

# Legal Aspects of Gender Assignment

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The birth of an intersex child presents difficult medical and ethical issues to the attending physicians. Recently, these issues have become the subject of a debate among doctors, psychiatrists, ethicists, sociologists, historians, and intersex activists. Largely absent in these debates, however, is any discussion of the legal ramifications of the medical and psychological treatment of intersex infants. This paper explores the legal implications of early surgical intervention in the treatment of intersexuality. It provides a summary of the history of the management of intersexuality, describes the current approaches and premises underlying them that are being advocated for the treatment of intersex infants, and explores the legal implications of the dominant treatment model for the intersex child and for the medical treatment team. This paper concludes with a note of caution: the current dominant treatment protocol may impair the legal rights of the intersex child as well as lead to legal liability for the treating physicians.

## MEDICAL MANAGEMENT OF INTERSEXUALITY

The medical management of intersexuality has not been consistent throughout history. Changes in the medical treatment have reflected not only advancements in the understanding of sexual differentiation and the development of surgical techniques to create and modify genitalia, but also societal gender norms and stereotypes and cultural bias [1]. Although doctors typically did not surgically alter an intersex infant before the middle of the 20th century, during the 1950s, surgical alteration of an intersex infant's genitalia became standard medical practice and remains the norm today [2].

## Development of the Current Model

Major changes in the medical management of intersexuality developed in the second half of the 20th century due in large part to the influential publications of John Money [3,4]. Money hypothesized that gender self-identity

was not irrevocably fixed at birth. Money also hypothesized that children will develop a gender identity that conforms to the gender role in which they are raised and the appearance of their genitalia. In other words, Money posited that other biologic sex aspects were relatively inconsequential compared to genital appearance and the gender role in which a child is raised. According to Money, newborns should be considered blank slates in terms of gender identity. If surgeons sculpt genitals of a certain size and shape onto these blank slates and administer the proper hormones, and parents reinforce the surgeon's creation, the children will grow up with an unambiguous gender identity that conforms to the shape of their surgically created genitalia.

Since the 1950s, intersex infants born with ambiguous genitalia have been surgically altered and assigned a gender that in part is based on sex role stereotypes. The presence of an "adequate" penis (one that is capable of vaginal penetration and will allow the male to stand while urinating) in an XY infant has led to the label "male." The absence of an "adequate" penis has led to the assignment of the child to the female sex and surgical alteration of the infant's genitalia into a more acceptable female appearance, even if it renders the XY child infertile as an adult. XX infants have not been similarly treated. An XX infant, who is capable of reproducing, typically has been assigned the female sex to preserve her reproductive capability, regardless of the appearance of her external genitalia. If her "phallus" is considered too large to meet the guidelines for a typical clitoris, it has been surgically reduced, even if the reduction reduces or destroys her capacity for satisfactory sex. In other words, males have been defined by their ability to penetrate and females have been defined by their ability to procreate. Infants with atypical chromosomal patterns (neither XX nor XY) and ambiguous genitalia typically have been turned into females [2].

## Surgical Alteration Protocol Receives Support From a Surgical Mistake

In 1973, the protocol suggested by Money during the 1950s received widespread coverage in the popular press based on an "experiment" that Money performed on identical male twins. At age 8 months, the twins were supposed to be circumcised. One of the twin's penises was

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accidentally ablated. Money recommended that the infant's testicles be removed and that his genitalia be reconstructed to appear female. The parents were told to raise the child as a girl and to hide his medical history from him. According to Money, if the parents unambiguously raised the child as a girl, the child would develop a female gender identity. If, instead, they tried to raise him as a boy with an inadequate penis, the child would suffer severe psychological trauma [5,6].

This "male turned into a female" case made headlines. Because the doctors involved in the treatment reported that the child and the parents had successfully adapted to the sex/gender alteration, sociology, psychology, and women's studies texts were rewritten to argue, "[t]his dramatic case . . . provides strong support . . . that conventional patterns of masculine and feminine behavior can be altered. It also casts doubt on the theory that major sex differences, psychological as well as anatomical, are immutably set by the genes at conception" [5].

These conclusions reflected and reinforced beliefs held by many feminists who, during the 1970s, championed the cause of gender equality. They based their advocacy on the belief that gender differences were primarily the result of environmental influences rather than biologic differences between males and females. This "nurture theory" of gender development was used to help dismantle long-held discriminatory practices against women. Feminists argued that society and legal institutions could not differentiate between men and women if no biologic justification existed to support the dissimilar treatment. This theory was used to justify legislation that barred discrimination on the basis of sex.

