Allyship to the Intersex Community on Nonconsensual Genital "Normalizing" Surgery

Robert Hupf, Jr
ALLYSHIP TO THE INTERSEX COMMUNITY
ON NONCONSENSUAL GENITAL “NORMALIZING” SURGERY

ROBERT HUPF†

TABLE OF CONTENTS

I. A RESPONSE TO THE QUESTION “WHAT’S NEXT?” .............................. 2-5
II. BEFORE WE BEGIN, INTRODUCTIONS PLEASE .............................. 5-8
III. MANNERS: MINDING YOUR Ps AND Qs ........................................ 8-12
    A. “Intersex” ................................................................................. 8-9
    B. “Disorders of Sex Development” .............................................. 9-11
    C. “Transgender” ......................................................................... 11-12
    D. “Hermaphrodite” ....................................................................... 12
IV. LET’S GET TO WORK, WHERE DO WE STAND? .............................. 13-18
    A. Historical Development ............................................................ 13-16
    B. Current Movement .................................................................... 16-18
V. WHAT IF WE...BUT WHAT ABOUT...HOW ABOUT WE JUST .......... 18-24
    A. Alternative Theoretical Solutions ............................................. 18-21
    B. Intersex Community Perspective ................................................ 21-24
VI. BUT I HEAR THE INTERNATIONAL SCENE ALREADY SOLVED THIS? .. 24-35
    A. General Scene .......................................................................... 24
    B. Puerto Rico .............................................................................. 24-25
    C. India ....................................................................................... 25-27
    D. Nepal ...................................................................................... 27-28
    E. Colombia .................................................................................. 28-31
    F. Germany ................................................................................... 31-35
    G. Conclusion ............................................................................... 35
VII. OK, OK. SO WHAT’S NEXT? ......................................................... 35-39
VIII. YOU CAN COUNT ON ME.............................................................. 39

Copyright © 2014 by Robert Hupf.
† J.D. Candidate, City University of New York School of Law, May 2015;
B.A., University of Miami, 2012. The author would like to thank Professor
Ruthann Robson for her invaluable comments, suggestions, and critical feedback
throughout the drafting process. Additionally, the author would like to thank Diana
Aragundi, Johanna Ocana, Michelle Rattoballi, Philippo Salvio, Joey Schofield,
and Sarah Verbil for all the support, counsel, and criticism throughout the process.
Despite marriage equality being further down my own list of priorities for the larger LGBTQ struggle, I remember celebrating after the *Windsor* decision. Several of my friends saw it as a personal victory; some, particularly friends down in Florida (where same-sex marriage has not yet been recognized at the state level), even began discussing whether they would travel / move to states that had already recognized same-sex marriages in the near future. Everyone was excited; I was excited for them. In that moment, what true allyship entailed was being there to celebrate a substantive victory that, for many individuals, felt like the overcoming of a major obstacle they had struggled against all their lives.

At the same time, true allyship also required not forgetting, in that celebratory moment, other individuals still fighting. Remembering that within the larger movement, marriage equality was only one of the more mainstream goals; it did not encompass the goal, or even that great an achievement, for other members of the LGBTQ community. And while the

---

1 In terms of my own list, many of the priorities I would like to see the larger LGBTQ movement focus more time on are systemic in nature – mass incarceration, lack of access to healthcare, cycles of poverty, homelessness, etc. These issues tend to disproportionately affect the LGBTQ community, particularly LGBTQ youth, and thus have a greater impact on the lives of all community members as a whole than issues such as marriage equality (which really is only an issue for individuals with the means and intent of supporting marriage as an institution).

2 LGBTQ is used in this article to refer to all members of the larger queer community for simplicity purposes. I acknowledge the fact that many other self-identity categories and labels exist along the sexuality, gender, and sex spectrum as well (gender non-conforming, pansexual, asexual, intersex, and questioning are some examples). Many also have chosen not to self-identify and reject the use of any such exclusive terminology. Some even reject the term “queer,” used in the postmodern sense to refer to performances beyond the dominant narrative required by society, believing it to ascribe to the same discursive system that excludes the Other whom does not self-identify within that category. However one self-identifies, if that identity falls beyond the dominant heterosexual, monogamous, male-female, masculinity / femininity norm of modern society, please know that this article embraces you as a member of the larger community being addressed, family in the struggle.


4 *Id.* at 2695-2696 (The Court narrowly applied its holding in *Windsor* to “persons who are joined in same-sex marriages made lawful by the State . . . This opinion and its holding are confined to those lawful [state] marriages”).
maxim “until we are all free, we are none of us free” is a difficult one to abide by, it stands (at least to me) as one of the largest litmus tests in assessing true allyship and movement solidarity.

Which meant it was a bit odd to me that, after Windsor, a particular discussion kept coming up concerning the larger LGBTQ movement: “what’s next?”

That question is odd to me because various members of our community have already answered that question, have been answering that question for a long time. Folks seem to be searching for a cause, an issue to rally around, but members of our own family have expressed concerns, raised immediate needs, and requested support on fights occurring on a daily basis.

Most likely, the explanation for the lack of focus on these sub-community issues is a numbers game – because there are fewer members of a particular sub-community, their concerns, needs, and demands ring out less. But numbers are irrelevant under the allyship model encouraged above; instead of searching for the next big issue, the movement should


Although Emma’s work has sometimes drawn criticism for problematic assumptions made, the phrase used here has lived on and grown to encompass a radical ideology of solidarity amongst anti-oppression allies.


7 For example, the most recent estimates concerning the prevalence of those born with an intersex condition place their numbers around 1.9% of all live births, substantially more if the definition of intersex is expanded to include those born with genitalia that deviates from the norm. Organization Intersex International places the rate at about 1 out of 1500 births. Organization Intersex International, On the Prevalence of Intersex and the Various Numbers Quoted for It, http://oiiinternational.com/587/prevalence-intersex-numbers-quoted/ (last updated January, 2012).
look inwards and attempt to address the smaller (and sometimes much larger) pressing needs of various members of the community. In doing so, the community must also be mindful of the specific recommendations and requests those sub-communities have encouraged in addressing their problems. “True allyship” does not exist when well-intentioned, privileged individuals assume that they know the best solution to a problem, even against the expressed wishes of those most affected. Deference to those with lived experiences, who bear the brunt of the consequences of the problem, must take precedence.

This article will be discussing and recommending support for one such sub-community and their needs: the intersex community and their fight against nonconsensual genital “normalizing” surgery. The framework for the paper will be one encouraging the adoption and acceptance of a movement based on allyship, even if what is requested of allies seems difficult or counterintuitive. Part II will be an introduction to the issue of nonconsensual genital “normalizing” surgery, including a discussion of concerns raised by the intersex community regarding well-intentioned, but ultimately unhelpful (at least in the immediate sense), contributions of would-be allies. Part III will examine the intersex community itself, how it self-identifies, understands, and operates internally, particularly noting various disputes and divergent movements that have arisen internally.

See also Emi Koyama, Suggested Guidelines for Non-Intersex Individuals Writing About Intersexuality and Intersex People, http://www.isna.org/pdf/writing-guidelines.pdf (“Recognize that you are not the experts about intersex people, intersexuality, or what it means to be intersexed; intersex people are. When writing a people about intersexuality, make sure to center voices of intersex people.”).
within the past few years. Part IV will examine the history of nonconsensual genital “normalizing” surgery and assess the current status and struggle of intersex activists. Part V will examine various theoretical contributions by scholars on breaking down sex-based binary systems as a possible solution to the needs expressed by the intersex community. Part VI will examine how various international agents have responded to the concerns of the intersex community and assess whether the approaches taken actually solve, or even address, those particular concerns. Part VII will examine the current situation in the United States and assess the approach being taken there to engage with the nonconsensual genital “normalizing” surgery issue. Part VIII will conclude by advocating for the larger movement to embrace a “true allyship” approach moving forward – instead of looking for an issue to rally around, the community should instead focus its attention on members who need solidarity right now. In doing so, the community must also be mindful of the approaches suggested, mindfully considering whether they actually help or hinder those individuals most affected by the problem.

BEFORE WE BEGIN, INTRODUCTIONS PLEASE

“This movement is not about me. It is about the persons . . . most affected by this injustice.”

Since it’s founding in 1993, the Intersex Society of North America (ISNA) had consistently advocated “for patients and families who felt they had been harmed by their experiences with the health care system.” As noted by Cheryl Chase, ISNA’s founder, and various other personal narratives shared by intersex individuals within the community, this harm

10 This particular part of the article is necessary in order to affirm the terminology and language embraced by the community itself. Noting and embracing these preferences is needed to prevent discursive violence by non-members merely commenting on the community.
14 See Alice Dreger, Why Do We Need ISNA? ISNA NEWS, May 2001 http://isna.org/newsletter/may2001/may2001.html (noting that, due to the sensitivity of the topic, many members of the intersex community are hesitant
chiefly manifested itself through “unwanted genital surgeries for people born with an anatomy that someone decided is not standard for male or female.” While the fight still continues on this issue, ISNA itself unfortunately closed its doors in March 2008.

