Regulating Middlesex

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“I was born twice: first, as a baby girl, on a remarkably smogless Detroit day in 1960; and, then again, as a teenage boy, in an emergency room near Petroskey, Michigan, in 1974.”

From *Middlesex* (Eugenides 2002: 3)

“The Concern of the magistrates was less with corporeal reality – with what we could call sex – than with maintaining clear social boundaries, maintaining the categories of gender.”

(Laquer 1990: 135)

Introduction

*Middlesex* is the title of a best-selling book in the United States. Authored by Jeffrey Eugenides, it is a fictional account of the life of an intersexual, who is raised as a girl until puberty, when she makes the decision to live life, more or less, as a male. Like many intersexuals, the protagonist of *Middlesex* struggles with feelings of monstrosity. Although fictional, the themes of *Middlesex* echo those of the real-life saga of David Reimer, whose story was publicized widely a few years ago, in another best selling book entitled *As Nature Made Him: The Boy Who Was Raised as a Girl* (Colapinto 2000). David was not born intersexed but, rather, as a biological male, named Bruce. At about six months of age, however, Bruce’s penis was destroyed during a botched circumcision. On the advice of medical experts, David’s parents decided that the appropriate course of action was to reconstruct Bruce as a girl, who they re-
named Brenda.

Over the next several years, Bruce/Brenda underwent several surgeries, in which his penis and testes were removed. Somewhat later, he took estrogen and grew breasts. Although his doctors reported otherwise, Bruce/Brenda suffered severe psychological problems stemming from the sex change operations and related treatments. At the age of 14, following several threats of suicide, Bruce/Brenda made the independent decision to become a male again. This, of course, required more surgery to, among other things, remove his breasts and reconstruct his penis.

Inspired by the biblical tale of David and Goliath, Bruce/Brenda also decided to re-christen himself as David. About ten years later, David went on to marry a woman and to father several children through adoption. In 2000, he agreed to make his story public, with the hope that greater knowledge about his experience might help to prevent other infants and small children from being forced to undergo sex change operations before they are old enough to give meaningful consent. A few years later, for reasons that are not entirely clear, David Reimer took his own life.

David Reimer and his family did not attempt to sue the doctors who recommended the sex change in his instance. Had they attempted to sue, they most likely would have been precluded by legal doctrines in tort law that protect doctors from liability when the medical procedures are consistent with the custom of the profession and where they have obtained the patient’s consent. In the case of intersexed children and children with severe genital injuries, it was, and remains, standard practice for doctors to perform sex change operations on boys with damaged penises and on children with ambiguous genitalia. Doctors readily obtain the consent
of the children’s parents, who are eager to do whatever they must to help their children conform to cultural expectations about what their children should look like. For both reasons, it would be difficult to establish tort liability in U.S. courts through a breach of the standard of care.

It is not inconceivable, however, that a court would rule otherwise. In 1995, the Constitutional Court of Columbia heard the claims of a young Columbian man who underwent a very similar experience to David Reimer. Like David Reimer, the plaintiff in the Columbian case had undergone a surgical sex reassignment, following a traumatic injury to his penis. In a precedent-setting ruling that is being watched by specialists in sex change surgery around the world, the Columbian Court held that parents cannot give consent on a child’s behalf to surgeries to determine sexual identity. Instead, the court held the surgery must, in most instances, be delayed until the child has an opportunity to comprehend the nature of the surgery and give meaningful consent (Sentencia T-477/95 1995).

What is perhaps most remarkable about the Columbian Court’s ruling is its recognition of the role that cultural expectations played in the decision to subject the Columbian child to surgery in the first place and in its own rulings about what actions were appropriate. Specifically, the ruling noted the surgery might have been motivated by societal intolerance of bodies that do not live up to cultural expectations about sexual difference. If that were the case, the Court reasoned, it would constitute discrimination for the Court to place its imprimatur on this intolerance by allowing the practices to go unchallenged.

At stake in the Columbian case, and in other cases involving individuals with bodies that do not clearly conform to cultural expectations, is the legitimacy of one our most deeply held cultural understandings. Conventional wisdom holds that sexual identity occurs “naturally” as a
binary category, which consists of two “opposite” sexes: male and female. But, as the two stories recounted above suggest, the question of sexual identity is often much more complex than this. As it turns out, many bodies, even in nature, simply do not fit very well into the rigid boundaries of a male/female classification. Others do not comport with cultural expectations about the characteristics that are typically associated with the two categories.