Although the infant in Money's study was not born with an intersex condition, the alleged success of his gender alteration was used to support Money's recommended course of treatment for intersex infants.

### Reassessing the Standard Protocol

During the last decade, the traditional treatment has come under attack from a number of fronts. Its underlying assumptions are being questioned as a result of: (1) a follow-up report on the male twin turned into a female; (2) additional research on gender identity formation; (3) the surge of public protest led by intersex activists who are dissatisfied with the results of their medical management during infancy; and (4) scholars who support the intersex activist movement and maintain that the current treatment protocol is based in part on inappropriate gender role stereotyping.

In 1997, Milton Diamond and Keith Sigmundson reported in the *Archives of Pediatric & Adolescent Medicine* that the boy who had been turned into a girl was now living as a married man. According to this report, the child had always thought of himself as different from other girls.

As a child, he preferred "boy" toys and preferred to mimic his father's rather than his mother's behavior. He also preferred to urinate in a standing position, although he had no penis. Because of the cognitive dissonance, he often had thoughts of suicide. At 14, he confessed to a doctor that he believed that he was a boy and wanted to live as a male. At that point, the doctors told him the truth and began the process of remasculinization [5].

Researchers are also beginning to study the relationship between certain intersex conditions, surgical intervention, and gender identity. Preliminary results also appear to discredit Money's thesis and the standard medical management model that maintains that gender identity is malleable and early surgical intervention is necessary [7-9]. For example, William Reiner, a psychiatrist and urologist at Johns Hopkins, reported his preliminary findings of a study of 27 male infants born without a penis at the Lawson Wilkins Pediatric Endocrine Society Meeting in May 2000. Reiner reported that of the 25 boys who were surgically altered and raised as girls, 14 declared themselves to be boys. Furthermore, the two children raised as boys were better adjusted than the reassigned children [10,11].

During the 1990s, a number of intersex activist groups also began to question the standard protocol for treating intersexuality. Because genital surgery may result in a loss of reproductive capacity, a loss of erotic response, genital pain or discomfort, infections, scarring, urinary incontinence, and genitalia that are not cosmetically acceptable, these groups believe that such surgery should not be performed without the informed consent of the intersex patient. In addition, they maintain that the current treatment protocol exacerbates an intersexual's sense of shame by reinforcing cultural norms of sexual abnormality [12].

Finally, a number of activists and scholars question the underlying basis for the dominant treatment protocol and maintain that it is based on inappropriate sex-role stereotypes because XY and XX infants are treated dissimilarly. As discussed above, the emphasis for XY infants is on their need as adults to engage in satisfactory sexual intercourse, while the emphasis for XX infants is on preserving their ability to procreate. This penetration/procreation gender stereotype is further reinforced by the medical community's emphasis on the need for a female to have an acceptable-looking clitoris over her need for sexual satisfaction. Creation of a sensitive clitoris and a vagina that properly lubricates during sex are not the primary concerns during female genital modification surgery. A successful surgical modification of a female is not defined as one that will likely result in her ability to achieve sexual pleasure; instead it is defined as one that results in the creation of a proper-sized clitoris (that may not be as sensitive as the unaltered clitoris) and a vagina that will allow penetration by a penis [5,7,13,14].

## ALTERNATIVE APPROACHES AND UNDERLYING PREMISES

As a result of these recent developments, the standard medical treatment protocol has come under scrutiny [7,15–17]. This section provides a comparison of the three approaches that are currently being advocated and their underlying premises.

### Current Dominant Medical Practice

Most physicians and the American Academy of Pediatrics (AAP) maintain that the traditional treatment model is still the proper approach [16]. These experts maintain that the birth of an intersex infant is a medical and social emergency requiring early surgical intervention. Supporters of the standard treatment protocol believe that living with ambiguous or anomalous genitalia would be so psychologically traumatic that intersex children would be unable to form a successful gender identity. In addition, they are concerned that an intersex child's atypical genitalia will lead to ostracism from peers and potentially weaken the bond the parents form with their intersex child [18]. This model emphasizes the need for a clear and unambiguous gender identification. To achieve this goal, the child should receive surgery and the parents and the intersex child may benefit by being told less than the whole truth about the nature of the condition [2].