Other intersex activist organizations, including ISNA’s direct successor Accord Alliance\(^{17}\), the Intersex Initiative\(^{18}\), and the Organization Intersex International (OII)\(^{19}\), have all consistently and repeatedly noted this same primary goal: to end the medical standard of secret, unnecessary (often referred to as “cosmetic”), nonconsensual genital “normalizing” surgeries.\(^{20}\)

At the same time, several legal scholars, theorists, and authors commenting on the intersex community have focused their attention on the existence of the intersex community as illustrative of the failings of the

---

\(^{15}\) ISNA, supra note 12.


\(^{21}\) This sample selection of intersex organizations is not meant to embody the entire perspective and / or sentiments of every individual within the intersex community. The organizations themselves disagree on various positions. These organizations do provide, however, illustrations on how the intersex activist community has consolidated testimonials and generated support in the fight against nonconsensual genital “normalizing” surgery.
male / female sex binary system of identification. Proposals have been made to challenge this binary through the creation of a “third gender” and the elimination of government-mandated sex identification on documentation (birth certificates, passports, etc.). These proposals are connected to the intersex activist movement against nonconsensual genital “normalizing” surgery through the premise that it is the sex binary system itself that justifies and pressures the use of such surgeries.

This paper argues that social theorists, while necessarily commenting on the systemic structures maintaining oppression generally, while necessarily commenting on the systemic structures maintaining oppression generally,

---

22 But see Koyama, Suggested Guidelines (“Do not use intersex people merely to illustrate the social construction of binary sexes.”).

23 See Jo Bird, Outside the Law: Intersex, Medicine, And the Discourse of Rights, 12 Cardozo J.L. & Gender 65, 77 (Fall, 2005) (noting the recommendation made by Tony Briffa on behalf of the Androgen Insensitivity Syndrome Support Group Australia (AIISSGA) seeking for intersex individuals to be “legally recognized as intersex in lieu of male or female.”).

24 Elizabeth Reilly, Radical Tweak – Relocating the Power to Assign Sex: From Enforcer of Differentiation to Facilitator of Inclusiveness: Revising the Response to Intersexuality, 12 Cardozo J.L. & Gender 297, 297-298 (Fall, 2005).

25 Samantha Uslan, What Parents Don’t Know: Informed Consent, Marriage, and Genital-Normalizing Surgery on Intersex Children, 85 Ind. L.J. 301, 302 (Winter, 2010) (“The driving force behind the performance of genital-normalizing surgeries is society’s insistence that each person fit neatly within the binary gender system, which includes only the categories of male and female. It is this insistence that pressures parents to consent to genital-normalizing surgeries in the first place.”).

26 It is here that I wanted to note how often I myself fall into this theorizing group; I am just as guilty as anyone else in struggling with the belief that feminist, postmodern, and queer theories hold the key to emancipatory liberation for the oppressed masses. As someone who only recently began client-centered legal work, I would like to stress the need for social interaction and discussion with actual members of these oppressed communities, particularly for social justice allies who also intend to be lawyers. The conversations, and lived experiences shared, have really grounded my theorizing to attempt to match such theoretical solutions to the real problems of clients. It is often incredibly hard to do so, even more so when the solution offered is so remote and abstract as to be beyond any immediate practicability to their lives.

I have sometimes also felt that the immediate needs and desires requested of me would merely entrench and reify various systems of oppression. In asking more experienced social justice lawyers how they overcome this struggle, I am constantly told that the movement is to be led by the people most affected. Even though I may personally disagree, as a social justice lawyer, my role is to listen and zealously advocate; my own hesitations and beliefs, often born from a privileged
are forgetting the people they are attempting to liberate through such criticism. As such, they are failing to be true social justice allies.\textsuperscript{27}

Of particular note is these proposals having an impact beyond the mere theoretical world of academia.\textsuperscript{28} Internationally, instead of addressing the continued abuse of nonconsensual genital “normalizing” surgery, nations have attempted to assist the intersex community by recognizing the community’s status as an \textit{identity} outside the ordinary sex binary, either through the creation of a new category of sex or through the elimination of sex identification requirements. Only two countries,\textsuperscript{29} despite 20+ years of directed advocacy from the intersex community about its main concern, have ever specifically addressed nonconsensual genital “normalizing” surgery itself.

\textbf{MANNERS: MINDING YOUR PS AND QS}

“I serve in this movement as an invited guest.”\textsuperscript{30}

\textbf{A) “Intersex”}

The label “intersex” itself has a contentious history, even within the community itself. OII defines intersex as “congenital difference in anatomical sex. That is, physical differences in reproductive parts like the testicles, penis, vulva, clitoris, ovaries and so on. Intersex is also physical differences in secondary sexual characteristics such as muscle mass, hair distribution, breast development and stature.”\textsuperscript{31} Generally, members of the position, should not trump the knowledge of those who bear lived experiences of oppression. There are things I do not, and cannot, know without those lived experiences. \textit{See} Koyama, \textit{supra} note 9.

\textsuperscript{27} \textit{See} Rigby, \textit{supra} note 11.
\textsuperscript{28} \textit{See infra} section VI.
\textsuperscript{29} Colombia and, most recently, the United States.
\textsuperscript{30} Rigby, \textit{supra} note 11.
\textsuperscript{31} Board of OII Australia, \textit{“What is Intersex?”} \url{http://oiiinternational.com/intersex-library/intersex-articles/what-is-intersex-oii-australia/} (last updated June, 2011); \textit{see also} United Nations Free & Equal Campaign, \textit{Fact Sheet: LGBT Rights: Frequently Asked Questions} \url{https://unfe-uploads-production.s3.amazonaws.com/unfe-7-UN_Fact_Sheets_v6_-FAQ.pdf} (“An intersex person is born with sexual anatomy, reproductive organs, and/or chromosome patterns that do not fit the typical definition of male or female. This may be apparent at birth or become so later in life. An intersex person may identify as male or female or as neither. Intersex status is not about sexual orientation or gender identity: intersex people experience the same range of sexual orientations and gender identities as non-intersex people”); Gina Wilson, \textit{The Terminology of Intersex}, \url{http://oiiinternational.com/2602/terminology-intersex/} (“[I]t is simply a
2014] ALLYSHIP TO THE INTERSEX COMMUNITY

community do not treat the term as a self-identity category; instead, the term is used to describe a medical condition or a unique physical state possessed by individuals within the community. The “intersex community” thus refers more to individuals born with a specific physical state than to individuals self-identified as such. Other labels, including male, female, straight/heteronormative, and LGBT are common within the community. In terms of Preferred Gender Pronouns (PGPs), intersex organizations recommend that “pronouns should not be based on the shape of one’s genitalia, but on what the person prefers to be called . . . [However,] Do not call intersex children “it,” because it is dehumanizing.

B) “Disorders of Sex Development”

In the medical community, intersex conditions are referred to as “disorders of sex development" (hereinafter “DSD” or “DSDs”). The decision to drop the term “intersex,” focusing instead on labeling intersex conditions, was a result of the 2006 Consensus Statement on Management of Intersex Disorders [hereinafter Consensus Statement]. The Consensus Statement concluded that, because terms such as “intersex” are “controversial,” “potentially pejorative,” and “confusing to practitioners and parents alike,” a better term was needed. The Consensus Statement defined DSDs as “congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical.”

way of describing the continuum of differences from wholly male to wholly female.” (last updated January, 2012).

32 Wilson, The Terminology of Intersex; see also Intersex Initiative, Intersex FAQ. See Intersex Initiative, Intersex FAQ.
33 See Organization Intersex International, Brief Guidelines for Intersex Allies.
34 See Intersex Initiative, supra note 32.
35 Id.
36 Id.
39 Id.
40 Id.
41 Id.
42 Id.
Different segments of the community have expressed divergent views on the label. For some members of the community, the word “disorders” pathologizes the existence of intersex individuals and further asserts the need of doctors to “cure” any intersex condition. For others, the term avoids the widely variant definitions of “intersex,” focusing attention on the physical body’s condition and rejecting the somewhat confusing use of “intersex” as a self-identity label.

More recent commentary on the label by members of the intersex community seems to reject the usage of DSD. Organization Intersex International acknowledges that while “not all intersex like being called intersex,” the creation and usage of the term DSD merely promotes the invisibility and homophobic exclusion of the intersex community. Additionally, members of the community feel as if the language change was made without their contribution and without any discussion, even if such a change was medically convenient and/or necessary. Because of this history, many members of the community still embrace the term “intersex.”

---


44 See Wilson, The Terminology of Intersex.

45 Emi Koyama, Frequently Asked Questions about the “DSD” Controversy, http://www.intersexinitiative.org/articles/dsdfaq.html (last updated June, 2008); see also Koyama, From “Intersex” to “DSD.”

46 Wilson, supra note 43 (“There are no intersex people, to our certain knowledge, who use or approve of this terminology.”).


49 See Koyama, Frequently Asked Questions about the “DSD” Controversy (“[O]nly two intersex activists were invited to the LWPES / ESPE meeting that produced “Consensus Statement” and sanctioned the term “DSD,” . . . . Then, the participants subdivided into six working groups, effectively denying activists’ ability to influence majority of the proceedings . . . . One could reasonably argue that the whole setup was rigged and activists should have simply run out of the door . . . .”).