Instead, doctors observe physical characteristics which defy a binary categorization of sex on a regular basis: men with breasts, women with facial hair, and, of course, inter-sexed individuals whose genitalia cannot be distinguished clearly as either male or female. Doctors respond to this dilemma with medical treatment aimed at helping the body to comply with the cultural demand. In David Reimer’s case, and in the case of many other infants who suffer from a traumatic penis injury, the recommended treatment is often to surgically reassign the infant into a girl (Ben-Asher 2006). Other non-conforming bodies may be provided with prostheses (e.g., breast implants and penile implants), hormone therapy or other treatments, such as electrolysis, to help them better fit the norm.

However, some individuals, like David Reimer and the protagonist in Middlesex, refuse to conform. More commonly, there are problems in transition. Sex re-assignment surgery fails, implants rupture, or someone is incarcerated before their sex-change is complete. Quite frequently, the law is called upon to mediate the resulting conflicts. When that happens, U.S. courts face their own dilemma. Should they, like doctors, follow the lead of cultural expectations, and insist that bodies fit into a male/female classification? Or should they, like the Constitutional Court of Columbia, recognize that the categories themselves may be grounded in intolerance of sexual difference and refuse to enforce them?
This essay explores the role of U.S. tort law in negotiating this dilemma. I argue that, in contrast to the Constitutional Court of Columbia, U.S. courts routinely embrace and, indeed, enforce an understanding of sexual identity that is deeply rooted in cultural assumptions about what is “natural” and “normal.” The most fundamental of these cultural understandings is the assumption that sexual identity occurs “naturally” as a binary category, with distinct physiological features associated with each sex. U.S. courts enforce this understanding of sexual identity not only in cases involving intersexuals and transsexuals, I argue, but in other contexts as well, when individuals have acted to reconstruct and/or amplify their sexual identity in ways which “mess with nature.”

The remainder of the essay is divided into four parts. Part I provides an introduction to some of the scientific and medical issues surrounding sexual identity. Part II addresses the theoretical issues that guide my analysis of the cases that follow. Part III provides some historical background on how U.S. courts have responded to questions about the biological “nature” of binary sexual identity. Part IV looks at several tort cases to show how tort law operates to enforce cultural understandings about sexual identity as naturally binary.

I: The “Science” of Sexual Identity

When a child is born, we ask: “is it a boy or girl”? When we ask this question, we assume that sexual identity is binary. You are born either male or female, with identifying characteristics that allow the doctor to assign you to your appropriate category. Even at birth, however, many bodies do not fit neatly within the rigid boundaries of a male/female classification. Perhaps because of this, sex classification experts struggle to identify reliable criteria for assigning sexual identity.
By one conservative estimate, some one in 2,000 children are born intersexed (Hermer 2002) and approximately one in 100 people have bodies which differ from the standard traits of a male or female (Blackless et al. 2000). Some intersexed children display ambiguous genitalia, such as children born with the external genitalia of a male but with ovaries instead of testes. Others have genital features that seem under or over-developed as compared to other children. An apparent “girl,” for example, might be born with an enlarged clitoris that looks like a penis. Alternatively, an apparent “boy” might be born with an extremely small penis, which doctors refer to as “micropenis.”

In some instances, however, the external genitalia are not ambiguous and the intersex condition is not discovered until puberty, when the child begins to exhibit developmental patterns that are at odds with the initial sex designation. This was the case with the protagonist of Middlesex. At birth, the child’s external genitalia appeared to be that of a girl. During adolescence, however, she began to develop traits that were more classically “male,” such as a deepening voice and a failure to menstruate. Upon closer examination, doctors discovered undescended testes and the presence of male (XY) chromosomes.

Under a chromosome-based classification system, the protagonist in Middlesex and many real people with this condition are categorized as male because of the presence of both an X and a Y chromosome. Individuals with two X chromosomes, on the other hand, are typically designated as “female.” Many individuals, however, have a chromosomal make-up that places them somewhat outside a simple XX versus XY classification.

Some babies, for example, are born XXY or XYY; others are born with only one X or extra Xs. In other words, chromosomal structure is considerably more variable than a simple XX
= female and XY= male classification. In general, the existence of a Y chromosome results in a “male” classification and the absence of a Y chromosome results in classification as a “female.” Such classifications can be confusing, however, particularly when the individual develops physical traits that do not fit clearly within their designated categories. Even in seemingly unambiguous cases (i.e., a clear XX or XY), chromosomal analysis can result in confusing classifications. Some XX individuals, for example, have both ovaries and external genitalia that appear “male” (Ben-Asher 2006: 51-52, n. 2). Others have undescended testes and “female” appearing genitalia.

For medical experts, the appearance of external genitalia tends to be considered more important than chromosomes in determining sexual identity. Current medical protocols, for example, indicate that newborn boys should have a penis that is at least 2.5 centimeters long and newborn girls should have a clitoris that is no larger than 1 centimeter (Ben-Asher 2006:61). Children who do not conform to these norms are designated for medical treatment, including hormone therapy and surgery, to help them more closely approximate the traits of either a male or female classification.