### Alternative Treatment Recommendations

Other authorities, however, have begun to counsel a more cautious approach. Intersex activist organizations and some experts have called for a moratorium on all intersex surgeries (other than those that are truly medically necessary) until long-term studies prove that such surgeries provide benefits that outweigh the potential risks. They are opposed to the predominant management model for a number of reasons. First, they believe that the traditional model results in stigma and trauma. Because of the emphasis on "normalizing" the infant's genitalia, parents will experience guilt and shame over giving birth to an "abnormal" baby and the intersex patient will experience a sense of rejection. They question the traditional assumption that concealing or downplaying the existence of the intersex condition will help the family lead a "normal" life. Second, they believe that relieving the parents' anxiety over the birth of their intersex child should not be accomplished by surgically altering the child to fit societal norms. Instead, they emphasize that parents should be educated and provided with proper professional counseling and peer support. Third, they recommend honest and complete disclosure and mental health support for the parents and the child. Finally, they oppose the dominant medical practice of performing surgery on infants unless there is an

actual risk to the child's health. They maintain that the decision about surgical intervention should be postponed until the child is old enough to make the decision whether or not to undergo surgery. Instead of surgical intervention, they recommend that: (1) experts should assess the likely gender identity of intersex infants; (2) intersex children should be raised in the recommended gender identity; (3) parents should be educated and put in touch with people who can provide counseling and support; and (4) surgical intervention should be delayed until the children reach an age when they can decide for themselves whether they want any surgical alteration [2,5,7,12–14].

### Middle-Ground Approach: Qualified, Persistent Informed Consent

In 1999, the Constitutional Court of Colombia adopted a third middle-ground approach. The Colombia court had before it evidence supporting both of the above approaches. The court concluded that the contrary opinions put the law at an impasse: to prohibit surgeries until the children reach the age of consent would be engaging in social experimentation, but to allow the surgeries to continue under the standard protocol would not ensure that the best interests of the children are protected. To overcome this impasse, the court settled on a compromise approach. The Colombia court allowed parents to continue to consent to surgeries, but the court insisted that procedures be developed to guarantee that parents are consenting solely based upon their child's best interests and not their own self-interest. The court suggested that legal and medical institutions develop informed consent procedures that guarantee that the child's interests are the only concern. To ensure that the consent is truly informed, the court required that it be "qualified and persistent," and any procedures developed must meet the following requirements:

1. The consent must be in writing.
2. The information provided must be complete. The parents must be informed about the dangers of current treatments, the existence of other paradigms, and the possibility of delaying surgeries and giving adequate psychological support to the child.
3. The authorization must be given on several occasions over a reasonable time period to make sure the parents have enough time to truly understand the situation [19].

The remainder of this paper focuses on the legal implications to the intersex patient and the medical treatment team of these alternative approaches. The legal conclusions reached in this paper are not based on court cases involving intersex persons because the legal status of intersexuals and their treatment has not been litigated in the United States or most other countries. Therefore, the conclusions are based on a review of the legal precedents re-

lating to transsexuals, gender discrimination cases, and informed consent cases (including the Colombia decision and other cases involving parental informed consent for other medical treatments).

### LEGAL EFFECTS ON THE INTERSEX PATIENT

The medical treatment of intersex infants may have profound legal implications for the intersex patient upon reaching adulthood. The most important legal effects clearly flow from the sex assigned by the birth attendant, but any medical treatment that affects an intersex person's ability to reproduce or engage in sexual intercourse may also have legal ramifications.

#### Sex Assignment

Sex assignment by medical professionals will have critical legal implications for the intersex patient. Legal institutions require that humans be categorized into discrete, binary sex categories, and sexual classification has significant legal consequences. It may affect: (1) the ability to marry in a particular gender role; (2) the sex designation on official documents; (3) the ability to state a cause of action for violation of employment discrimination laws; (4) the ability to state a cause of action for a constitutional equal protection violation; (5) the ability to participate in athletic competitions as a female; (6) pension and insurance payments; (7) liability for sex-based crimes; and (8) the right to be housed with male or female prisoners [20].

Of all of these legal consequences, the one that most profoundly alters an intersex person's fundamental rights relates to the prerogatives that flow from the marital relationship. Marital status dictates a wealth of economic rights, including inheritance rights, spousal support awards, social security benefits, tax filing status, and employee health-related benefits. Equally important, however, are the non-economic rights that flow from the marital relationship, including the ability to be declared a legal parent. Recent legislation and litigation involving gay, lesbian, and transsexual marital rights will likely shape the outcome of cases involving intersexuals, and a brief review of the basis for the holdings in these cases will illuminate how the court may determine the legal sex status of an intersex person for purposes of marriage.