50 See Koyama, supra note 48.
C) Transgender

In recent years, the grouping of intersex as a subcategory of transgender has also become prevalent. Intersex activists dispute the transgender classification and view the grouping as an attempt to make the unique needs of the intersex community invisible or secondary.

Intersex activists particularly point out that the transgender community often frames the issue concerning infant nonconsensual genital “normalizing” surgery as a fight against being assigned the “wrong gender.” However, for the intersex community, “treatment is painful and traumatic whether or not one’s gender identity happens to match her or his assigned gender.”

Additionally, the grouping of the two categories suggests that both groups are similarly conflicted over “gender identity.” While some intersex individuals do self-identify as transgender, the community itself more generally views intersex as concerning the biological sex characteristics of one’s body. The term “intersex” is not about how one “identifies as” in terms of the gender binary. Unlike the transgender community, the intersex community’s main concern has never been about

---

51 In terms of this article, I have chosen to use the term “intersex” and “intersex conditions” over DSDs. This was done to acknowledge members of the intersex community that identity “disorders of sex development” as stigmatizing and unfairly placed upon the community without active engagement or acknowledgment of community interests.


53 Id.

54 But see Wilson, supra note 43 (“[T]ranssexuals who express envy to those of us who have been mutilated at birth. (“You’re so lucky! You got the sex change that I wanted!”)) (last updated January, 2012).

55 Hida Viloria, Calling a Spade a Spade; Intersex is Intersex; http://oiiinternational.com/2786/calling-a-spade-a-spade-intersex-is-intersex/ (last updated April, 2013).

56 Intersex Initiative, supra note 32.

57 Viloria, supra note 54.

58 Id.

59 Id.
choosing whether to change the body to conform to the right gender; the issue has been about choices concerning the body being denied in the first place.

D) Hermaphrodite

While some have used the term as a method of reclamation, most intersex activists reject the use of the term “hermaphrodite.” The word refers to animals, such as snails and worms, which have a functioning set of both male and female organs. The same is not true of individuals born with an intersex condition. Due to its inaccuracy and mythologizing history, members of the intersex community treat the term as a pejorative.

LET’S GET TO WORK. WHERE DO WE STAND?

“I will not patronize or rescue the people for which I am [an] ally,
But will support them in their efforts at self-determination.”

A) Historical Development

Before the 1950s, the medical standard concerning infants born with an intersex condition did not generally require genital “normalizing”

60 Noa Ben-Asher, The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties, 29 Harv. J.L. & Gender 51, 51 (2006) (“Transsex individuals often desire the future body that they should have, while intersex individuals often mourn the body they had before an unwarranted normalizing surgery interfered with it.”).
61 See Intersex Initiative, supra note 32.
62 Id.
63 Id.
64 See Alice Dreger, When to Do Surgery on a Child With ‘Both’ Genitalia http://m.theatlantic.com/health/archive/2013/05/when-to-do-surgery-on-a-child-with-both-genitalia/275884/ (“The clitoris and the penis are homologues – they are the same organ developmentally – so you get one or the other, or one in-between organ. Similarly, the labia majora and the scrotum are homologues – so you get either a set of labia majora, a scrotum, or something in between. But you can’t have all the female parts (clitoris, labia majora, etc.) and all the male parts (penis, scrotum, etc.) on one person . . . .) (last visited December, 2013).
65 See Bird, supra note 23 (citing Howard Jones & William Scott, Hermaphroditism, Genital Anomalies and Related Endocrine Disorders 7-9 (Williams & Wilkins Co., 1971)) (retelling one version of the myth behind the term’s origin).
66 See Intersex Initiative, supra note 32.
67 Rigby, supra note 11.
surgery. This changed in the 1950s due to two developments in the medical field: the development of surgical techniques making it possible to modify genitalia in a “cosmetically acceptable” fashion (to make the genitalia conform more to the male / female sex binary) and the theoretical contributions of Dr. John Money concerning the relationship of one’s gender identity to how one was nurtured, irrelevant of the natural sexual anatomy one was born with.

Due to his theory of nurture trumping nature in regards to the development of one’s gender identity, Money advocated for a change in the medical standard: infants born with ambiguous / intersex genitalia should undergo genital “normalizing” surgery to change “unacceptable’ genitalia into “normal” genitalia. The test in determining whether genitalia were “ambiguous” was to examine the chromosomal make-up of the child and then assess the presence and size of a phallus. For boys, “normal” genitalia required an “adequate” sized penis that would allow penetration of the vagina (infants born with a micro-penis condition were surgically altered to be raised as a girl). For girls, “normal” genitalia simply required a vagina that could accommodate a penis; at the same time, clitorises that were deemed “too large” (too similar to a penis) were surgically removed or reduced in size. Money asserted that failing to undertake genital

---


69 *Id*. at 856.


72 Greenberg, *supra* note 68.

73 Dreger, “`Ambiguous Sex' at 30 (noting that “if the length of the stretched phallus is greater than 2.5 centimeters, or one inch,” then the child will be raised as a male).

74 Greenberg, *supra* note 68, at 857 n. 25.

75 Greenberg, *supra* note 73, at n. 22.


surgery would result in social exclusion, severe psychological trauma, and the weakening of bonds between parents and the child.\textsuperscript{78}

Unfortunately, Money tested his theory on David Reimer, an infant whose penis was accidentally castrated during a routine circumcision\textsuperscript{79}; through the removal of David’s testicles and the construction of female appearing genitalia, Money attempted to show that David could successfully be raised as a girl, despite David having been born with male genitalia and with the hormones and chromosomes of a male.\textsuperscript{80} David ultimately rejected his female assignment, even at a young age\textsuperscript{81}, and underwent several surgeries in an attempt to restore his male genitalia.\textsuperscript{82} In 2004, David took his own life.\textsuperscript{83}

As infants born with intersex conditions were deemed “unacceptable” and “abnormal,” the development of nonconsensual genital “normalizing” surgery as the medical standard encouraged a culture of secrecy and shaming.\textsuperscript{84} Parents were only told half-truths or were intentionally lied to about the existence, future effects, and / or urgency of intersex conditions.\textsuperscript{85}

It was not until the 1990s and the growth of intersex organizations such as ISNA that education and criticisms concerning these practices

\textsuperscript{78} Alison Davidian, Beyond the Locker Room: Changing Narratives on Early Surgery for Intersex Children, 26 Wis. J.L. Gender & Soc’y 1, 8 n. 50 (Spring 2011) (citing Julie Greenberg, Legal Aspects of Gender Assignment, 13 Endocrinologist 277, 279 n. 19 (2003)).

\textsuperscript{79} Id. at 6.

\textsuperscript{80} Id.

\textsuperscript{81} Id.

\textsuperscript{82} Id. at 7.

\textsuperscript{83} Id.; for more information on David Reimer’s story, see John Colapinto, As Nature Made Him: The Boy Who Was Raised as a Girl, New York: HarperCollins, 2000; John Colapinto, What Were the Real Reasons Behind David Reimer’s Suicide, http://www.slate.com/articles/health_and_science/medical_examiner/2004/06/gender_gap_2.html (“David’s blighted childhood was never far from his mind. Just before he died, he talked to his wife about his sexual “inadequacy,” his inability to be a true husband. Jane tried to reassure him. But David was already heading for the door.”) (last visited December, 2013).

\textsuperscript{84} See Dreger, A History of Intersexuality, at n. 9 (“Patients are lied to; risky procedures are performed without follow-up; consent is not fully informed; autonomy and health are risked because of unproven (and even disproven) fears that atypical anatomy will lead to psychological disaster.”); see also Greenberg at n. 38 (citing Suzanne Kessler, J. Lessons from the Intersexed, New Brunswick, NJ: Rutgers UP, 1998 at 18).

\textsuperscript{85} Greenberg, supra note 68, at 859 n. 40-41.
began to reach a wider audience. There were three primary concerns behind these criticisms of nonconsensual genital “normalizing” surgery: 1) that the secrecy and shaming culture behind the medical standard led to psychological trauma associated with feelings of sexual “abnormality”; 2) that the nurture over nature theory of gender identity advocated by Money had been empirically disproven through countless personal narratives of irreversibly harmed intersex individuals; and 3) that the benefits of “cosmetic” genital surgeries (done despite a lack of life-threatening / medically necessary conditions), are outweighed by the risks of sterilization, genital scarring, urinary discomfort, and the loss of erotic sensation. Despite these positions by the intersex community and the lack of evidence supporting Money’s medical standard, the American Academy of Pediatrics continued to maintain that the birth of an intersex child was a “social emergency” requiring early surgical intervention up through the early 2000s.