Although ambiguous genitalia pose no physical health risk, the birth of a child with ambiguous genitalia is deemed by medical experts to be a “social emergency” requiring immediate medical attention (AAP Policy 2000:138). As a practical matter, it is much easier to construct an artificial vagina than an artificial penis. Because of this, it remains standard practice within the medical profession to perform a sex change operation on children with unusually small penises or other “under-masculinized” traits, even if their chromosomes fit the XY classification as “male.” XX babies with enlarged clitoris, on the other hand, are not converted
into “boys” but undergo surgery to either remove or alter the clitoris to conform to medical expectations for girls.

The theory underlying these practices embodies two fundamental principles. The first principle is that it is essential to designate all babies as either “male” or “female” as quickly as possible. The second is that children cannot develop “proper gender identity” unless their bodies exhibit consistent “male” or “female” traits (Levit 1998: 240; Pleck 1987: 19). Under these protocols, “proper gender identity” means identifying as either a male or female, with the appropriate, matching genitalia. Individuals without appropriate genitalia are slated for surgery and counseling and individuals who fail to develop an appropriate gender identity are diagnosed with “gender identity disorder.”

Medical protocols on the appropriateness of transsexual surgery for adults follow essentially the same principles. With adults, however, candidates for surgery must have already developed a “proper gender identity.” Because of this, sexual reassignment surgery is recommended for adults only when the individual has a demonstrated history of identifying clearly as either a male or female. Individuals who espouse a more ambiguous sexual identity do not qualify (Spade 2003).

Much of the science to support these principles was developed in the 1950s and 1960s. Although the principles adhere strictly to a conceptualization of sexual identity as “naturally” binary (male/female), they also reflect the consensus of the medical community at the time that the development of sexual identity in any given individual was primarily a product of “nurture” rather than “nature” (Ben-Asher 2006). As a result, experts believed (and many still believe) that sexual identity can be altered with surgery and appropriate social conditioning.
As it turns out, the poster child for the nurture over nature perspective was David Reimer, whose initial conversion from a biological male to a biological female was widely reported as an unequivocal “success” in critically acclaimed articles published in peer reviewed journals and highly publicized media accounts which concealed his name. Although this perspective has been widely questioned since David Reimer went public with his subsequent change back to being a male, doctors in the U.S. continue to perform sex change operations on infants and children. This is largely because, regardless of whether the doctor adopts a view of sexual identity that is grounded primarily in “nurture” or “nature,” there is still a perceived need to identify the child as either male or female and surgery is one means of perfecting the categorization.

In sum, despite evidence to the contrary, medical protocols continue to operate on the assumption that sexual identity is, or perhaps should be, binary. Moreover, binary sexual classification is assumed to be “natural” and the categories of “male” and “female” are presumed to have certain “natural” characteristics, such as penises and clitorises of a particular size and shape. Put differently, the American medical community treats sexual identity and the classification of individuals into “males” and “females” as if the categories were a pre-cultural, biological given.

This is so despite the fact that, for many years, scientists spoke of sexual identity in terms of one sex, rather than two (Laquer 1990). And, even today, the existence of a “middlesex” is acknowledged in other cultures. Many Native Americans, for example, recognize intersexuels as a separate sex, which they refer to as “two spirit.” And, in India, Pakistan, and Bangladesh intersexuels are identified as “hijras” who are neither male nor female. All this suggests that sexual identity might be better understood as a cultural category that is mediated, at least in part,
II. Constructing Sexual Identity

If doctors observe bodies that defy a binary classification, why not abandon the classification scheme for one that seems more workable? Laquer (1990) argues that the conceptualization of sex as binary is a relatively recent cultural phenomenon that took place in the late seventeenth and eighteenth centuries. This reinterpretation of bodies took place in tandem with other political and cultural developments, including the rise of evangelical religion, Lockean ideas of marriage as a contract and post-revolutionary feminism, all of which led to greater emphasis on binary sexual differentiation.

Others present a somewhat more complex historical view of the development of contemporary understandings of sexual difference while still acknowledging the important role of culture in shaping these understandings (Cadden 1993). The studies agree, however, that our understanding of sexual difference is not based entirely on biological observation but rather, is “explicable only within the context of battles over gender and power” (Laquer 1990: 11). Moreover, because these battles play out in the form of competing narratives, cultural texts play a role in generating sexual difference.