Sex determination for purposes of marriage is critical because of the widespread ban on same-sex marriages. Although the Netherlands now allows same-sex marriages, and a number of other European countries and Vermont provide the same benefits to same-sex couples that married couples receive, most jurisdictions currently prohibit marriages between two people of the same sex [20]. Because of this ban, a number of cases involving the validity of a transsexual's marriage have been litigated in U.S. courts, as well as in a number of courts in other countries [20].

In each of these transsexual marriage cases, the courts were required to determine the legal sex of the parties to ascertain whether the relationship was an illegal same-sex union or a valid heterosexual marriage. In some of these cases, the courts relied on scientific definitions of sex. In others, the courts relied on less scientific sources, including Webster's Dictionary and religious precedent. Of interest to medical professionals who treat intersex patients are the cases that relied on biologic criteria to determine legal sex. The recent cases are summarized in Table 1 [21–28].

As can be seen from the table, legal institutions use a variety of factors to establish legal sex. Some courts rely exclusively on chromosomes, while others consider additional factors that medical professionals rely upon, including gonads, genitalia, hormones, internal and external morphology, phenotype, and gender identity. Some courts ignore medical intervention, while others consider surgical and hormonal modifications. Some courts maintain that the sex established by the attending physicians at birth controls, while others will consider other factors. Physicians treating intersex infants must consider the legal ramifications of their medical treatment. If a sex is assigned at birth that does not comport with a person's later self-identified gender, courts may find that the assigned sex at birth is conclusive. Finally, courts may place a greater emphasis on chromosomes than do the majority of the medical professionals treating intersex patients.

#### Capacity for Reproduction and Sexual Intercourse

Medical treatment of intersexuals that renders them sterile or incapable of "normal" sexual intercourse may also lead to legal marital problems. Historically, sterility and sexual incapacity were considered grounds for a marital annulment. Although most states have modified these rules so that infertility and sexual incapacity are no longer adequate reasons for an annulment unless the infertility or incapacity is fraudulently misrepresented or concealed, ability to reproduce and engage in sexual intercourse are sometimes still cited as prerequisites to a valid marriage.

For example, this year, the Kansas Supreme Court, when deciding the proper factors to determine a person's legal sex, relied on the Webster's Dictionary definition of male and female. According to the Kansas Supreme Court, male is defined as "the sex that fertilizes the ovum and begets offspring." Female is defined as "the sex that produces ova and bears offspring." In holding that a male-to-female post-operative transsexual is legally a man for purposes of marriage, the court stated that her ability to "produce ova and bear offspring does not and never did exist. There is no womb, cervix, or ovaries, nor is there any change in his



