is defined as one "whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent . . . to exercise a minimum degree of care."¹³⁷ Courts interpreting the statute have also required parents to "be aware of, and to act in accordance with, [their] child's particular needs."¹³⁸ The advantages of the statute (as judicially interpreted) include its imposition of a parental duty to provide due care for the child, its recognition that causing or failing to prevent mental and emotional harm is neglect, and its creation of opportunities for individual assessment of each child's situation. Using a specifically worded definition of neglect is preferable to the vague best interests approach because it directs the court's focus to the harm resulting from the parents' actions, rather than inviting a third-party determination of what gender is "right" or "best" for the child.

I propose coupling the minor consent provision outlined above with a neglect provision explicitly identifying parents' refusal to allow the social gender transition of an intersexed child as a failure to exercise due care to prevent physical, emotional, and mental harm to the child, in light of the child's particular needs. A court could, if need be, declare the child neglected on these grounds. The court could then enjoin the parents from interfering with the child's gender transition.¹³⁹

rather that she was a young lesbian. . . . It is possible that all concerned looked at lesbianism in A and saw masculinity instead, because masculinity is what they most expected to see.

Jenni Millbank, *When Is a Girl a Boy?* Re A (A Child), 9 AUSTL. J. FAM. L. 173, 177-78 (1995).

¹³⁷ N.Y. JUD. CT. ACTS LAW § 1012(f)(i) (McKinney 1999 & Supp. 2006); see also Karolyn Ann Hicks, Comment, "Reparative" Therapy: Whether Parental Attempts To Change a Child's Sexual Orientation Can Legally Constitute Child Abuse, 49 AM. U. L. REV. 505, 521 & n.77 (1999) (describing New York statute and its application by courts). At least one other statute contains similar language. MINN. STAT. ANN. § 260C.301(b)(2) (West 2003) (allowing juvenile court to terminate parental rights upon finding that parent "has substantially, continuously, or repeatedly refused or neglected to comply with the duties imposed upon that parent by the parent and child relationship, including . . . [providing the] care and control necessary for the child's physical, mental, or emotional health and development").

¹³⁸ Hicks, *supra* note 137, at 544 & n.241 (citing opinions that "charg[e] parents with the duty of recognizing their child's special needs").

¹³⁹ In other words, a first-time finding of neglect in these circumstances would not result in the removal of the child or termination of parental rights. See Sher, *supra* note 132, at 202 ("[C]ourts should act on the assumption that parents would . . . still wish to continue in their parental roles. . . . The important step, then, is to ensure that the family unit is preserved whenever possible and that the state is granted only sufficient authority to effect the

Just as the neglect provision reinforces the consent prong by providing an enforcement mechanism when necessary, the consent provision, by establishing the child as the decisionmaker, makes the neglect prong easier to apply. A generalized affirmative parental duty to protect children's well-being, standing alone, may not provide sufficient protection for intersexed children in a cultural climate hostile to non-traditional conceptions of sex and gender. The New York statute, for example, is vulnerable to conflicting interpretations based on the social and cultural climate.¹⁴⁰ We could avoid a similarly subjective result in the intersex context because the minor consent prong of the law would specifically require deference to the intersexed child's gender identification. In other words, even if a judge were predisposed¹⁴¹ to conclude that parental resistance to the child's desire to make a social gender transition complies with the parental duty of care, the statutory language of the consent provision would preclude the judge from implementing that belief in her ruling.

III

THE CONSTITUTIONALITY OF THE PROPOSED STATUTE

Crafting a statute to protect the decisions of intersexed children regarding their gender identity will do little good if that statute cannot pass constitutional muster. While the approach I propose has the admittedly controversial effect of removing decisionmaking authority in this arena from parents and investing it in children, it does not violate Supreme Court precedent. Historically, the Court has given parents considerable latitude to raise their children, but there are some contexts in which the Court allows greater state intervention in family affairs.

Although the Supreme Court has occasionally spoken in dicta about "parental rights" in sweeping language, close analysis of key cases reveals that parental prerogatives are in fact limited: Parents

court decision without parental interference."); *see also* CAL. WELF. & INST. CODE § 360(b)–(c) (West 1998) (allowing court, instead of removing child from parental custody, to place parent or guardian under supervision for probationary period, and allowing supervising social worker to file additional petition if he or she finds that "the family subsequently is unable or unwilling to cooperate with the services being provided").