Medieval scientists conceptualized sexual identity in terms of one sex instead of two primarily because “[l]anguage constrained the seeing of opposites and sustained the male body as the canonical human form” (Laquer 1990: 96). The conceptualization of sexual identity in terms of two sexes, on the other hand, grew out of a cultural climate that emphasized the importance of physical, and especially sexual, difference. Although the cultural settings were
quite different, in both instances, scientific understanding of sexual identity was shaped by “the rhetorical exigencies of the moment.” (Laqueur 1990: 243)

Judith Butler makes a similar argument in *Bodies that Matter* (1993). Butler analyzes gender (including sexual identity) in terms of how language and performance construct gender/sex in particular discursive contexts. Language does not simply create cultural categories (such as males and females), however, but extends to the *production* of material subjects, including human bodies, which correspond with the regulatory demands of a particular discourse (Butler 1993).

This conceptualization of sexual identity questions both the categorical distinctions between nature and culture, and the parallel distinction between sex and gender (Butler 1993: 223-26). These distinctions assert that culture and gender accrue to ontologically pre-existing or “biological” matter, such as biological sex. Butler argues, however, that this binary opposition between bodies (matter) and cultural constructions leads to a misconception of sexuality as either biological and natural (“sex”) or culturally constructed (“gender”). In fact, Butler suggests, both gender and sex are more likely the product of processes of both biological and cultural construction.

In making this move, Butler effectively asks us to transform our thinking about the stability of biological matter. In her analysis, the category of “matter” becomes a “process of materialization,” in which matter is materialized as an effect of cultural practices. In *Bodies That Matter*, Butler illustrates the materialization of sex and gender through a practice she calls “girling” (Butler 1993: 232-33). “Girling” is a process that is compelled by the naming of a “girl” as a “girl.” The symbolic power of this naming, in turn, effectively “governs the formation
of a corporeally enacted femininity” (Butler 1993: 232). In other words, gender and sex are produced and maintained through the repetition and citation of authoritative speech and actions. Seen in this way, gender and sex are not the products of “nature,” or even a particular choice, but are instead the effect of particular discursive practices.

Butler’s argument seems quite radical because it suggests that sexual identity is constituted by something other than naturally occurring biological differences. But, in many ways, Butler’s theory provides a powerful explanation of contemporary medical protocols concerning sexual identity. The fact that medical texts describe the birth of a child with ambiguous genitalia as a “social emergency,” for example, is indicative of the extent to which medical experts are themselves cognizant of the fact that the situation poses more of a cultural, rather than medical, dilemma.

The situation is said to constitute a “social emergency,” Butler’s theory suggests, because it reveals a gap between the cultural demand that sexual identity be binary and the reality of human experience. How doctors respond to this gap between the normative demands of sexual identity and what Butler would call the performance of sexual identity is also revealing. Although ambiguous genitalia pose no threat to the physical health of the child, surgical reconstruction and other physical treatments are typically employed almost immediately to literally construct binary sexual difference onto bodies that do not comply on their own. With this move, doctors expose their own role in the construction of sexual identity by, among other things, delineating and reconstructing bodies to fit within normative expectations (see Laquer 1990: 17).

Although the medical community is aware that these activities are problematic from a
health perspective (among other things, the surgeries pose risks of sexual dysfunction), the
treatments are defended on psychological grounds (Weil 2006). David Reimer’s story and other
anecdotal evidence, however, suggest that the psychological benefits of surgery are far from
clear (Weil 2006). Because of this, the Intersex Society of America opposes cosmetic genital
surgery on children (Weil 2006). At the same time, the Society supports assigning children a
gender at birth, primarily because its members believe that it is unfair to expect intersex children
to combat normative expectations of binary sexual identification on their own.

As Butler notes, this process of classifying individuals into binary categories is clearly an
artificial and “forcible” act, with its own consequences, including reification of the hegemonic,
binary regime (Butler 1993: 232). Scientific and cultural narratives that insist on a view of
sexual identity which privileges binary sexual identification play an important role in this
process. So does the law.

**III: Legal Narratives**

Most of us associate the study of law with formal rules and regulations and with the legal
institutions that play a role in enforcing societal norms and obligations. But “the formal
institutions of law” are “but a small part” of the legal universe “that ought to claim our
attention” (Cover 1994: 96). Legal narratives are of equal, if not greater importance. Like other
cultural narratives, legal narratives send a “message” about how the world is constituted (Merry
1990:9). Because of this, legal narratives can become hegemonic and, as a result, operate as a
mechanism of social control.

Legal narratives about sexual difference have taken two, somewhat divergent paths in the
United States. On the one hand, courts have moved in the direction of avoiding sex-based
distinctions that are based on stereotypes and unfounded assumptions. In *Craig v. Boren* (1976), for example, the Supreme Court proclaimed that there is a “weak congruence between gender and the characteristic or trait that gender purport[s] to represent” (*Craig v. Boren* 1976: 199). Because of this, the court held, gender-based distinctions should be scrutinized closely to ensure that sex-based generalizations comport with factual realities.