In 2006, the push and awareness generated by intersex activists lead to the development of the Consensus Statement. The Consensus Statement advocated for a change of the genital “normalizing” surgery medical standard to a patient-centered model – “open communication with patients and families is essential, and participation in decision-making is encouraged.” Additionally, the Consensus Statement explicitly noted that “systematic evidence” supporting the belief that surgery should be performed for cosmetic reasons in the first year of life was ultimately “lacking,” despite the intervening years since the medical standard first adopted that perspective. While this shift is an improvement, the

86 Id. at n. 42 and accompanying text.
87 Id.
88 Davidian, supra note 78, at 8 (“[S]ince Money’s John / Joan case study was discredited, not a single case has been found or cited to support the long-term physical and psychological successes of this surgery.”).
89 See Cheryl, supra note 14, at 189-191.
92 Lee et al., supra note 37.
93 Id. at e490.
94 Id. at e491.
95 See Hazel Glenn Beh & Milton Diamond, An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia, 7 Mich. J. Gender & L. 1, 9 n. 30 (2000) (noting that even
Consensus Statement did not advocate for the ultimate end of nonconsensual genital “normalizing” surgery as demanded by the intersex community. Moreover, intersex activists noted how changing the medical standard is not something that occurs overnight— even with the recommendations under the Consensus Statement, doctors and hospitals could, and likely would, still push forward the old model under the same flawed view that intersex conditions are something to “cure.”

B) Current Movement
Since the 2006 Consensus Statement, both the intersex community and an increasing number of medical experts have continued to request a moratorium on all cosmetic genital “normalizing” surgeries done without the express informed consent of the individual undergoing that treatment (emphasis on prevention of intrusive medical interference with one’s

Money has “acknowledged the failure of treatment,” although he theorized that other variables, such as surgical delay, was the cause of David Reimer’s assigned gender rejection).

See Accord Alliance, supra note 20, at 27 (noting the “patient-centered” model as the ideal model to deal with the long term physical, psychological, and sexual well being of individuals born with an intersex condition).

See Koyama, supra note 42 (citing Dreger in stating “I thought the standard treatment of intersex was so morally outrageous that, once exposed, it would quickly change. I’m often asked why intersex medicine hasn’t changed, and nowadays I think that the reason must be because, in spite of what I thought in 1998, the treatment of intersex actually looks a lot like other realms of modern medicine. I have come to realize that I was really naïve about medicine.”).

See Greenberg, supra note 68, at 863-884 n. 56-61 (citing Sarah Creighton, Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood, 358 Lancet 124, 124 (2001); N.K. Alizai et al., Feminizing Genitoplasty for Congenital Adrenal Hyperplasia: What Happens at Puberty? 161 J. Urology 1588, 1589 (1999); Birgit Kohler et al., Satisfaction with Genital Surgery and Sexual Life of Adults with XY Disorders of Sex Development: Results from the German Clinical Evaluation Study, 97 J. Clinical Endocrinology & Metabolism 1441 (2001); Joel Frader et al., Health Care Professionals and Intersex Conditions, 158 Archives Pediatrics & Adolescent Med. 426, 427-428 (2004)) (noting studies and recommendations by various medical experts and organizations concluding that unnecessary cosmetic surgeries should be delayed until the child is old enough to provide informed consent to the procedure); but see Id. at supra note 71 (citing Katrina Karkazis, Fixing Sex: Intersex, Medical Authority, and Lived Experience, 134-135 (2008); Claudia Wiese-Mann et al., Ethical Principles and Recommendations for the Medical Management of Differences of Sex Development (DSD) / Intersex in Children and Adolescents, 169 Eur. J. Pediatrics 671, 674-676 (2009)).
These groups assert that surgeries should be delayed until the child has reached the age to have the capacity to determine whether or not they want to undergo the treatment themselves.\textsuperscript{100}

On February 1\textsuperscript{101} 2013, the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan Mendez, presented a report on “certain forms of abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment.”\textsuperscript{102} Amongst those procedures highlighted were “genital normalizing surgeries under the guise of so called ’reparative therapies.’”\textsuperscript{102} In response to the “accounts and testimonies” of those who had undergone these surgeries, the report asserted that “The Special Rapporteur calls upon all States to repeal any law allowing intrusive and irreversible treatments, including forced genital-normalizing surgery . . . when enforced or administered without the free and informed consent of the person concerned.”\textsuperscript{103}

This recent success is notable for its overall condemnation of the practice of nonconsensual genital “normalizing” surgery and its call for an outright moratorium until the point in time in which the child has the ability to consent. Such recognition of the pressing need and concerns of the intersex community is laudable and reflects the success of the movement in pushing forward awareness of the harms done by forced “treatment” of intersex conditions.

\begin{quote}
\textbf{WHAT IF WE...BUT WHAT ABOUT...HOW ABOUT WE JUST...}
If I disagree with decisions made by the oppressed group, I will either offer my silent support or I will stand down.\textsuperscript{104}
\end{quote}

\begin{flushleft}
\begin{footnotesize}

\textsuperscript{100} See Intersex Initiative, supra note 32.

\textsuperscript{101} Juan E. Mendez, \textit{Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment}, at 18 (February, 2013) (available at \url{http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf}).

\textsuperscript{102} Id.

\textsuperscript{103} Id. at 23.

\textsuperscript{104} Rigby, supra note 11.
\end{footnotesize}
\end{flushleft}
A) Alternative Theoretical Solutions
In attempting to address the concerns of the intersex community, to serve as allies of a community in need, many academics, theorists, and legal scholars have provided alternative solutions to addressing the continued practice of nonconsensual genital “normalizing” surgery. Many of these solutions focus on the existence of a male / female sex binary within society that denies the very existence of those with intersex conditions. Due to an ontologically enforced requirement of a “male” or “female” sex, the birth of an infant that defies such classification provides the justification for labeling intersex individuals as a “social emergency.” Because the intersex community’s very existence defies ordinary sorting into the comfortably rigid social roles that make up society, their existence is treated as something to be “cured” due to its abnormality.

The main thrust of these theoretical analyses of society is to suggest that breaking down the male / female sex binary is an a priori need to assist the intersex community in its struggle against nonconsensual genital “normalizing” surgery. The “normalizing” aspect of these

105 James McGrath, Are You A Boy or a Girl? Show Me Your REAL ID, 9 Nev. L.J. 368, 369 (Winter 2000) (“[T]he presence of intersex people reveals the impossibility of identification of all people into two categories of sex, spurring some authors to call for removing a gender or sex identifier on birth certificates. The intersex may be born with ambiguous genitalia, defying simple sex assignment.”).

106 Reilly, supra note 24, at 297-298.

107 Davidian, supra note 78, at 9-10.

108 Id. at 20 (“Only in a society where sex is understood in binary terms with everyone either male or female does the body of an intersex child become an abnormality that requires fixing. This notion of a sex binary appears to overwhelm other factors in considering the merits and risks of surgery.”).

109 Within this article, sex, gender, and sexuality are understood to be socially constructed performances (in the sense that they are “roles” intentionally, sometimes unintentionally or subconsciously, adopted by individuals). These multiple performances intersect and form a cohesive self-identity, in addition to other such constructs like race. As constructions, these performances are fluid, but are often treated as fixed by normalizing institutions that enforce fixed categorization (such as the male / female sex binary or the masculinity / femininity gender binary). In practice, it is often difficult to escape binary-based assumptions, even when one has appreciation of their constructed natures.

Sex generally refers to the body, the physical body, and is thus about being. Gender generally refers to the nature assumed, in regards to “masculine” or “feminine” traits, and is thus about doing. Greenberg, supra note 68 (“While gender is often considered to be something that bodies do, sex is often considered
surgeries is grounded in the logic of a rigid sex binary; by challenging that assumption, the true horror and harms of performing nonconsensual surgeries (that carry a risk of sterilization, genital scarring, urinary discomfort, and the loss of erotic sensation) can be made apparent to individuals outside the intersex community.

In carrying out this challenge to the sex binary system, several solutions have been proposed: the creation of a “third gender” / “indeterminable” / “intersex” category of sex identity and the elimination of the use of government-mandated sex identification on identity documentation (particularly birth certificates, passports, etc.) are the two options most often discussed.

The argument for creating a recognized “third gender” / third sex identification is premised on creating a recognized safe space within the legal realm for the intersex community. Because “intersex” is a term that exists primarily within the medical field, with little substance or context outside of the medical field (particularly as those with intersex conditions generally adopt other terms of self-identity), official legal recognition would allow the community to avoid the invisibility of being a non-entity (legally). Jo Bird discusses this analysis by pointing out “To be considered as a human by the law, one must have a recognizable, classifiable sex. Certain human rights of the intersex child are treated as non-existent, because the child who inhabits a body that is “without a sex” is not considered human.” In making this analysis, Bird discusses the famous case of C. v. D., an Australian case between a biological woman and her intersex husband. The court ultimately declared the marriage null on the grounds that the husband was neither male nor female – due to him being intersex, the husband was literally treated as being “outside of law,” denied even the right to marry any other human being. Bird also discusses the use of intersex as its own distinct category within the...
Australian Capital Territory (ACT)\textsuperscript{116} by legally recognizing the existence of the intersex community\textsuperscript{117}, Bird asserts that the community is now “within the law” and more likely to fall within its protection concerning previous violations (such as nonconsensual genital “normalizing” surgery).