¹⁴⁰ *See generally* Hicks, *supra* note 137 (assessing New York statute's ability to protect interests of lesbian, gay, bisexual, and transgender youths whose parents enroll them in "reparative" therapy programs in order to "cure" them of their nonconforming behavior). Hicks concludes that "[w]hether a court or legislature would ever extend protection to juveniles subjected to 'reparative' therapy may turn in part on the jurisdiction and community in which the juvenile resides." *Id.* at 543.

¹⁴¹ This predisposition could result from culturally instilled bias or a reliance on gender stereotypes. *See supra* notes 50–51 and accompanying text.

are not always presumed to act in their children's best interests,¹⁴² and the Court abandons its deferential stance when treatment implicates sensitive interests and cannot be postponed without causing harm to the child. The persisting pattern of secrecy, shame, and coercion in the treatment and rearing of intersexed children rebuts the presumption that parents will act in an intersexed child's best interests. Furthermore, issues of gender identification implicate uniquely private concerns, and a delay in treatment could cause harm to the child. These factors justify the proposed statutory departure from the general tradition of deference to parental decisionmaking authority.

A. *Early Cases: Protection of Parental Authority*

Meyer v. Nebraska,¹⁴³ *Pierce v. Society of Sisters*,¹⁴⁴ and *Wisconsin v. Yoder*¹⁴⁵ laid the foundation for the debate regarding the interconnected—and sometimes conflicting—rights of parents, their children, and the state. In each of these cases, the Court struck down state laws because they intruded on family decisionmaking. The *Meyer* Court, in striking down a law prohibiting the teaching of foreign languages to children below the eighth grade, mentioned several interests unconstitutionally infringed upon by the statute at issue, including the right of children to acquire knowledge and the right of parents to control their children's education.¹⁴⁶ In *Yoder*, a group of Amish parents challenged a law that required all children between the ages of seven and sixteen to attend school¹⁴⁷ because, in accordance with Amish beliefs, children left school after the eighth grade to work within their own community.¹⁴⁸ The plaintiffs argued that the law infringed on their rights under the First and Fourteenth Amendments.¹⁴⁹ When invalidating the law, the *Yoder* Court stated that its primary concern was not the children's ability to receive the education of their choice, but the parents' interest in the upbringing of their children.¹⁵⁰

¹⁴² Note that the term "best interests" as discussed in Part III refers to terminology used by the Supreme Court and does not necessarily have the same meaning as the "best interests" statutes used in Part II, *supra*.

¹⁴³ 262 U.S. 390 (1923).

¹⁴⁴ 268 U.S. 510 (1925) (striking down law requiring all children between ages eight and sixteen to attend public schools).

¹⁴⁵ 406 U.S. 205 (1972).

¹⁴⁶ *Meyer*, 262 U.S. at 400–01. The *Pierce* Court relied on the same parental interest to justify its decision. *Pierce*, 268 U.S. at 534–35 (citing *Meyer*, 262 U.S. 390).

¹⁴⁷ *Yoder*, 406 U.S. at 207 n.2 (quoting Wis. STAT. § 118.15 (1969)).

¹⁴⁸ *Id.* at 210–11.

¹⁴⁹ *Id.* at 208–09.

¹⁵⁰ *Id.* at 213–14. Justice Stewart (joined by Justice Brennan) argued that a focus on parental liberty was warranted because the statute at issue imposed penalties on the par-

In these cases, the Court spoke in broad terms of parents' authority over their children. Justice McReynolds, writing for the majority in *Meyer*, warned of the dangers of a Platonic state,¹⁵¹ and in *Yoder*, Chief Justice Burger called "[the] primary role of the parents in the upbringing of their children . . . an enduring American tradition."¹⁵² If we look beyond the rhetoric, however, to reach the substance of the decisions, these early cases reflect not a categorical showing of deference to parental prerogatives but rather an open principle that parental autonomy in "childrearing decisions concerning education, religion, and morality"¹⁵³ is subject to limitation in appropriate circumstances.¹⁵⁴

Supreme Court precedent regarding the enigmatic "right to privacy" also contains broad statements about parental authority: *Loving v. Virginia*,¹⁵⁵ *Griswold v. Connecticut*,¹⁵⁶ and *Roe v. Wade*¹⁵⁷ all rest on the Court's recognition of a fundamental right to privacy that includes some degree of autonomy over family affairs. As one commentator has noted, however, "the decisions to marry and to have children" are "separate and distinct from the issue of parental autonomy in childrearing."¹⁵⁸ Therefore, while these cases acknowledge that important rights in the arena of family life *exist*, they do not fully explain the *scope* of these rights.