In other rulings, however, courts have adhered strictly to sex-based generalizations that embody popular assumptions about biological differences between males and females. One important example of this in the area of women’s rights is in the court’s use of a lower standard in assessing discrimination in sex discrimination cases than is employed in race discrimination cases. In cases alleging race discrimination, courts employ a “strict scrutiny standard,” in which the government must demonstrate a compelling state interest in treating people differently. Sex discrimination cases employ a less stringent standard, known as “intermediate scrutiny,” which requires only that the challenged differences in treatment be substantially related to an important governmental objective (Tribe 2000, see also Chamallas, this volume).

The use of a lower standard for sex than is employed for race is justified by the proposition that there are meaningful, biological differences between men and women that apply to every individual (Levit 1998: 66). In *Michael M. v. Superior Court of Sonoma County* (1981), for example, the Supreme Court ruled that biological differences between boys and girls provided an adequate justification for sex-based differences in California’s statutory rape law (*Michael M. v. Superior Court of Sonoma County* 1981: 464). And, in *Nguyen v. INS* (2001), the Court upheld different rules for attainment of citizenship by children born abroad out of wedlock, depending on whether the mother or the father was the American, on the ground that
“basic biological differences” between men and women affect parent-child relationships in meaningful ways (Nguyen v. INS 2001: 57).

Other court rulings reflect cultural expectations about what sexual difference should look like. For example, courts have upheld employers’ decisions to fire women who wear pants (see, e.g., Tamimim v. Howard Johnson Co. 1987) or refuse to wear make-up (Bartlett 1994). And employer policies that terminate men for having long hair or wearing jewelry have also withstood legal challenge (Levitt: 99-100). The rationale in these cases is nearly always the same and involves the reasoning that the dress codes do not discriminate on the basis of sex but, rather, require both men and women “to dress in conformity with the accepted standards of the community” (see, e.g., Harper v. Edgewood Board of Education 1987).

Courts enforce similar expectations in cases involving transsexuals. In a 1993 case decided by the Washington Supreme Court, for example, a corporate dress policy that required a pre-operative transsexual to dress in a unisex fashion against the advice of her doctor was upheld as an acceptable policy for the employer to enforce (Doe v. Boeing 1993). Central to the court’s reasoning was the fact that the transsexual plaintiff was still a “biological male.”

Rulings like these suggest the extent to which American law continues to enforce sex and gender-based distinctions believed to be grounded in “nature” or a pre-cultural, biological reality. In each of these cases, courts rely on an understanding of sex as “naturally” binary and associated with particular physical characteristics. In doing so, they employ a form of biological essentialism in determining the rights and remedies to be afforded to the complaining parties.

Cases involving transsexuals, of course, often pose serious challenges to these assumptions. And, in one recent case, a Kansas court suggested that, in cases involving
transsexuals, courts might consider abandoning an approach that relies on a binary conception of sexual identity. The case involved a male to female transsexual who, after sex reassignment surgery, married a biological male. After her husband died, her husband’s son from another marriage sought to disinherit her from her husband’s estate on the ground that the marriage was invalid because both parties had been born “male” (*In the Matter of the Estate of Marshall G. Gardiner* 2002).

In attempting to adjudicate the case, the Kansas intermediate court of appeal noted the difficulty in determining what constitutes a male or female. After considering an array of factors employed by medical experts, including appearance of the genitalia and chromosomes, the court concluded that it could not rely on only one factor because the question of sexual identity was “far more complex” than could be captured with a single factor (*In the Matter of the Estate of Marshall G. Gardiner* 2002:74). Ultimately, the court suggested “it is only the [individuals] themselves who can and must identify who and what they are” (id.: 75).

On appeal to the Kansas Supreme Court, the higher court reversed the intermediate court of appeals and instructed the trial court to rely solely on dictionary definitions of what constitutes males and females. According to the definitions employed by the court, a “‘male’ is defined as ‘designation or of the sex that fertilizes the ovum and begets offspring’” and a “‘female’ is defined as ‘designation or of the sex that produces ova and bears offspring’” (id.: 52). A male to female post-operative transsexual can not qualify as a female, according to this definition, the court concluded, because the “ability ‘to produce ova and bear offspring’ does not and never did exist” (id.: 53).

What is especially fascinating about this opinion is the large number of people that it
excludes. If we take the court seriously, individuals who cannot fertilize an ovum or ovulate do not qualify as either male or female and are thereby precluded from enjoying any of the benefits of the binary sex regime. In other words, sex is not only “natural” and binary in this legal narrative but also linked closely with reproductive capacity.