Focusing on the government’s use of mandated sex identification on identity documents, Professor Elizabeth Reilly emphasized “It is problematic enough when the law fails to recognize a pattern of exclusionary behavior as deserving of legal remedy. It is much worse for the law to be the very mechanism that requires and enforces exclusionary behavior.”\textsuperscript{119} Highlighting the government’s mandated need to know the proper sex of each individual, Professor Reilly proposed a “radical tweak” to the system – “We must cease using the Birth Certificate to assign sex to a child.”\textsuperscript{120} In doing so, Professor Reilly asserted that nonconsensual genital “normalizing” surgery would be directly challenged, for it is the requirement of filing out the birth certificate that “helps convert intersexuality into a medical ‘problem’ during which the strictures of informed consent ethics and law can be notably suspended.”\textsuperscript{121} Notably, Professor Reilly suggests that the social elimination of the sex binary system is not the goal of her proposal – the proposal “simply refuses to give the legal imprimatur of truth and permanence to the assignment on behalf of any given individual.”\textsuperscript{122} This distinction reflects the idea that while individuals may personally self-identity as a particular category, due to powerful social constructions, such identification should not be governmentally enforced as a permanent and binding construction upon that person (particularly upon individuals who, at the time, lack the ability to self-identity).

Ultimately, Professor Reilly hopes that her proposal will allow parents to avoid the pressure of making the “right” choice; as parents will no longer need to place a sex on the birth certificate, there will no longer be an impetus to “match” the chosen gender with the sex of the child through

\begin{itemize}
\item \textsuperscript{116} Id. at 77 n. 52 and accompanying text.
\item \textsuperscript{117} Id. at 77 n. 53 and accompanying text.
\item \textsuperscript{118} Id. at 79-80.
\item \textsuperscript{119} Reilly, supra note 24, at 299.
\item \textsuperscript{120} Id. at 308.
\item \textsuperscript{121} Id. at 310.
\item \textsuperscript{122} Id. at 324.
\item \textsuperscript{123} For additional material assessing this theory and solution at the international level, see Dorian Needham, \textit{A Categorical Imperative? Questioning the Need for Sexual Classification in Quebec}, 52 C. de D. 71, 86 (March, 2011) (assessing Canada’s identity documentation system).
\end{itemize}
genital surgery. In doing so, genital “normalizing” surgery itself will come to be seen as harmful to the child, a forced and irreversible “treatment” of an individual for something that needs no “cure.” Ideally, such a treatment, particularly in light of the lack of any informed consent by the child, would no longer be treated as “reasonable.”

B) Intersex Community Perspective

While the intersex community has noted that such theoretical challenges to the male / female sex binary are laudable and address a factor justifying the use of nonconsensual genital “normalizing” surgery, in addition to representing the viewpoint of certain individuals within the group, the community has also explicitly noted that such solutions are not synonymous with a direct challenge on the use of nonconsensual genital “normalizing” surgery itself. In fact, members of the community have asserted the opposite: the focus of theorists on breaking the male / female sex binary may actually create greater barriers in the fight against nonconsensual genital “normalizing” surgery by creating societal confusion / misplaced emphasis surrounding intersex individuals concerning whether or not they desire to or are asserting any particular self-identity classification.

---

124 Reilly, supra note 24, at 330.
125 Id.
126 Id. at 331.
127 Intersex Society of North America, Why Doesn’t ISNA Want to Eradicate Gender? [link]
128 OII, supra note 33 (“While some intersex individuals may agree that sex and gender are not binary concepts, the goals of intersex activists are to raise awareness and to gain the right to consent to what is and is not done to our bodies.”); see also ISNA, supra note 126 (“We hope that scholars, particularly those invested in helping members of marginalized groups gain a voice in conversations about themselves, will take seriously the concerns about surgery, secrecy, and shame raised by intersex people and understand that ISNA and the majority of its constituency don’t necessarily share the goal of eradicating the very notion of gender).
129 Viloria, supra note 54 (“Intersex people must break through people’s cultural resistance to accepting us in order for “normalizing” surgeries to stop, and the last thing we need is confusion about who we are and what we deal with.”).
This internal criticism is particularly relevant in light of the repeated assertions by intersex activists that the intersex community is NOT necessarily in support of breaking the male / female sex binary, despite being a possible target of its construction.\footnote{OII, supra note 33 (“Intersex activists are not explicitly trying to bring down the binary.”); see also ISNA, supra note 126 (“[M]any intersex people are perfectly comfortable adopting either a male or female gender identity and are not seeking a genderless society or to label themselves as a member of a third gender class.”).} To suggest that the existence of the intersex community itself, found outside of the typical binary, requires and / or creates the expectation that all or most members of the community are against the binary is a false generalization.\footnote{Intersex Initiative, supra note 32 (“Many people with intersex conditions identify solidly as a man or as a woman, like many non-intersex people. There are some who identify as a member of an alternative gender, like some non-intersex people do. While we support everyone’s right to define her or his own identities, we do not believe that people with intersex conditions should be expected to be gender-transgressive just because of their physical condition.”); see also ISNA, supra note 126 (“[M]any of the people with intersex we know—both those subjected to early surgeries and those who escaped surgery—very happily accepted a gender assignment of male or female (either the one given them at birth or one they chose later for themselves later in life). Instead, adults with intersex conditions who underwent genital surgeries at early ages most often cite those early genital surgeries and the lies and shame surrounding those procedures as their source of pain. Later in life, like many people with typical anatomies, intersex people take pleasure in what some gender scholars (like Judith Butler) might call doing their gender. Thus, intersex people don’t tell us that the very concept of gender is oppressive to them. Instead, it’s the childhood surgeries performed on them and the accompanying lies and shame that are problematic.”).} As evidence of this claim, intersex activists often remind non-members that the intersex community is only against the forced, permanent, nonconsensual assignment of sex through surgery; in terms of whether or not the community embraces the ordinary gender binary, these activists recommend and affirm the notion that children should be assigned a gender, male or female, based on appropriate medical factors at the time of infancy.\footnote{Intersex Initiative, supra note 32 (“We recommend that the child be assigned a gender based on our best prediction, and allow her or him to determine for herself or himself once she or he is old enough to do so.”); see also Accord Alliance, supra note 95, at 25-26; but see Ben-Asher, supra note 59, at 71 (“[T]his same reasoning is used by John Money and others to justify intersex surgery: the child will adjust better to the environment with “normal” looking genitals than with genitals that are unintelligible. Therefore, challenging sex assignment while using the same logic to justify gender assignment deserves rethinking.”).} Note that some of these recommendations are based on the
safety of the intersex community in today’s society, a concern based on lived experiences of harm and social ostracizing rather than theoretical perspectives of what societal change may be possible in the future.\footnote{See Intersex Society of North America, Does ISNA Think Children with Intersex Should Be Raised Without a Gender, or in a Third Gender? http://www.isna.org/faq/third-gender (“We are trying to make the world a safe place for intersex kids, and we don’t think labeling them with a gender category that in essence doesn’t exist would help them. (Duh, huh?)”) (last visited December, 2013); see also Ben-Asher, supra note 59, at 71 (citing Judith Butler’s claim that “[C]hildren do not need to take on the burden of being heroes for a movement without first assenting to such a role. In this sense, categorization has its place and cannot be reduced to forms of anatomical essentialism.” (citing Butler, Undoing Gender at 7-8)).}

While well-intentioned, a true allyship framework requires those theorizing down the path of challenging the binary system to at least acknowledge these criticisms - from the perspective of those who bear the greatest consequences of the procedure, actual intersex individuals, a challenge to the sex binary system is simply not enough. It may be a long-term goal, one to consolidate considerable weight and support behind, perhaps even something to unite the entire LGBTQ movement as whole, but it does not affect the immediate and significant needs of the intersex community on nonconsensual genital “normalizing” surgery.

**BUT I HEAR THE INTERNATIONAL SCENE ALREADY SOLVED THIS?**

“I recognize that giving my moment in the spotlight or chair at the table May be the ultimate triumph of an ally.”\footnote{Rigby, supra note 11.}

A) General Scene

In fact, the theorizing done by allies may have inadvertently made the immediate demands of the intersex community invisible. Despite the movement’s incessant demand for a moratorium on nonconsensual genital “normalizing” surgery and the community’s assertion that, while important, deconstruction of the binary system is not the primary goal, the international scene seems to have responded more favorably to the theorists than to members of the intersex community itself. Many countries have implicitly or explicitly passed recognition of “third gender” / “intersex” categories of identity; meanwhile, only two countries, Colombia and most recently the United States, have ever specifically addressed nonconsensual genital “normalizing” surgery. Despite the expressed international intent of countries to assist, protect, and recognize the intersex community within
society, the feedback from the intersex community itself has been negative. Not only have many of these international efforts failed to provide any true protection - at the end of the day, these efforts at breaking down the sex binary system also fail to address the immediate harms arising from the legal sanction of violent acts of medical interference with intersex bodies. Aside from why these acts occur, intersex activists are simply looking for an immediate end to the practice of nonconsensual genital “normalizing” surgery.

B) Puerto Rico

Puerto Rico recognizes the category of “ambiguous genitalia” to be used on identity documents through the Puerto Rico Vital Statistics Registry, although only temporarily. At the time of birth, individuals born with “ambiguous genitalia” are allowed to mark the category labeled as such on Formulary RD-103, administratively referred to as the Addendum to the Birth Certificate. In doing so, Puerto Rico has ascribed to the solution of granting legal recognition to a “third gender” category encompassing the intersex community.