B. Limitations on Parental Prerogatives

Although it appears to have established a default principle of deference to parental decisionmaking authority, the Court has in certain circumstances upheld state interference with parents' rights in order to protect children's interests. Judicial exceptions to the pattern of

ents, not the children. *Id.* at 237 (Stewart, J., concurring). Justice Stewart also explicitly declined to consider what would happen if a child opposed her parents' decision regarding her education. *Id.*; see also *id.* at 246 (Douglas, J., dissenting) ("The views of the two children in question were not canvassed by the Wisconsin courts.").

¹⁵¹ *Meyer*, 262 U.S. at 401–02 (noting that "common" childrearing would "do [] violence to both letter and spirit of the Constitution").

¹⁵² *Yoder*, 406 U.S. at 232.

¹⁵³ Sher, *supra* note 132, at 175–76.

¹⁵⁴ *Id.* The *Pierce* and *Yoder* opinions themselves suggest the possibility for state intervention in parental decisions. In addressing the parents' free exercise claims, the Court noted that state interests must sometimes give way to "the traditional interest of parents with respect to the religious upbringing of their children *so long as [parents] . . . 'prepare [children] for additional obligations.'*" *Yoder*, 406 U.S. at 214 (quoting *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925)) (emphasis added).

¹⁵⁵ 388 U.S. 1 (1967) (striking down law preventing marriage on basis of race).

¹⁵⁶ 381 U.S. 479 (1965) (striking down law prohibiting distribution of contraceptives to married couples).

¹⁵⁷ 410 U.S. 113 (1973) (striking down state abortion ban).

¹⁵⁸ Sher, *supra* note 132, at 179.

deference began with *Prince v. Massachusetts*,¹⁵⁹ where the Court upheld a child labor law used to penalize a guardian for allowing a minor to sell religious literature in the street.¹⁶⁰ In *Prince*, the majority justified state intervention based on a broader characterization of the state's interest in children. According to the *Prince* Court, the state has an interest not only in the cultivation of good citizens but in the protection of the welfare of children.¹⁶¹ The majority's couching of the state interest in these terms allows it to curtail parental rights when necessary to protect children. *Prince* essentially establishes harm as a limiting principle on the broad language of *Meyer*, *Pierce*, and *Yoder*: To the extent that parental choices cause harm to a child, they do not receive constitutional protection.

1. Parental Decisionmaking in "Medical Neglect" Cases

In the wake of *Prince*, application of the harm (or avoidance of harm) principle has not always been clear or consistent. For example, when the issue of whether, when, or how to allow a child access to medical care arises, courts have differed in the extent to which they allow parental control over decisionmaking. In most cases, the risk and invasiveness of the proposed treatment and the likelihood of death¹⁶² or impairment if the child remains untreated appear to be relevant factors. But, while many courts agree that parents have an affirmative duty to provide medical care for their children, they differ in the degree to which they will allow the state to enforce that duty. Thus, the extent of permissible parental control depends on factors such as the medical condition at issue, the type of treatment chosen and/or refused by the parent, and the language of the state's neglect statutes.¹⁶³

¹⁵⁹ 321 U.S. 158 (1944).

¹⁶⁰ *Id.* at 160–62.

¹⁶¹ *Id.* at 165.

¹⁶² See, e.g., *Custody of a Minor*, 379 N.E.2d 1053, 1055–56, 1062 (Mass. 1978) (upholding order mandating chemotherapy for infant over parental objection); *In re Sampson*, 317 N.Y.S.2d 641, 643–46 (N.Y. Fam. Ct. 1970) (considering refusal of mother, who was practicing Jehovah's Witness, to allow blood transfusion that was prerequisite for surgery to correct son's facial deformity).

¹⁶³ Compare *Custody of a Minor*, 379 N.E.2d at 1063 (noting that parents lack "life and death authority over their children" and allowing removal of child from parental custody on showing that parents are unwilling to provide child with necessary and proper physical care), and *Sampson*, 317 N.Y.S.2d at 652 (overriding mother's refusal to consent to transfusion and remarking that state has "paramount duty to insure his right to live and grow up without disfigurement—the right to live and grow up with a sound mind in a sound body"), with *In re Hofbauer*, 393 N.E.2d 1009, 1014 (N.Y. 1979) (concluding that parents' choice of nutritional and metabolic therapy for child instead of chemotherapy does not constitute neglect because of reversible nature of decision, physician's approval of alternative treatment, and parents' concerns about side effects of chemotherapy).