IV: Torts and Sexual Identity

Legal narratives about sexual identity and difference have also played an important role in the development of American tort law. As Chamallas (this volume) notes, recovery for mental distress in American tort law, for example, was made possible, in part, because it proved effective at reinforcing cultural beliefs about the emotional sensitivity of white women. And, in a similar way, cultural conceptions of “male honor” and “female chastity” inflected the development of the tort of solicitation (id.).

This section looks at more contemporary cases to show how tort law continues to operate to enforce cultural expectations about sexual difference. Drawing on cases in three different areas of tort law – wrongful death/survival claims, products liability, and medical malpractice – I argue that cultural and legal narratives both enforce and reproduce a binary conception of sexual identity which links sexual classification to bodies that look and operate in particular ways.

A. Wrongful Death/Survival Claims

Christie Littleton was born Lee Cavazos, Jr. and designated a male at birth (Littleton v. Prange 1999). At the age of 27, however, Christie underwent sex assignment surgery and became an anatomical female. A few years later, she married Jonathan Littleton and lived with him until his death. After he died, Christie filed a medical malpractice claim against her husband’s doctor in her capacity as the surviving spouse. The doctor argued, however, that the
case should be dismissed because Christie was not a “real” woman and therefore could not be the surviving spouse of Jonathon Littleton. The trial court agreed and entered summary judgment for the doctor. (Littleton v. Prange 1999: 224).

On appeal, the court noted that since Texas did not recognize marriages between persons of the same sex, the key question before the court was whether “Christie [is] a man or a woman?” In attempting to answer this question, the court acknowledged that Christie currently had the “anatomical and genital features” of a female and that she had “the capacity to function sexually as a female” (Littleton v. Prange 1999: 225). The court also acknowledged that many physicians would consider her a female. For the court, however, the most important question was not what Christie looked like now but whether Christie was “created and born a male” (Littleton v. Prange 1999: 231). Because Christie’s female anatomy was “all man-made,” the court reasoned she was not a “real” woman (Littleton v. Prange 1999:230). As a result, her marriage to Jonathan Littleton was illegal and she could not recover as his surviving spouse.

As the Littleton case illustrates, many tort claims, including wrongful death, alienation of affection, loss of consortium and negligent infliction of emotional distress, rely upon the existence of a marital relationship for the plaintiff to establish a claim. When that relationship comes into question as a result of questions about the validity of the marriage, then the claim itself may be in jeopardy. In the case of transsexuals, for those courts (and there are many) which refuse to recognize a marriage between a transsexual and an individual of the same birth sex, tort litigation of this kind is not an option for the recovery of damages stemming from negligent or intentional conduct which had an impact on the marriage (see also Bume v. Dr. Roy J. Catanne 1971 (rejecting similar claims brought by male to female transsexual wife)).
*Littleton* is also indicative of the extent to which the courts’ confusion over how to determine sexual identity can lead to somewhat unexpected results. *Littleton* relied upon the designated sex at birth to determine sexual identity. As two lesbians discovered recently, however, this means that, under *Littleton*, a male to female transsexual may legally marry another female in Texas. Interestingly enough, the marriage received the blessings of the president of the Texas Conservative Coalition, which ordinarily opposes same sex marriage, because, anatomy aside, “[t]hey are *legally* a man and a woman” (Kurtz 2000).

The ruling also raises questions about the legal status of those millions of Americans who do not clearly qualify as a man or a woman, in terms of their chromosomes or external genitalia at birth, and of those individuals whose external genitalia and/or sexual identification change significantly during puberty. Under the court’s ruling, these individuals are also precluded from bringing tort claims that rely upon the existence of a marriage between two individuals whose sexual identity classifies them as members of the “opposite” sex (cf. Chamallas, this volume, noting how, in a similar way, gender ideology historically closed off recovery for certain types of “dignitary” harms).

**B. Products Liability**

In cases involving transsexuals, the law’s role in regulating sexual identity is often directly at issue. As in the *Littleton* case, the court must face the question of what constitutes a man or a woman directly. In other tort cases, however, tort law may act more subtly to enforce and reproduce sex and gender norms in litigation that do not ostensibly address such questions. An example of this can be found in the regulation and litigation surrounding breast implants.

Like genitalia, breasts have tremendous symbolic import in the differentiation of sexes.
Medical literature describes breasts of an appropriate size and shape as “essential” for a female’s mental health and well-being (Spanbauer 1997: 183). Individuals with breasts that are deemed too small are diagnosed with a condition called “micromastia” and, along with those who have lost breasts due to mastectomy, are recommended for reconstructive surgery. Others choose to undergo implantation surgery without a medical diagnosis, so as to “emphasize something specifically female about themselves” (Allen 1984: 83-84). Silicone implants were, and remain, extremely popular because they look and feel more “natural” than other options, such as saline implants or prostheses (Coniff 1997).