However, as noted by Frances Nieves, this solution ultimately fails to provide any true protection whatsoever to the intersex community. Not only does the term “ambiguous genitalia” fail to protect all members of the community, the temporariness of the category merely reinforces the pressure on parents to medically determine the “right” sex and enforce that decision through nonconsensual genital “normalizing” surgery.

---


136 Id. at n. 4.

137 Id. at 1235 n. 11 and accompanying text (noting how the category only is allowed for 30 days at a maximum).

138 Id. at 1235.

139 Nieves, supra note 134 (noting how the category “ambiguous genitalia” actually fails to encompass the entire intersex community).

140 Id. at 1235.

141 Id. at 1246 (“In Puerto Rico, sex assignment surgeries need to be performed within a period of thirty (3) days after the birth of an intersex child occurs. Otherwise, the medical community would not be able to meet the legal mandate of defining the sex for purposes of the Birth Certificate.”).
Additionally, the temporariness of the category also shows how the solution fails in successfully challenging any male/female sex binary. By labeling the category “ambiguous,” and only allowing such category for a very short period of time, the category reinforces the normal of “male” and “female” and suggests that time is only granted to allow the infant to be properly assigned. A third sex existing independently of male/female is not being permanently endorsed.

C) India

India has also legally begun recognizing the existence of a “third gender”/third sex category: “E,” standing for eunuchs. Eunuchs is the less commonly used term referring to India’s historical community of “hijras.” On Indian passports, voter registration documents, and on the 2011 federal census, the hijra community has been able to legally check “E” when asked for their sex identity. As all hijras have a female gender identity, this recognition was likely done to make travel easier for the hijra community so that they will no longer have to break their gender performance and dress as men to match the sex identifier on their passports when traveling through airports.

Due to their cultural significance and acceptance in Indian society, many theorists challenging the existence of the male/female binary use the illustration of the hijra community as an example of a socially accepted “third gender” category. Indeed, there is evidence that the Indian community has come to accept the hijra community to a greater degree than the American community has accepted intersex individuals. At the

---

143 Id. at 227 n. 15 (“Indian society seems to use the terms eunuch and hijra interchangeably, even though hijras do not prefer the term eunuch.”).
144 Id. at 227-229 (noting the history and social position of the hijra community).
146 Id. at 32 n. 114.
148 Id. at 228.
149 Id. at 233.
150 Id. at 229 (Noting such recognition seems to stem from the historical and religious weight associated to hijras through the practice of badhai, a ceremony where hijras bless births and marriages.).
same time, however, hijras still are forced to live on the periphery of society as “objects of fear, abuse, ridicule, and sometimes pity.” The greater recognition of the community’s “third gender” category on passports, allowing for easier travel, has not transferred to Indian society as a whole; other identity documents (such as the state identity card) do not recognize the category, thereby denying the community access to many legal rights granted to individuals that fall into the male / female sex binary. Most importantly, the social (and now legal) acceptance of the hijra community has also not empirically lead to protection of individuals born with an intersex condition from nonconsensual genital “normalizing” surgery.

D) Nepal

Nepal legally began recognizing a “third gender” through court order – in 2007, the Supreme Court of Nepal in Pant v. Nepal legally established a gender category beyond the male / female binary, to be referred to as “other” (anya) on official documents. The court also asserted that identification as such category was not to be based on any medical criteria – the only criterion to be legally recognized as “anya” is

151 Id. at n. 31 (citing Serena Nanda, Neither Man nor Woman: The Hijras of India 13 (2nd ed. 1999)).
152 Id. at 231 n. 49 (citing People’s Union for Civil Liberties, Karnataka, Human Rights Violations Against the Transgender Community 17 (2003) available at http://ai.eecs.umich.edu/people/coway/TS/PUCL/PUCL%20Report.pdf).
154 See Bochenek and Knight, supra note 144, at 11.
156 Id. at 13 n. 8 (citing Interview with Sunil Babu Pant, President, Blue Diamond Soc’y, in Kathmandu, Nepal (March 2012)).
self-identification as such. \[158\] Since that decision, the government of Nepal has slowly but steadily implemented “anya” recognition.\[159\] “Nepal stands as one of the most effective examples of comprehensively introducing a third gender category for people who do not identity within the male-female binary.”\[160\] Soon, Nepal’s constitution, new civil code, and new criminal code will be finalized to reflect the change in society in recognizing this third gender.\[161\] For all intents and purposes, at least for now considering its infancy, it seems as if Nepal would serve as an ideal illustrative of the challenge to the male / female sex binary system. Yet, despite all of this success, no statement has been made concerning a ban on the continued practice of nonconsensual genital “normalizing” surgery.\[162\] While some might argue that more time is needed to see if the binary challenge experiment will allow for a true societal change / impetus against the medical procedure, it is notable that while we wait (6 years since the 2007 decision), infants born with intersex conditions may be still subjected to nonconsensual medical interference with their bodies everyday.\[163\] This reflects the other problem with the theoretical approach – even in the best of circumstances, the solution takes considerable time to be effective. Society’s notions concerning sex and gender binaries will take quite a few years to deconstruct, and the immediacy of the harms being suffered by the intersex community should not have to wait that long.

E) Colombia

\[158\] Id. at 19; see also Id. at n. 30-34 and accompanying text (noting identity categories that may fall into this category of “anya”: intersex, transgender, homosexual, metis and kothis, tas, bisexuals, hijras, transsexuals, and transvestites).
\[159\] Id. at 13 (defining “anya” to describe biological males who have “feminine” gender identity or expression and biological females who have “masculine” gender identity or expression”).
\[160\] Id. at 31-32 (noting recognition on India’s national citizenship ID, registry to vote, and on India’s 2011 federal census).
\[161\] Id. at 41.
\[162\] Id.
\[163\] A search for whether or not any statement, article, publication, or other source had commented on the continuance of the practice failed to find anything. Bochenek and Knight do not discuss the practice within the confines of their article.
\[164\] See OII, supra note 33 (“No writings about intersex or intersex people should make light of the immediate crisis: many children are subjected to non-consensual sex binary-reinforcing surgery and/or hormone therapy every day.”).
Until recently, Colombia was the only country that had ever considered addressing the practice of genital “normalizing” surgery in and of itself. In Sentencia No. T-477/95 [hereinafter Gonzalez], the Colombia Constitutional Court was first asked to determine the legality of nonconsensual genital “normalizing” surgery. The court found that Gonzalez’s fundamental right to human dignity and gender identity had been violated by the surgery. In doing so, the court held that “doctors could not alter the gender of a patient, regardless of the patient’s age, without the patient’s own informed consent.”

Two subsequent cases followed the Gonzalez decision, Sentencia No. SU-337/99 [hereinafter Ramos] and Sentencia No. T-551/99 [hereinafter Cruz]. In Ramos, the court upheld the lower court’s decision to deny Ramos’s mother the right to consent to “genital reconstruction surgery” on Ramos’s behalf; in doing so, the court found that it would be wrong for anyone to consent to a sex change operation other than the child herself. In Cruz, the court qualified its previous holdings by stating that

---

165 Greenberg, supra note 68, at 876.
166 Note that the names chosen to humanize and simplify the parties in these Colombian cases was a decision originally made by Kate Haas in her article Who Will Make Room for the Intersexed? The names chosen are not the names of the parties in the case. For consistency purposes, particularly considering my use of Haas’s breakdown of these cases, I have maintained the use of these chosen names in this article. Kate Haas, Who Will Make Room for the Intersexed? 30 Am. J. L. and Med. 41, 49 (2004).
168 Id. at 49.
169 Id. at n. 99 and accompanying text.
170 Id. at n. 104.
171 Id. at n. 103.
172 Id. at 52.
173 Id. (also noting that the court justified its holding through the “lack of evidence of any psychological harm to children that are not operated on, and the existence of actual evidence of psychological harm to children that have had such operations.”); Davidian, supra note 78, at 15 (“The Court acknowledged that the treatment proposed was invasive, proven to cause grave and irreversible harm to the patient and that its usefulness remains in doubt”) (citing Paisley Currah et al., The Rights
“parents should be allowed to consent to surgery on children under age five” because children younger than five lack the capacity to have formed a gender identity. 

The standard for parental consent concerning children under five would require the Gonzalez standard of “informed consent.”

While the final holding on nonconsensual genital “normalizing” surgery in Colombia ultimately fails to protect those intersex infants most vulnerable to the procedure, the surgery issue was at least addressed and a higher form of “consent” required by the Court. By requiring “informed consent” of the parents, some of the secrecy and shaming practices underlying the medical standard could, possibly, be mitigated and surgeries ultimately prevented.

_of Intersexed Infants and Children: Decision of the Colombian Constitutional Court, Bogota, Colombia, 23 May 1999 (SU-337/99), Transgender Rights 122, 123-127 (2006)).

Haas, supra note 167, at 53.

Id. (noting that “three criteria must be met: (i) detailed information must be provided, and the parent must be informed of the pros and cons that have sparked the current debate; (ii) the consent must be in writing, to formalize the decision and to ensure its seriousness; and (iii) the authorization must be given in stages.”).