**TABLE 1.** Recent Cases Establishing Legal Sex for Purposes of Marriage

Case	Jurisdiction and Date	Sex Determinant(s) and Reasoning	Legal Right at Issue	Current Status (2003)
In re Kevin <sup>[23]</sup>	Family Court of Australia at Sydney (2003)	Court held that legal sex should be determined as of date of marriage and not at birth. In holding that a f-to-m transsexual is legally a male, the court relied on self-identity, gender perception of others, hormonal and surgical intervention, and acceptance of this legal status as a man for other purposes. Court specifically rejected In Marriage of C & D [28] as an insupportable conclusion.	Declaration of marriage validity	No appeal pending.
Kantraras v. Kantraras <sup>[25]</sup>	Florida Trial Court (22)	Court held that f-to-m husband was legally a man for purposes of marriage and custody of the children born to his wife.	Right to custody and visitation of children born during union.	No precedential value because only a trial court. Decision may be appealed.
In re the Estate of Gardiner <sup>[21]</sup>	Kansas Supreme Court (2002)	Declared a postoperative m-to-f transsexual was legally a male. Rejected reliance on scientific evidence. Referred to plain meaning and dictionary definitions of sex. Recognized that some people “do not fit nearly into the commonly recognized category of male or female,” but held that the sex designated at birth remains the legal sex. Chromosomes appear to be the most important biologic determinant of sex.	Whether marriage between a m-to-f transsexual and man is legal so that wife is entitled to inherit from husband’s estate.	Final decision. Chromosomes determine sex.
In re the Estate of Gardiner <sup>[22]</sup>	Kansas Court of Appeals (2001)	Court reviewed scientific and legal literature and held that sex should be determined by considering a number of factors, including: chromosomes, genitalia, gonads, internal and external morphologic sex, hormonal sex, phenotypic sex, assigned sex and gender of rearing, sexual identity, and other criteria as science advances its understanding of sex determinants.	See above. This court declared the m-to-f transsexual was legally a woman and could inherit as the wife.	Reversed on appeal [21]. No longer valid law.
Littleton v. Prange <sup>[24]</sup>	Texas Court of Appeals (1999)	Court referred to sex provided by “our Creator” as opposed to sex created by physicians and rejected any “man-made” sex attributes. In holding that a m-to-f transsexual is legally a male, the court appeared to rely exclusively on chromosomes. This decision could cause problems for intersexuals whose chromosomes do not comport with other sexual features and intersexuals who do not fit into the XX or XY mold. The concurring opinion specifically stated that the legal sex of intersexuals was not at issue, but the Chief Justice’s opinion did not distinguish between intersexuals and transsexuals.	Right to sue under a wrongful death statute for death of husband	Texas and U.S. Supreme Courts refused to hear. Therefore, chromosomes establish legal sex in Texas
Vecchione v. Vecchione <sup>[26]</sup>	California Trial Court (1997)	No written opinion, but court held that a postoperative transsexual acquires his postoperative sex for purposes of marriage.	Rights to custody of children born during union.	No precedential value because it is only a trial court decision.
Older cases involving transsexual marriages	England, U.S., and other countries (1970–1997)	Most of the older cases refer to Corbett <sup>[27]</sup> a decision from England in 1970. There was some debate in the case about whether the wife was intersex or a transsexual. The court treated her as a m-t-f transsexual. It looked to chromosomes, gonads, and genitalia to define sex and held that the birth sex remains the legal sex throughout life. It was rejected in New Zealand and New Jersey courts that accepted a postoperative transsexual’s sex as the legal sex.	Validity of a marriage for a variety of purposes.	Since these cases were decided, some jurisdictions have adopted statutes that authorize a change of legal sex on identity documents.

(continued)

TABLE 1. Recent Cases Establishing Legal Sex for Purposes of Marriage

Case	Jurisdiction and Date	Sex Determinant(s) and Reasoning	Legal Right at Issue	Current Status (2003)
In Marriage of C and D <sup>[28]</sup>	Australia (1979)	Only marriage case involving an intersexual. Marriage lasted 12 years and couple raised two children. Husband had XX chromosomes and a combination of male and female biological aspects which he had surgically modified so he would appear more male. Court held marriage was invalid because the husband was "neither a man nor a woman." Case has been severely criticized by commentators and rejected in re Kevin <sup>[23]</sup>	Wife wanted marriage declared a nullity.	Questionable precedential value because lower court, older case, and recently criticized.

chromosomes . . . [T]he transsexual still inhabits . . . a male body in all aspects other than what the physicians have supplied" [29]. Therefore, surgical and hormonal alteration of intersex infants by physicians may not be considered by some courts in establishing legal sex. If intersex persons do not have the proper internal organs and the ability to beget or bear offspring, they may not be considered the sex assigned by the physicians.

Similarly, the inability to engage in "normal" copulation may be cited as a reason to invalidate a marriage. Although no cases have reached such a holding recently, some jurisdictions could legally invalidate a marriage if either of the parties is incapable of "normal" sexual intercourse. Of interest to intersexuals are cases involving male-to-female transsexuals who have had a vagina constructed. In the most often cited transsexual marriage case involving sexual incapacity, *Corbett v. Corbett*, the court invalidated the marriage and held that "sexual intercourse, using the completely artificial cavity" cannot be described as "ordinary and complete intercourse" [30].

When physicians decide on a medical course of treatment for intersex infants, they should be cognizant of the legal ramifications that may result when the infant becomes an adult. Depending upon the jurisdiction, the intersex adult may be declared a sex other than the one assigned by the physician. Depending upon the court hearing the matter, intersex adults may have their marriages declared invalid because they: (1) are not the "opposite sex" of their partner; (2) may be incapable of bearing or begetting children; or (3) may be incapable of "ordinary intercourse."

### LEGAL EFFECTS ON THE TREATING PHYSICIANS

Legal authority specifically addressing the liability of physicians who treat intersex infants is as sparse as the authority establishing the legal sex of an intersexual. Despite the absence of authority, given the division among experts about the appropriate treatment protocol, the issues at

stake, the call for a moratorium on surgeries, and the recent Colombia decision on this issue, future litigation is a distinct possibility. Therefore, physicians would be wise to consider the legal ramifications of their medical decisions. Litigation will likely focus on the issue of informed consent, but intersex persons may also file claims in the future based on sex discrimination or violation of their fundamental right to privacy.