2. *Parental Authority in the Commitment Context*

The Supreme Court has allowed deference—but not *absolute* deference—to parental decisions regarding children’s medical treatment in the context of commitment for mental health treatment. In *Parham v. J.R.*,¹⁶⁴ the Court upheld a Georgia statute allowing parents to seek commitment of a child over the child’s objection without a prior adversary proceeding. When discussing the parental interest at stake, the Court referred to the “Western civilization concepts of the family as a unit with broad parental authority over minor children.”¹⁶⁵ The Court also relied on its faith that the family’s “natural bonds of affection lead parents to act in the best interests of their children”¹⁶⁶ and on the child’s general inability to make “sound judgments” regarding his own medical care,¹⁶⁷ ultimately concluding that parents’ “maturity, experience, and capacity for judgment” justified delegation of decisionmaking authority to them.¹⁶⁸ Finally, the Court remarked that the child’s discontent with the parents’ decision “does not diminish the parents’ authority to decide what is best for the child.”¹⁶⁹

The *Parham* Court, however, repeatedly noted that “parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized.”¹⁷⁰ It cited *Yoder* and *Prince* for the proposition that the state could restrict parental authority “when [the child’s] physical or mental health is jeopardized.”¹⁷¹ Therefore, even though the Court noted that the “presumption that the parents act in the best interests of their child should apply” in the commitment context, it did not vest parents with unlimited authority to seek commitment.¹⁷² Instead, it tempered parents’ decisionmaking authority by requiring “a physician’s independent examination and medical judgment” of whether the child requires commitment.¹⁷³ Thus, even in a context in which the Court has found the best interests presumption to apply, it has interposed the judgment of an independent evaluator in order to safeguard the child’s liberty interest and to avoid the “adverse social consequences for the child

¹⁶⁴ 442 U.S. 584 (1979).

¹⁶⁵ *Id.* at 602.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* at 603.

¹⁶⁸ *Id.* at 602.

¹⁶⁹ *Id.* at 604.

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 603.

¹⁷² *Id.* at 604.

¹⁷³ *Id.*

because of the reaction of some to the discovery that the child has received psychiatric care.”¹⁷⁴

3. *Minors' Right to Sex-Related Medical Care*

The Court has definitively departed from its pattern of strong protection of parental authority in the area of sex-related medical care, particularly abortion. In *Planned Parenthood v. Danforth*,¹⁷⁵ the Court held that states cannot require parental consent in order for a minor to obtain an abortion.¹⁷⁶ Later, in *Bellotti v. Baird*,¹⁷⁷ the Court restated its position that children are unable to make critical decisions,¹⁷⁸ that parents have a naturally inhering liberty interest in directing their children's upbringing, and that parents have primary authority in raising, caring for, and nurturing their children.¹⁷⁹ Nevertheless, the Court emphasized the “unique”¹⁸⁰ and sensitive nature of the abortion decision, and again refused to give parents an absolute veto in this decision by requiring the state to provide an alternative procedure through which a minor could receive an abortion without her parent's consent.¹⁸¹

¹⁷⁴ *Id.* at 600.

¹⁷⁵ 428 U.S. 52 (1976).

¹⁷⁶ *Id.* at 74–75 (holding that state lacks constitutional authority to give third party “an absolute, and possibly arbitrary, veto” over minor's decision regarding abortion).

¹⁷⁷ 443 U.S. 622 (1979).