Id. ("Despite the Colombian Court’s reticence about banning infant genital reconstruction surgery, Colombian law still provides far more protection for intersex children than current American law.").

Id. at 62 (“The Colombian standard of informed consent ensures that doctors provide parents with all of the known information about intersex conditions over a prolonged period of time. Doctors must provide surgical and non-surgical options for treatment, and refer parents to support organizations for intersexed individuals. This model ensures that parents are not deceived about their child's prognosis, and that they understand that genital reconstruction surgery is not the only solution for their child. In the United States, parents of intersexed children are not given enough information to make a truly informed decision about their child's treatment. Some parents are not told that their child is intersexed, but instead that their child is a girl or boy with "unfinished" genitals that the doctor will repair with surgery. Physicians may also tell the parents that their baby will have "normal" genitals after surgery. Surgery may make the child's genitals look more clearly male or female, but it will also leave scarring and possibly diminish sexual functions. Generally, more than one surgery is needed to alter completely the genital appearance, and the average number of surgeries is three or more. Surgery and check-ups will continue through the child's early years and may be extremely stressful for the child and his or her parents.").
At the same time, it is necessary to note the widespread criticisms of the parental “informed consent” model. The intersex community itself has repeatedly asserted that informed consent must be given by the person being operated on, not the parents\(^\text{180}\) – it is the infant / child’s bodily autonomy that is being violated through medical interference, and their voice that is silenced when any genital “normalizing” surgery is approved by parental consent.\(^\text{181}\) Additionally, parents may not be in the ideal state of mind to truly develop an “informed” decision concerning the surgery.\(^\text{182}\) Some parents may even place their own comfort and interests over that of the still infant child.\(^\text{183}\) Even in the United States, there are areas of particular note where the authority of parents to make medical decisions on behalf of their children has been rejected as absolute.\(^\text{184}\)

F) Germany

Germany, following international precedents, also recently chose to address (at least in name) nonconsensual genital “normalizing” surgery. However, unlike Colombia, Germany’s action returned to the theoretical solutions offered up by theorists to challenge the male / female sex binary instead of directly challenging the medical practice itself. Not only did

\(^{180}\) Intersex Society of North America, *What Does ISNA Recommend for Children with Intersex?* [http://www.isna.org/faq/patient-centered](http://www.isna.org/faq/patient-centered) (“Surgeries done to make the genitals look “more normal” should not be performed until a child is mature enough to make an informed decision for herself or himself. Before the patient makes a decision, she or he should be introduced to patients who have and have not had the surgery. Once she or he is fully informed, she or he should be provided access to a patient-centered surgeon.”) (last visited December, 2013); see also Accord Alliance, *supra* note 95, at 3 (“Delay elective surgical and hormonal treatments until the patient can actively participate in decision-making about how his or her own body will look, feel, and function; when surgery and hormone treatments are considered, health care professionals must ask themselves whether they are truly needed for the benefit of the child or are being offered to allay parental distress.”).

\(^{181}\) Uslan, *supra* note 25, at 321.

\(^{182}\) Haas, *supra* note 167, at 63.

\(^{183}\) Davidian, *supra* note 78, at 17 (“A common reason given for performing early surgery on intersex infants is the belief that without surgery, parents are unable to bond with their children.”); see Ramos, at 126 n. 113 (“Prohibition of these surgeries could deprive children of their parent’s love, because [the parents] believe a judicial decision left them with defective children.”).

\(^{184}\) *Id.* at 18-19 (recognizing potential conflicts of interests, such as consent to sterilization or organ donation, that have been held by the court to require judicial oversight over the decision of the parents); Greenberg, *supra* note 68, at 869-874 (same); Uslan, *supra* note 25, at 308-311 (same).
Germany embrace the theoretical solution of creating a “third gender” category, it took implementation of that solution to its farthest application yet, as compared to other nations, by recognizing that “third gender” as a category from birth itself.

On November 1, 2013, Germany became the first European country to recognize a “third sex” category on birth certificates by allowing children to leave the gender blank. Analysts have said this functionally recognizes an “undetermined,” “unspecified,” or “indefinite” gender designation that may be affirmed later on through the selection of an “x option” on passports instead of M or F.

The impetus behind the law was an ethics report released by the German Ethics Council. In this report, the Ethics Council stated:

“Irreversible medical sex assignment measures in persons of ambiguous gender infringe the right to physical integrity, to preservation of sexual and gender identity, to an open future and often also to procreative freedom. The decision concerned is personal. The Ethics Council therefore recommends that it should always be taken solely by the individual concerned. In the case of a minor, such measures should be adopted only after thorough consideration of all their advantages, disadvantages and long-term consequences and for irrefutable reasons of child welfare. This is at any rate the case if the measure concerned serves to avert a serious concrete risk to the life or physical health of the affected individual.

…

185 See James, supra note 98.
187 Id.
188 Id.
189 Id.
191 Castillo, supra note 185.
192 Id.
The Ethics Council also believes that personal rights and the right to equality of treatment are unjustifiably infringed if persons whose physical constitution is such that they cannot be categorized as belonging to the female or male sex are compelled to register in one of these categories. Provision should be made for such persons to register not only as “female” or “male” but also as “other”, or for no entry to be made until they have decided for themselves.”

It is particularly useful to note that the Ethics Council distinguished the recommendations, restricting nonconsensual genital “normalizing” surgery and the creation of an “other” category, as two distinct issues. The law Germany subsequently passed seems to ignore this distinction and treats the two issues as one.

The stated purpose of Germany’s law allowing infants to leave the gender blank on birth certificates was stated to be “to take the pressure off parents who might make hasty decisions on sex assignment surgery . . . .”

By explicitly drawing the connection between this interest and the means chosen, the creation of a “third gender,” the law clearly harkens back and affirms theoretical views that demand the deconstruction of the male / female sex binary system as an a priori need to eliminating the practice of nonconsensual genital “normalizing” surgery.

Progressive groups have hailed the law as a success for intersex rights. Unfortunately, members of the community itself do not express the same sentiments. While appreciative of the attention and concern being drawn to the issue,

194 Id. (emphasis added).
195 See James, supra note 98 (“The law gives parents some space not to have to rush into making decisions themselves . . . It gives them the time to do some tests and figure it out . . . We don’t have to rush into surgery that is irreversible.”) (citing Dr. Arlene Baratz).
196 See also Jacinta Nandi, Germany Got it Right by Offering a Third Gender Option on Birth Certificates, http://www.theguardian.com/commentisfree/2013/nov/10/germany-third-gender-birth-certificate (“[T]he German government and legal experts are keen to stress that this third blank box isn’t an official third gender, or the “other” box – so it doesn’t actually mean that there are now three recognized genders in Germany. It’s seen as a temporary solution for very specific intersex cases – the children aren’t expected to live their lives as X’s, but to make a decision to be male or female at a non-specified point in the future.”) (last visited December, 2013).
197 See Castillo, supra note 185.
law as failing to really challenge the practice of nonconsensual genital “normalizing” surgery.

Some intersex activists have noted that the fear of the blank box may actually encourage parents to be “under more pressure than ever to avoid being forcibly outed by the state.” In a desperate desire to “fit in,” parents may actually be more likely to consent to these nonconsensual genital surgeries.

Others have reaffirmed that concern about the “right” gender has never been the primary issue of the intersex community. In fact, intersex activist organizations have actually encouraged the ordinary selection of a male/female gender at the time of infancy until such time as the child has the capacity to affirm or change such selection. In creating a “third gender,” but one lacking any other relevancy in terms of basic services (health insurance, marriage rights, etc.), the law intentionally leaves those who choose that option even more “outside the law” than usual.

The most common criticism, however, has been that the German law simply does nothing to affect nonconsensual genital “normalizing” surgery, either by restricting them or by placing a moratorium on the practice. As such, the law does not actually address the immediate qualify of life concerns of individuals within the intersex community. In fact, the law may actually encourage increased medical intrusion on intersex

199 See Nandi, supra note 195.
200 See James, supra note 98 (quoting Anne Tamar-Mattis, executive director of Advocates for Informed Choice, stating: “A lot of activists are concerned that what the German rule will do is encourage parents to make quick decisions and give the child an ‘undetermined.’ . . . We are afraid it will encourage intervention. We think a better process is assigning male or female sex, then waiting.”).
201 See supra notes 129-131.
202 See Viloria, supra note 129, at 1.
203 See Castillo, supra note 185 (quoting Silvan Agius of IGLA-Europe, “It does not address the surgeries and the medicalization of intersex people and that’s not good – that has to change.”); Viloria, supra note 201, at 2 (“Intersex people in Germany and around the globe have been calling for this ban for decades. However, rather than banning intersex genital mutilation, the German government instead created a law that local intersex advocates believe puts intersex babies at greater risk.”).
individuals because of how the law is worded: “If the child can be assigned to neither the female nor the male sex, then the child has to be entered into the register of births without such a specification.”\textsuperscript{204} As noted by OII, the determination of whether the child “can be assigned to neither the female nor the male sex” is one made by the medical community,\textsuperscript{205} thus reasserting the medical community’s role in assessing the “appropriateness” of intersex bodies.\textsuperscript{206}

\textbf{G) Conclusion}

Although much has been done at the international level in the name of the intersex community, or communities of similar disposition, these acts have failed to actually follow the demands of the people most affected; for decades now, the one and pressing demand requested by intersex activists has been for a moratorium on the practice of nonconsensual genital “normalizing” surgery. Instead, the international scene has appropriated the perspective of theorists in attempting to challenge the male / female sex binary. Largely, these efforts have failed, at least in regards to halting the practice of nonconsensual genital “normalizing” surgery. And in the meantime, infants born with intersex conditions around the world are being violated through unnecessary medical interventions on a daily basis.