### Informed Consent

The current treatment protocol may be legally challenged under the informed consent doctrine for two reasons. First, parents are consenting to surgical intervention that may affect their infant's fundamental rights, and under the dominant treatment model parents may not be in an optimal position to assess the best interests of their child. Second, parents may be consenting to these surgeries based upon incomplete information, and thus the consent may be considered invalid because it is not truly "informed."

The informed consent doctrine preserves patients' rights to make medical decisions on their own behalf. Generally, the doctrine requires that patients be fully informed of all the material risks associated with the medical treatment being provided before their consent to a procedure is considered valid. In the case of minors who are too young to understand and balance the risks and benefits of a particular medical choice, the informed consent is required of a surrogate, typically the minors' parent(s) [31,32].

Parental decisions are generally accorded great deference to protect family privacy and parental authority. Courts rarely intervene in a parent's medical decision unless the decision conflicts with the medical advice of the infant's doctor. It is extremely unusual for anyone to intervene in a medical decision agreed upon by the treating physician and parents, even though the child's long-term interests may be seriously compromised.

Court intervention in parental decisions is rare because legal institutions generally presume that parents will make decisions that will be in the best interests of their children. In some circumstances, however, courts will carefully scrutinize parental decisions because they are concerned that parents are not able to objectively distinguish the interests of their child from their own self-interest. Classic parental consent cases requiring a heightened level of scrutiny involve minors or incompetents who are involuntarily sterilized or used as organ donors. Courts will carefully scrutinize sterilization decisions because the constitutional right to procreate is entitled to protection and the incompetent's interest in preserving the ability to procreate may conflict with the parents' desires to avoid procreation [33,34]. Similarly, a parent's decision to remove an organ from a child or incompetent to save the life of another relative involves inherent conflicts of interest between the rights of the child/incompetent and the interests of other family members [35,36]. In these types of cases, courts will not automatically defer to the parents and instead will carefully scrutinize parental decisions to ensure that the rights of the child/incompetent are being protected [33–36].

Intersex surgical procedures involve similar conflict-of-interest issues. These surgeries may result in involuntary sterilization, decreased capacity to achieve sexual satisfaction, serious long-term medical complications, and surgical alteration into the sex that does not conform to the person's gender identity. Although parents believe they are considering the best interests of their children when they make their treatment decision, it is difficult for parents to rationally assess whether they are focusing on their need to have a "normal" infant over the long-term interests of their child. Therefore, a court could decide not to give the deference typically accorded to medical decisions made by parents on behalf of their children.

The second reason these decisions may be subjected to court review is because parents may be consenting based upon less than full information. The dominant treatment protocol emphasizes avoiding psychological confusion about the patient's gender identity. Therefore, physicians do not always tell intersexuals and their parents that the child may not self-identify as the assigned gender. Information that may lead to confusion may be downplayed or not disclosed so that parents can feel comfortable with their decision to approve surgical intervention [2].

The doctrine of informed consent requires that physicians provide full information. In rare circumstances, under the therapeutic privilege exception, physicians may withhold information if disclosure would be harmful to the patient. This exception is infrequently applied, and it is clear that "the privilege does not accept the paternalistic notion that the physician may remain silent simply be-

cause divulgence might prompt the patient to forego therapy the physician feels the patient really needs" [37]. Therefore, if parents consent to surgical alteration of their children's genitalia without first receiving full information, the consent may be considered invalid.

Parental consent to intersex surgery cases has not been litigated because no one has a stake in bringing the lawsuit to enjoin the surgery at the time the decision is made if the parents and the treating physicians are in agreement. The intersex patients would have standing to bring the suit when they reach the age of maturity. To date, however, the emotional trauma involved in bringing this suit to light, 20 or more years after the event, has ensured that these types of actions have not been brought.

Although these suits have not yet been brought in the United States or most other countries, given the current controversy about the efficacy of the current treatment protocol and the recent decision by the Colombia court, suits against physicians are a distinct possibility. Although the Colombia court decision is not binding outside of Colombia, courts in other jurisdictions may find it highly persuasive when rendering their decisions.

The informed consent doctrine in Colombia is based on the same principles as the informed consent doctrine in the United States and most other countries. In a lengthy and thoroughly researched decision, the Colombia court acknowledged the profound ethical dilemmas presented when parents consent to surgical genital alteration of their children. The court found that surgical modification of intersex infants must be treated differently from other types of parental consent issues [19].