¹⁷⁸ More recently, when considering the constitutionality of the juvenile death penalty, the Court noted juveniles' “lack of maturity” and “underdeveloped sense of responsibility.” *Roper v. Simmons*, 543 U.S. 551, 668–69 (2005) (concluding that these traits often lead to “impetuous and ill-considered actions and decisions” (quoting *Johnson v. Texas*, 509 U.S. 350, 367 (1993))). This observation, however, does not undercut the argument for protecting and enforcing a child's declaration of his or her gender. First, the *Bellotti* Court recognized that some decisions implicate interests so uniquely private that parents cannot have absolute discretion over them, despite the risks posed by the child's relative lack of maturity. See *infra* text accompanying notes 180–81. The decision to commit a crime is vastly different from the realization that one identifies as a different gender, and the decision to complete a social gender transition is more analogous to the decision to obtain sex-related medical care or terminate a pregnancy. Second, the relative immaturity of juveniles was not the only—or even the main—factor on which the Court relied when deciding that capital punishment for minors violated the Eighth Amendment. It also considered the lack of a “national consensus in favor of capital punishment for juveniles.” *Roper*, 543 U.S. at 564–67, the international opposition to such punishment, *id.* at 577–78, juveniles' vulnerability to peer pressure, *id.* at 569, and the fact that a minor's “character” is not as completely formed as an adult's, see *id.* at 570 (“The personality traits of juveniles are more transitory, less fixed.”). If anything, the final observation supports the idea that an intersexed child's gender identity may evolve to be different than his or her gender of assignment.

¹⁷⁹ *Bellotti*, 443 U.S. at 635–38.

¹⁸⁰ *Id.* at 642.

¹⁸¹ *Id.* at 647–48; see also *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 439–40 (1983) (striking down statute prohibiting abortion on minors under age fifteen

Two other aspects of the *Danforth* and *Bellotti* decisions deserve mention. First, the *Danforth* opinion explicitly rejected the argument that refusing to allow parents to veto their child's decision regarding abortion would run contrary to the state interest in "the safeguarding of the family unit and of parental authority."¹⁸² The Court explained that "where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure," giving parents absolute authority over the abortion decision would neither "enhance parental authority" nor "strengthen the family unit."¹⁸³ Second, *Bellotti* explained that requiring parental consent is inappropriate when the decision at issue is one that cannot be postponed until the minor reaches the age of majority: "[A] minor not permitted to marry before the age of majority is required simply to postpone her decision," but "[a] pregnant adolescent . . . cannot preserve for long the possibility of aborting."¹⁸⁴

C. Judicial Deference to Parental Authority in the Context of Social Gender Transitions

Ultimately, the risks inherent in the situation of an intersexed child wishing to transition genders distinguish it from *Parham* and make it more similar to abortion and other sex-related medical care. From the time an intersexed child is born, parents are often pressured, either by doctors or their own fears, to consent to surgical alterations that at least one government agency has found to be human rights abuses.¹⁸⁵ This, combined with evidence of the secretive and coercive environment in which many intersexed children have been raised, belies the *Parham* Court's presumption that parents are acting in their children's best interests.

Indeed, the Constitutional Court of Colombia reached exactly this conclusion in a recent case regarding parents' ability to consent to surgery for intersexed children.¹⁸⁶ The court determined that while parents are generally assumed to act in their children's best interests,

absent parental consent or court order because statute did not expressly create alternative bypass procedure).

¹⁸² *Planned Parenthood v. Danforth*, 428 U.S. 52, 75 (1976).

¹⁸³ *Id.*; see also *Parham v. J.R.*, 442 U.S. 584, 625, 631 (1979) (Brennan, J., dissenting) ("Notions of parental authority and family autonomy cannot stand as absolute and invariable barriers to the assertion of constitutional rights by children.").

¹⁸⁴ *Bellotti*, 443 U.S. at 642.

¹⁸⁵ See *supra* notes 63–64 and accompanying text.

¹⁸⁶ See Julie A. Greenberg & Cheryl Chase, *Intersex Society of North America, Colombia's Highest Court Restricts Surgery on Intersex Children: Background of Colombia Decisions*, <http://www.isna.org/node/21> (last visited Mar. 9, 2007).

the parents of intersexed children “are likely to make decisions based upon their own fears and concerns rather than what is best for the child, especially if they are pressed to decide quickly.”¹⁸⁷ The court also held that parents cannot consent to genital surgery for children over the age of five, “because the child has achieved an autonomy that must be respected, and because the child has already developed a gender identity, which reduces the urgency of a decision as well as any potential benefits of surgery.”¹⁸⁸ Whether or not parents consent to genital surgery during infancy, intersexed children are frequently raised in accordance with a treatment paradigm that is grounded in secrecy about their condition and has as its goal the imposition of a consistent gender identity.¹⁸⁹ Some parents obstruct children’s expressions of a different gender identity, and some even resort to physical violence.¹⁹⁰