In terms of whether or not the theory-based strategy to challenging the sex binary system has been an effective form of allyship, it seems as if the opposite effect is true – in adopting these theoretical views, the lived experiences and voices of actual intersex individuals has been silenced at the international level. In light of this rather unfortunate consequence, only one sentiment can likely capture the feeling of frustrated intersex activists who have been fighting this fight for years - Thanks, but no thanks.

\textbf{OK, OK. SO WHAT’S NEXT?}

“I will recognize my cultural privilege as a part of their oppression, and will broker that privilege on their behalf and under their guidance.”\textsuperscript{207}

Interestingly enough, it may be the United States that is most poised to follow Colombia’s route and directly assess the practice of nonconsensual genital “normalizing” surgery. For the first time in the U.S., a lawsuit has been filed on behalf of an intersex individual alleging a

\begin{footnotes}
\item[204] See Viloria, \textit{supra} note 201.
\item[205] \textit{Id.}
\item[206] \textit{Id.}
\item[207] Rigby, \textit{supra} note 11.
\end{footnotes}
violation of constitutional rights due to the practice of nonconsensual genital “normalizing” surgery.208

The plaintiff is M.C.,209 a boy identified as male at birth but with genitals “sufficiently indeterminate that surgeons removed his ambiguous phallus, a testis, and testicular tissue on one gonad, and surgically created an ostensible appropriation of female genitals.”210 This procedure was done to M.C. while he was in the foster care system of the South Carolina Department of Social Services211 – it was the South Carolina department officials that consented to M.C.’s genital “normalizing” surgery.212

As a result of the surgery, M.C. has been irreversible denied the ability to decide what to do with his body; currently, M.C. has renounced ever having lived as a girl and only identifies as a boy.213 He has already asked his adoptive mother “When will I get my penis?”214 There is a possibility that M.C. was sterilized through the procedure.215

The claim asserts that there was no medically necessary reason for this surgery - the procedure was merely “cosmetic.”216 In consenting to the procedure, South Carolina therefore violated M.C.’s substantive due process rights of procreation, sexual autonomy, and bodily integrity under the Fourteenth Amendment.217 The claim also asserts a violation of M.C.’s procedural due process rights under the Fourteenth Amendment by submitting M.C. to this procedure “without notice or a hearing to determine whether the procedure was in M.C.’s best interest.”218

---

209 Id.
211 See Southern Poverty Law Center, supra note 207.
212 Id.
213 Id.
214 See Reis, supra note 209.
215 See Southern Poverty Law Center, supra note 207.
217 See Reis, supra note 209.
218 Id.
United States District Judge David Norton has already allowed the case to survive the initial motion to dismiss phase. In doing so, the court particularly found there to be a sufficiently alleged violation of M.C.’s right to procreation. The court traced the history of the right to procreation, noting “'[T]he decision whether or not to beget or bear a child is at the very heart of [the] cluster’ of choices protected by the Due Process Clause” and “A number of decisions issued by the Supreme Court and the Fourth Circuit have determined that forced sterilization . . . implicates significant due process concerns.” Because the court found at least one substantive due process right sufficiently violated, the court did not consider M.C.’s other asserted claims. Similarly, the court also found there to be a violation of M.C.’s procedural due process to a pre-deprivation hearing concerning his right to procreation as defendants chose “to perform the surgery and potential sterilization without requesting, initiating, or inquiring as to a pre-deprivation hearing.” While the survival of the motion to dismiss stage is significant, the court did conclude on a cautionary note: “Underlying this case’s complex legal questions is a series of medical and administrative decisions that had an enormous impact on one child’s life . . . Whether M.C.’s claims can withstand summary judgment challenges, or even the assertion of qualified immunity at the summary judgment stage, is not for the court to hazard a guess at this time.”

Intersex activists are excited about this case as a possibility for a “radical shift in perspective about who gets to consent to what is done to intersex bodies.” For the first time since the Colombian decisions, there is the possibility that nonconsensual genital “normalizing” surgeries will be directly halted or limited in some capacity.

220 Id. at 10.
221 Id. at 9 (citing Carey v. Population Servs., Int’l, 431 U.S. 678, 694-685 (1977))
222 Id. (citing Skinner v. Oklahoma, 316 U.S. 535, 541 (1942); Buck v. Bell, 274 U.S. 200, 206-207 (1927); Avery v. Burke Cnty., 600 F.2d 111, 115 (4th Cir. 1981); Cox v. Stanton, 529 F.2d 47, 50 (4th Cir. 1975)).
223 Id. at 10.
224 Id. at 11-12.
225 Id. at 14; For a more thorough analysis of the right to procreation, see generally Skylar Curtis, Reproductive Organs and Differences of Sex Development: The Constitutional Issues Created by the Surgical Treatment of Intersex Children, 42 McGeorge L. Rev. 841, (2011); see also Haas, supra note 167, at 59-60.
226 See Astorino, supra note 215.
One note should be made concerning M.C.’s case, and other cases in the future moving to challenge nonconsensual genital “normalizing” surgery through the use of minors (particularly when operating under an allyship framework that acknowledges the voices of individuals first) – while M.C.’s challenge is in line with what interests and perspectives articulated by the adult intersex community, M.C. himself is still only 8 years old. Such an age, arguably, suggests that M.C. is not being granted any more autonomy and self-determinism than any other infant in a nonconsensual genital “normalizing” surgery situation because the decisions being made by M.C. are more likely decisions being determined by his parents and the Southern Poverty Law Center. In fact, some of the injuries being asserted in M.C.’s claim are unlikely to have actually been felt yet by M.C. – the risk of sterilization and the possible loss of sexual autonomy (sexual stimuli) are consequences that M.C. is more likely to be affected by in years to come. Unlike the narratives shared throughout this article, M.C. is not an adult reflecting on a lifetime of injury relating to nonconsensual genital “normalizing” surgery with a clear demand for a moratorium on the procedure in order to protect others from living those same experiences. M.C. is a child (albeit mature enough to already be reclaiming and affirming his male gender identity despite any social pressures).

The need for the above concern is premised on affirming self-autonomy within the context of an allyship framework for individuals that would otherwise lack certain self-autonomy rights due to age, status, or competency. True allyship to M.C. would have meant determining and assisting him in his own choices and reflections on self-autonomy, to allow him to make the choice to bring forward his procedure and use it in a federal court challenge to be publicly discussed by media and law school reviews alike, even if such a decision took years to develop. Instead, his actual use in M.C. v. Aaronson, while still an 8-year-old boy, more likely reflects a decision made by his parents to express feelings of violation they themselves had. Such appropriation of M.C.’s life is difficult to reconcile in an allyship-based model.

Ultimately, the risks of the procedure - sterilization, genital scarring, urinary discomfort, and the loss of erotic sensation – likely still weigh in favor of the use of minors like M.C., out of dire necessity (when no adult with greater self-reflective abilities sufficiently satisfies), to establish the moratorium against nonconsensual genital “normalizing” surgery. After all, failing to act would result in subsequent harm to many

---

227 See Southern Poverty Law Center, supra note 207.
228 Id.
more infants born with an intersex condition. But in making this very complicated calculus, the individualized needs of youths like M.C. should not, and cannot, ever be forgotten.

YOU CAN COUNT ON ME
“I will remember at all times that working for justice is not a gift, but a duty.”

This article was intended to be a call-out to the larger LGBTQ community that it should stop searching for issues in response to the question “what’s next?” As is often the case, the answer was always there. Pressing and immediate needs are already being demanded and fought for within sub-communities of the movement. These communities should be supported, and supported in ways that are effective and affirm the lived experiences and reflections of those individuals that bear the blunt of the consequences in terms of whether the movement succeeds or fails. The intersex community is one such sub-community, and it has been fighting its fight against nonconsensual genital “normalizing” surgery for a long time without the wider assistance of the community. It is time to be true allies and support our comrades within the intersex community in their struggle. This is true even if when we disagree on tactics; while notable and praise-worthy, the theory based challenges to the sex binary system need to take a step back. This is not to say that these criticisms are unimportant; the step back is necessary because the theorizing has not led to decreased medical intrusions on the intersex body. As that decrease is the primary, and most pressing, focus of the community, a more effective strategy must be embraced immediately. On an international and domestic level, true allies of the intersex community should focus their efforts on calling for an immediate moratorium / end to the practice of nonconsensual genital “normalizing” surgery once and for.

It is time to acknowledge the voice of the intersex community in regards to current efforts to address nonconsensual genital “normalizing” surgery, a voice that has been repeating one thing for a while now:
“Thanks, but no thanks.”

229 Rigby, supra note 11.