The Colombia court acknowledged that under the then existing medical practices in Colombia (which were similar to current U.S. practices), parents may not be in the best position to make a decision on behalf of their intersex children for a number of reasons, including: (1) parents typically lack information about intersexuality; (2) intersexuality is viewed as a disease that must be "cured"; and (3) the treating physicians convey a sense of urgency to provide a quick cure. The Colombia court also recognized that parents consenting on behalf of their intersex children may be motivated by their own concerns and fears rather than by the "best interests" of their children [19].

The Colombia court decided that protecting the human rights of the intersex infant required it to strike a balance between allowing parents full autonomy to consent to surgical alteration on behalf of their intersex infants and barring all intersex surgeries. The court decided that a balance was needed until it is clearly proven that delaying surgery until the child reaches the age of consent is not in the best interests of the child [19].

The court required legal and medical institutions to establish rules and procedures that force parents to make

their decision in a manner that will focus the parents on the best interests of their child. The court imposed three requirements: (1) the consent must be in writing; (2) the parents must be given accurate information about the potential complications from performing surgery and the existence of other paradigms that call for delayed surgeries that can be performed once the child is able to understand the risks and benefits involved; and (3) the consent must be given on more than one occasion spread out over a reasonable time period so that parents have enough time to truly understand their child's condition and the ramifications of alternative treatment protocols [19].

The Colombia decision was based upon a thorough examination of the potential harm that can occur under the dominant and alternative treatment protocols. It decided that parental consent decisions must be subjected to heightened scrutiny, given the nature of the rights affected. Although this decision is not mandatory on courts in the United States and other countries, other courts could find the Colombia approach highly persuasive and find the current procedures may not adequately protect the intersex infant.

### Sex Discrimination

Although the most likely legal implication for physicians is that a court could find them liable for failing to obtain informed consent, a court could also determine that the current treatment protocol constitutes sex discrimination. Sex discrimination is illegal under a number of federal and state civil rights laws and is unconstitutional if engaged in by a government official under the 14th Amendment Equal Protection clause. The current treatment protocol for intersex infants dictates differential treatment of XX and XY infants. As discussed above, according to the AAP, a penis that is of adequate size and capable of penetration is of "paramount" importance if a child is to be raised as a boy. A determination that the infant phallus may become an inadequate penis for an adult male dictates that the child should be designated a female. The potential for fertility, however, is the paramount factor in determining whether an XX infant should be raised as a girl. Therefore, XX and XY infants are not treated similarly. The emphasis for XY infants is on the ability to engage in satisfactory intercourse, and the emphasis for XX infants is on preserving reproductive capacity.

The law does not require that males and females be treated identically. It does, however, require that any differential treatment of males and females be based on legitimate differences between the sexes and not on sex-role stereotypes [38]. To survive court scrutiny under the Equal Protection clause, differential treatment of males and females must be based on an "exceedingly persuasive justification" and the means used must bear a substantial relationship to an important interest [39,40].

Recently, many sex discrimination cases have focused on impermissible sex-role stereotyping. The Supreme Court has held that women and men cannot be treated differently based upon archaic sex stereotypes. Therefore, the Supreme Court has held that it is impermissible to discriminate against a woman because she is too aggressive for a woman and fails to walk femininely, talk femininely, dress femininely, wear make-up, have her hair styled, and wear jewelry [38]. Similarly, other courts have held that it is impermissible to discriminate against men who fail to dress in traditional male attire or conform to traditional male behavioral patterns and transsexuals who fail to conform to the gender role appropriate to their biologic sex [41-45].

Physicians who prioritize penis size and ability to engage in satisfactory sexual intercourse for males and ability to procreate and have a clitoris that appears dainty and feminine (rather than large and masculine) for females are engaging in differential treatment based on sex. Whether this approach will be considered legally acceptable will depend upon whether the differential treatment is justified by actual biologic differences between the sexes or impermissible sex stereotyping. Even if a majority of males would agree that they would choose satisfactory sex and "adequate" penises over biological children, and a majority of females would choose the ability to have biologic babies over sexual satisfaction, doctors are not free to render medical treatment based upon generalizations about a particular class. Courts have consistently held that even if generalizations about men and women are valid for some or most members of a particular group, differential treatment must be assessed on an individualized basis and not by a resort to group-based generalizations [46,47].