Finally, even though some parents and doctors make every effort to further the child’s interests, the gender of assignment amounts to little more than a prediction of how the child will identify later in life. This suggests that the child’s view should receive significantly more weight than that of the parents. In the commitment context, *Parham* gave judicial deference to parental decisions over the child’s objection, but only when a treating physician had actually diagnosed the child as mentally ill.¹⁹¹ In contrast, there is no indication that the average intersexed child suffers from any mental illness.¹⁹²

Ultimately, the plight of an intersexed child seeking assistance with a social gender transition is much like the dilemma of a minor seeking sex-related medical care. The sensitive nature of the situation creates the risk of a breakdown in family communication. The fear of parental anger or rejection might deter the child from seeking treatment, or the parents might try to obstruct the minor’s efforts. A social gender transition is also similar to an abortion in that it cannot realis-

¹⁸⁷ *Id.* The court also established “a new category of consent, ‘qualified, persistent informed consent,’” to ensure that parents act only in their child’s interest. *Id.* Anne Tamar-Mattis has made an argument similar to that of the Colombian court:

[T]he claim [frequently made by doctors wanting to perform early surgery] that the parent will be too alienated from the intersex child for normal parental attachment to occur undermines the premise on which parental authority to consent is founded: that the parent is best positioned to understand the needs and interests of the child.

Tamar-Mattis, *supra* note 23, at 89–90.

¹⁸⁸ *Id.*; see also Hughes et al., *supra* note 15, at 563 (explaining Colombian court’s decision).

¹⁸⁹ See *supra* notes 69–71 and accompanying text.

¹⁹⁰ See *supra* notes 101–02 and accompanying text.

¹⁹¹ See *supra* text accompanying notes 170–74.

¹⁹² See *supra* note 116.

tically be postponed.¹⁹³ This is not a precise comparison: Unlike the abortion context, the passage of time does not make a gender transition literally impossible. Nevertheless, each day of forced rearing in an assigned gender role with which one does not identify can inflict severe psychological harm on a child, harm that the state has a strong interest in preventing.¹⁹⁴ Exercise of parental authority in this context thus triggers the harm principle set forth in *Prince* and falls outside the realm of constitutionally protected decisionmaking.¹⁹⁵

The confidentiality and neglect provisions of the proposed statute—protective mechanisms which reflect the extent of the conflict that can occur between parents and their intersexed child—also find justification under Supreme Court precedent. In *Bellotti*, the Court noted the inherent vulnerability of pregnant minors—“especially those living at home”—whose parents could try to “obstruct both an abortion and their access to court.”¹⁹⁶ Therefore, although it had “no reason to believe” that a majority of parents would go to such lengths to prevent an abortion, the Court concluded that it would be “unrealistic” to think that “the mere existence of a legal right” would adequately protect minors’ interests.¹⁹⁷

I do not mean to denigrate all parents or doctors. There is a growing group of doctors pushing for change, and many parents have given steadfast support to their intersexed children.¹⁹⁸ My argument

¹⁹³ I am indebted for this insight to Professor Martin Guggenheim.

¹⁹⁴ The prevention of harm is, of course, an end in and of itself because the state has an interest in promoting and protecting the well-being of all its citizens. The state, however, may also have an economic reason for preventing harm to intersexed children, as prevention may allow the state to avoid the future cost of the more intensive psychological treatment that a forcibly reared individual might require later in life. See Sher, *supra* note 132, at 197 (“Another significant state interest [implicated when parents refuse to consent to a child’s mental health treatment] may be the economic benefit of immediate short-term crisis intervention as compared to future long-term institutionalization.”).

¹⁹⁵ See *supra* text accompanying note 161.

¹⁹⁶ *Bellotti v. Baird*, 443 U.S. 622, 647 (1979).

¹⁹⁷ *Id.*; see also *Ayotte v. Planned Parenthood of N. New Eng.*, 126 S. Ct. 961, 966 n.2 (2006) (“It is the sad reality . . . that young women sometimes lack a loving and supportive parent capable of aiding them to exercise their rights wisely.” (internal quotation marks and citations omitted)); *In re Mary P.*, 444 N.Y.S.2d 545, 548 (N.Y. Fam. Ct. 1981) (issuing “Order of Protection” pursuant to state law in order to prevent mother from “interfer[ing]” with minor’s decision to give birth or “forc[ing]” her to have abortion). The confidentiality that consent statutes afford minors addresses this very problem. See Wadlington, *supra* note 112, at 323–24 (noting that modern consent statutes that do not require minors to obtain parental consent reflect “the disturbing changes that have occurred in the counseling and consultative relationship between many parents and their children”).