Tort law became involved in regulating breast implantation practices when some individuals began to claim that silicone implants ruptured and leaked, causing serious injuries. The first products liability lawsuits were filed against the manufacturers in the early 1970s. Nearly all of these cases settled under conditions of secrecy. In the fall of 1991, however, the Food and Drug Administration (FDA) obtained access to some of the court documents and, after reviewing the documents, the FDA called for an immediate moratorium on some uses of silicone implants.

Because of concerns about safety, the FDA urged plastic surgeons to immediately stop using silicone implants in patients undergoing implantation for “purely cosmetic” purposes (Gladwell 1992). Exempted from the moratorium, however, were silicone implants used for purposes of reconstructing breasts lost to mastectomy or the correction of “micromastia.” The agency explained its decision to allow for this exemption by citing the unique physical and psychological “need” of individuals in these categories for access to the much more natural looking silicone implants (Gladwell 1992).
An explosion in breast-implant related lawsuits followed. Many of these cases were consolidated into a class action which ultimately settled (Lindsey v. Dow Corning Corp. 1994). Some implant recipients, however, chose to proceed with individual litigation, outside the class settlements. Despite the early litigation successes, public opinion began to turn against these individual implant recipients and manufacturers began to win a very large percentage of the individual cases.

Although sexual identity was not directly at issue in the breast implant litigation, the law operated in these cases to enforce and reproduce cultural understandings about sexual identity as “naturally” binary and associated with certain bodily characteristics. What is interesting about breast implantation practices, however, is that, much like sex reassignment surgery, the practices effectively reproduce a “natural” conception of sexual identity, while simultaneously exposing its artificiality. This is because, to the extent that implantation surgery is successful and the artificial breasts seem “real” to all observers, breast implantation practices help to regulate and produce a conception of sexual identity, in which females appear to “naturally” have breasts of a certain size and shape. At the same time, surgical implantation practices reveal a gap between the cultural message that binary sexual categorization is “natural” and the physical experience of being male and female, which sometimes requires artificial help to “fully approximate the norm” (Butler 1993:232)

The FDA’s regulatory decisions played a role in re-enforcing the cultural message that binary sexual categorization is “natural” and, specifically, that breasts of a particular size and shape are necessary to qualify as a woman. This is most clearly seen in the FDA’s conclusion that, despite concerns about the safety of silicone implants, it would continue to allow restricted
use of silicone gel implants for those women seeking reconstruction of breasts lost to
mastectomy or seeking treatment for “micromastia” (flat-chestedness).

Like genital surgery on intersex infants, from a safety perspective, the FDA’s decision is
difficult to understand. If there was a problem with the safety of silicone implants, then the
agency should have pulled silicone implants from the market for all purposes, especially since
alternatives to silicone implants, such as saline implants and prostheses, were readily available
(Yang 2001). The FDA’s decision begins to make more sense, however, when we consider, as
the FDA apparently did, that the absence of “natural” looking breasts in adult women constitutes
a “social emergency” (cf. AAP Policy 2000:138 (protocol for ambiguous genitalia)). Under
these circumstances, the risks associated with silicone implants were, in the FDA’s view,
outweighed by the fact that the alternatives did not provide women with breasts that appeared
sufficiently natural (Kessler 1992).

Like the FDA’s regulatory actions, the valuation of claims in the breast implant litigation
also enforced a conception of “natural” binary sexual identity by valuing the claims of
individuals who underwent surgery to replace a breast more highly than those who underwent
surgery for enlargement purposes. The implicit message of this differential valuing is that it is
wrong to “mess with nature,” for purposes other than reconstructing a “natural” state of affairs
(e.g., reconstruction after mastectomy). There is ample evidence, for example, that “juries tend
to be more sympathetic” to individuals who undergo breast implant surgery for what is perceived
as “purely reconstructive” rather than cosmetic purposes (Collins 1997; see also Chamallas, this
volume, noting that “traditional moralism … remains a live issue especially in cases brought by
plaintiffs who do not conform to contemporary models of respectability”).
A similar issue came up in a breast implants case which raised the issue of whether a claim for strict liability based on design defects should be available as a potential cause of action for implant recipients who did not undergo implant surgery to replace a breast lost to mastectomy (Artiglio v. Superior Court of San Diego County 1994). Ultimately, implant recipients were allowed to proceed with strict liability based claims, without regard to the implant recipients’ motivations for obtaining the implants. The court noted, however, that there were important differences between using the implants for purposes of “restoring the body to natural form” and using them to “enhance esteem and add to life’s enjoyment” (Artiglio v. Superior Court of San Diego County 1994: 1395). In this way, the court signaled, once again, that sexual identity is natural.