### Right to Privacy

The Constitution protects individuals from governmental intrusion into their private lives. The right to privacy traditionally has protected family decisions and marital intimacy. Intersexuals who have had their ability to procreate or their ability to achieve sexual satisfaction taken away or diminished by a governmental actor may also assert that their constitutional right to privacy has been violated. The right to privacy clearly protects a person's decision about whether to have a child [48-51]. Whether it would also protect a person's right to engage in satisfactory sexual activity is less clear. Justice Blackmun, in his dissenting opinion in *Bowers v. Hardwick*, 478 U.S. 186, 205 (1986), suggested that the right to engage in "sexual intimacy is a sensitive, key relationship of human existence, central to family life, community welfare, and the development of human personality" and should therefore be considered a fundamental interest deserving of constitutional protection. The majority of the current U.S.



Supreme Court is unlikely to adopt Blackmun's approach. If, however, physicians fully inform the infant's parents about the likelihood of these events occurring and parents still consent to the treatment, a successful privacy cause of action against a physician would be unlikely.

### RECOMMENDATIONS

Three approaches for the treatment of intersex infants have been advocated: the protocol established during the 1950s that is still the dominant practice, a moratorium on infant surgeries and the treatment plan suggested by intersex activist organizations and some experts, and the middle-ground approach mandated by the Colombia Constitutional Court. These concluding comments focus on the potential legal ramifications of these alternatives. This discussion is premised on the understanding that no long-term studies exist that confirm that either of the first two courses of treatment result in a better psychological outcome for the intersex patient.

Until long-term studies prove that the dominant treatment protocol provides a better psychological outcome than the alternative treatment proposed, physicians need to ensure that any consent provided by parents is based upon full information. Under current practices, physicians who do not disclose all of the potential psychological, medical, and legal risks that children may encounter are exposing themselves to potential legal liability.

The arguments against providing full information are based on the alleged risk that parents will be emotionally traumatized, may not bond with their child, and may choose to forego surgical intervention. Even if physicians strongly believe that surgical alteration during infancy should be the parental choice, the doctrine of informed consent requires that physicians allow parents to make the choice after they have received all relevant information. No legal liability can result from providing parents with full information and allowing them to make an informed decision. Because the emotional risks to the parents and the child and the benefits of surgical alteration during infancy have not been proven by long-term studies, physicians need to disclose this information to the parents.

The following is a suggested list of procedures that physicians should follow to ensure that the consent given by parents is truly informed and protects the rights of the child:

1. Parents should be provided with complete written information about their child's condition.
2. Parents should be given the opportunity to consult with mental health professionals who are experienced in the clinical management of intersexuality.
3. Parents should be provided with contact information for intersex support groups so that they can receive input from intersex adults who have experienced surgical

treatment as well as other parents of intersex infants who have had to make similar decisions.

4. Parents should be presented with the option of delaying any surgical intervention until the intersex patient is of an age to make his/her own decision about the appropriateness of surgical treatment.
5. Parents should be presented with complete information concerning the risks and complications attendant to surgical intervention, including the potential loss of sexual sensation, the potential loss of the ability to procreate, the possibility that the surgical intervention may not conform to the child's gender identity, the risk of scarring, the risk of incontinence, the potential need for future surgeries, and the negative emotional consequences that may result from surgical intervention.
6. Parents should be informed that no long-term studies have been performed that either prove that early surgical intervention provides a therapeutic benefit or assess the benefits of early surgical intervention compared to alternative treatment protocols.
7. Parents should be told that several pediatric endocrinologists and urologists have called for a complete moratorium on infant genital surgery until retrospective studies demonstrate that the benefits of such early surgical treatment outweigh the potential negative consequences.
8. The consent should be given in writing.
9. The consent must be given on more than one occasion spread out over a reasonable time period to ensure that parents have enough time to truly understand their child's condition and the ramifications of alternative treatment protocols.
10. Parents should be informed that their child's ability to receive medical care is not dependent upon the parents consenting to surgery.

A decision to surgically alter an intersex infant has the potential to affect a number of fundamental human rights, including the ability to marry, procreate, and achieve sexual satisfaction. In addition, by treating XY and XX infants differently, the dominant treatment protocol could be attacked as constituting sex discrimination. Given that most intersex surgeries are not performed until the child is at least 6 months old, it is unlikely that expanding the information provided to parents and requiring consent on multiple occasions over an extended period of time will result in any harm to the parents or the children. To choose to provide less than these protections has the potential for profound negative legal consequences for the intersex patient and legal liability for the treating physicians.

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