¹⁹⁸ See, e.g., *MARÍA ARANA*, *supra* note 63, at 32 (reporting Hida Viloría’s testimony crediting her family for supporting her choice not to pursue gender transition); Dreger & Chase, *supra* note 33, at 83–85 (describing mother’s and obstetrician’s decisions not to perform surgery on daughter with ambiguous genitalia); Brown, *supra* note 12 (reporting

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is only that, when there is evidence that intersexed children suffer severe harm as a result of a misguided treatment paradigm and parental action, we should protect a child's ability to change his or her social gender identity to accord with his or her sense of self.

If the existing studies are correct, most intersexed children will not make use of the consent provision. As the treatment paradigm and cultural attitudes evolve, even fewer will need the added protection of the neglect provision. There is little harm in empowering all intersexed children with a legal right that many of them will not use.¹⁹⁹ Perhaps the proposed law will ultimately provide an additional, more indirect benefit: An unequivocal statement that the child is the only one who can decide how to express his or her gender may dissuade parents from thinking that something must be done to steer the child toward conformity with notions of masculinity or femininity, and they may instead let the child express gender as he or she sees fit. Perhaps more parents will then realize that the children are, as one mother has said, "the only expert[s] on [their] own experience[s]."²⁰⁰

CONCLUSION

Although the statutory framework proposed in this Note may be a good starting point, several issues remain unresolved. For example, even if intersexed children obtain legal protection for gender change in the face of parental opposition, they will most likely need other protections to ensure that they are treated properly in schools.²⁰¹ Income and geographical disparity may also be an issue, as it may be

nascent trend of "young parents" who support "[c]hildren . . . who display predispositions to dress like the opposite sex").

¹⁹⁹ Professor Reilly seems to have a similar attitude about her birth certificate proposal, remarking that intersexed people "might notice—or they might not—whether their own identity matches that provisionally assigned [at birth]." Reilly, *supra* note 24, at 334–35; see also HOWARD COHEN, EQUAL RIGHTS FOR CHILDREN 60 (1980) ("Very little is lost by granting children rights which they rarely claim. Nobody is obliged to claim their rights, and as a practical matter young children might rarely do so.").

²⁰⁰ Florence Dillon, *Why Don't You Tell Them I'm a Boy?*, MINN. PARENT, Mar. 1999, at 29, 31, available at <http://www.safeschoolscoalition.org/whydontyoutellthem.pdf>.

²⁰¹ For an example of the conflicts that can arise when a child attempts gender nonconforming behavior at school, see Crozier, *supra* note 11, at 138–39, describing a case in which a court declared that a high school student who was raised male but identified with the female gender could not be prohibited from wearing a dress to school. A recent *New York Times* article reports that "Massachusetts, Minnesota, California, New Jersey and the District of Columbia have laws protecting the rights of transgender students, and some schools are engaged in a steep learning curve to dismantle gender stereotypes." Brown, *supra* note 12. It also notes, however, that "[t]he supportive attitudes are far easier to find in traditionally tolerant areas of the country" and references several incidents of schoolyard violence towards—and even one murder of—gender nonconforming youths. *Id.*

more difficult for children from low-income or geographically isolated families to continue with long term psychological support due to the dearth of medical and mental health providers for intersexed people.²⁰² Finally, it is impossible to overstate the need for more research on the long term physical and psychological effects of early assignment surgery (or forgoing such surgery). Once this research takes place, the legal and medical treatment paradigms should adapt accordingly.

In continuing discussions on this issue, it is critical to ensure that the debate does not degenerate into an argument over whether or not doctors “got it right” when they recommended a gender of assignment for an intersexed infant, or whether that infant, now eight years old and raised as a boy, has “got it right” in voicing a desire to live as a girl. Pointing fingers and assigning blame is not the point. The main goal should be fostering an open and supportive environment for the intersexed child and his or her parents in which they can come not only to accept, but even to celebrate, all aspects of the child’s identity, including his or her gender. If we could achieve that goal, the law that I envision might become obsolete. Until then, however, it may benefit intersexed children to have both the legally recognized right to identify with a given gender and judicial protection of that right against potential parental encroachment.

²⁰² See MARÍA ARANA, *supra* note 63, at 24 (“There are insufficient numbers of medical and mental health providers who are adequately trained in providing appropriate intersex care and treatment.”).