C. Medical Malpractice

One of the issues raised by the experience of David Reimer and other individuals who undergo sex re-assignment surgery as an infant or small child is whether the individuals might later bring tort litigation against the doctors for malpractice and/or battery. There are no reported cases to date of such litigation in the U.S. Several cases have been brought in Australia and Columbia, however, and these cases suggest that such litigation is also on the horizon of the U.S. legal landscape.

In Australia, one of the more publicized cases was brought by Tony Briffa, an intersex activist, who is attempting to sue his doctors for medical malpractice in reassigning him as female, including castration at age 7 and hormone treatments beginning at age 11 (see “Choosing the Right Gender” 2005). Like David Reimer, however, Briffa never identified as a female and, at age 30, reassigned himself as a male.
Other cases in Australia indicate that a court order may now be necessary before a physician may perform sexual reassignment surgery. In *In Re A (A Child)* (1993), an Australian court determined that, in a case involving genital injury after birth, a court order was required before a physician could reassign the child to a different sex. Physician and parental decisions to operate on children born intersexed, however, still require no outside authorization or approval. Instead, it is considered standard medical practice for the doctors to recommend, and the parents to authorize, surgery to make the child conform to a male or female sex at a very early age.

It is in Columbia, however, where courts have confronted the question most extensively. The Constitutional Court of Columbia has now heard three cases involving the question of surgery on intersexed infants. In two of those cases, the court issued rulings restricting the ability of parents and doctors to consent and perform the surgery (Sentencia Su-337/99 1999; Sentencia T-551/99 1999). The third case ruled in favour of a young man who had already undergone such surgery and determined that the consent given by his parents was insufficient (Sentencia T-477/95 1995).

These rulings have significantly altered the practice of surgery on intersexed infants in Columbia. Today, most physicians in Columbia will no longer perform the surgery without a court order. Encouraged by these rulings, intersex activists in the United States are also pursuing the possibility of suing physicians who perform the surgery at a very early age. Cases which result in a loss of sexual function and/or in which the adult gender identity conflicts with the surgically-created sex are considered the most promising. As in Columbia and Australia, parental consent to the surgery poses a key challenge to the successful suit of such litigation, as does the tort doctrine which bars medical malpractice claims when the doctor’s actions are
consistent with prevailing professional customs.

**Conclusion**

The foregoing cases reveal both the reliance on an understanding of sex as “naturally binary” in American tort law and the fragility of the assumptions upon which this understanding rests. By continuing to base legal rulings on invalid assumptions about sexual identity, courts enforce cultural norms about both the binary nature of sexual identity and what it means to be a male or female. In doing so, courts are handling sexual identity in much the same way that they once handled questions of racial identity (see, e.g., Wriggins, this volume). As was the case in race cases, courts are employing a kind of “biological essentialism” to determine who is a male and who is a female, which relies heavily on questionable medical protocols that are themselves deeply imbricated with cultural expectations.

As with race, the science of sexual difference is itself a cultural construction. Because of this, the so-called “biological indicators” of sexual identity are of questionable utility. The physical and social experience of sex and gender simply do not fit neatly into a binary categorization. As a result, when courts rely upon scientific and medical expertise to evaluate sexual difference, they necessarily play a role in the enforcement and reproduction of cultural norms about what bodies should like.

Tort law is not unique in the role that it plays in this process. Like other legal narratives, tort law narratives both reflect and contribute to broader cultural meanings. Cultural norms about sexual difference may be particularly susceptible to enforcement and reproduction in tort law, however, because of the way in which many tort doctrines operate to explicitly to draw upon dominant cultural norms.
First, and most obviously, is the fact that most tort cases are tried to a jury which, in many cases is explicitly charged with determining liability on the basis of norms (see generally Hans, this volume). Most tort cases also rely on expert testimony and, under current doctrine, medical viewpoints that are consistent with professional custom and/or have been published in peer review journals, are treated with extensive deference. As a practical matter, this means that, in the context of tort litigation, doctors and other medical experts become the arbiters of what constitutes sexual identity.

Finally, damages principles that focus on making the body “whole” may also play a role in encouraging a view of sexual identity in which assumptions about what is “natural” play a particularly important role. This is because the goal of making a victim whole is often interpreted as putting things back to their “natural” state. For all of these reasons, tort law may be especially vulnerable to cultural assumptions about the “nature” of sexual identity.
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