

What Parents Don't Know: Informed Consent, Marriage, and Genital-Normalizing Surgery on Intersex Children

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INTRODUCTION

When most children are born, the first words out of the doctor's mouth are "It's a boy!" or "It's a girl!" When Mani Bruce Mitchell was born, however, she was welcomed into the world by the words, "It's a hermaphrodite!"¹ Initially determined to be a member of the male sex, Mitchell was given the name Bruce and raised as a boy until just before her first birthday when "invasive surgery determined her sex as female and she became Margaret."² When Mitchell was eight years old, she underwent additional surgery to remove "what she describes as a small penis or very large clitoris, and [to] bring[] [her] uterus and vagina forward."³ The surgery left Mitchell with outwardly female genitalia and impaired sexual functioning.⁴

After years of living in secrecy and shame, Mitchell is finally comfortable with herself and her past.⁵ She is now open about her status as an intersexual and advocates against surgeries like those performed on her when she was a child.⁶ She hopes that one day the decision to undergo genital-normalizing surgery will "be left for the person who owns the body" and that "society [will] get to a place where it's comfortable with bodies that look different."⁷

Unfortunately, Mitchell's story is not unique.⁸ It has been estimated that somewhere between 1 in 1500 and 1 in 2000 children are born each year with sufficiently ambiguous genitalia such that the sex of the child cannot be immediately determined.⁹

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1. *Standing Proud to Break the Cycle of Shame and Secrecy*, N.Z. HERALD, Apr. 5, 2008, at A18, available at 2008 WLNR 6356352. The term "hermaphrodite" is used to refer to individuals with ambiguous external genitalia. Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265, 285 (1999). While some members of the medical profession continue to use the term "hermaphrodite," the term is felt by many to be both mythologizing and stigmatizing and has been largely replaced by the term "intersexual," which is now the preferred term. See CATHERINE HARPER, INTERSEX 2-3 (2007).

2. *Standing Proud to Break the Cycle of Shame and Secrecy*, *supra* note 1, at A18.

3. *Id.*

4. *Id.*

5. See *id.* In addition to the trauma and secrecy surrounding her childhood surgeries, Mitchell was also the victim of childhood sexual abuse. *Id.* Unfortunately, sexual abuse is not uncommon among intersex and transgender children. *Id.*

6. *Id.*

7. *Id.*

8. See, for example, INTERSEX IN THE AGE OF ETHICS (Alice Dormurat Dreger ed., 1999), and SHARON E. PREVES, INTERSEX AND IDENTITY: THE CONTESTED SELF (2003), for additional stories on the personal experiences of intersex individuals.

9. Intersex Soc'y of N. Am., How Common is Intersex?, <http://www.isna.org/faq/>

In 2005, the San Francisco Human Rights Commission estimated that genital-normalizing surgeries are performed on approximately five babies every day in the United States.¹⁰

The practice of surgically altering the ambiguous genitalia of intersex¹¹ infants has grown out of the theories posed by psychologist John Money.¹² Money believed that all children are psychosexually neutral at birth and can be molded into either gender, so long as the child's anatomy is altered to reflect the chosen gender at an early age and the people around the child treat the child as a member of the chosen gender.¹³ Money was given the opportunity to test his theories when he was presented with David Reimer, an eight-month-old male whose penis was accidentally destroyed during surgery.¹⁴ Reimer also had an identical twin brother.¹⁵ Upon Money's recommendation, Reimer's parents consented to sex-reassignment surgery, and Reimer's "testicles were removed, female-appearing genitalia were constructed, and he was raised as a girl."¹⁶ Money continued to meet with both Reimer and his twin for several years, and though Reimer displayed a number of boyish tendencies, Money deemed the procedure a success.¹⁷ In 1972, Money published his findings on Reimer's successful transformation from a male child to a female child in what became known as the John/Joan case.¹⁸

The story of David Reimer, however, does not end there. Contrary to Money's findings, it was ultimately revealed that Reimer never truly accepted his status as a female, despite the surgical and hormonal alterations.¹⁹ When he was fourteen years

frequency. It is difficult to state the frequency of intersex births due to the vagueness inherent in the definition of intersexuality. See Alice Dormurat Dreger, "Ambiguous Sex"—Or Ambivalent Medicine? Ethical Issues in the Treatment of Intersexuality, HASTINGS CENTER REP., May–June 1998, at 24, 26 (discussing the difficulty in determining the rate of intersexuality because of the "struggle[] with the question of what should count as 'ambiguous'"). The frequency may also be higher due to the secrecy often surrounding intersexuality, Intersex Initiative: Intersex Frequently Asked Questions, <http://www.intersexinitiative.org/articles/intersex-faq.html>, and the fact that not all intersex conditions are readily identifiable at birth, Intersex Soc'y of N. Am., *supra*.

10. MARCUS DE MARÍA ARANA, S.F. HUMAN RIGHTS COMM'N, A HUMAN RIGHTS INVESTIGATION INTO THE MEDICAL "NORMALIZATION" OF INTERSEX PEOPLE 23 (2005).

11. While there is no universal definition of intersexuality, the term generally refers to a broad range of conditions in which an individual possesses both male and female anatomical characteristics. See, e.g., Dreger, *supra* note 9, at 26.

12. See ALICE DORMURAT DREGER, HERMAPHRODITES AND THE MEDICAL INVENTION OF SEX 181–82 (1998).

13. Dreger, *supra* note 9, at 25.

14. See Hazel Glenn Beh & Milton Diamond, *David Reimer's Legacy: Limiting Parental Discretion*, 12 CARDOZO J.L. & GENDER 5, 11 (2005).

15. *Id.*

16. *Id.*

17. 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, 7–8 (2000).

18. See *id.* at 5–7 & n.12. "Money and others repeatedly asserted that 'Johns' could be made into 'Joans' and 'Joans' into 'Johns' so long as the genitals looked 'right' and everyone agreed to agree on the child's assigned gender." Dreger, *supra* note 9, at 25.

19. See Kenneth Kipnis & Milton Diamond, *Pediatric Ethics and the Surgical Assignment of Sex*, in INTERSEX IN THE AGE OF ETHICS, *supra* note 8, at 173, 179–80. John Money

old, Reimer threatened to kill himself if he could not live as a male, prompting his parents to finally tell him the truth about his past.²⁰ Reimer rejected his female sex assignment, underwent multiple surgeries in an effort to restore his male genitalia, and began living as a man.²¹ Reimer ultimately took his own life in 2004.²²

The revelation of the true outcome of the John/Joan case as well as its tragic ending have led many to question whether the surgical alteration of intersex children continues to be an appropriate treatment²³ and, more fundamentally, whether the parents of intersex children, like those of Mani Bruce Mitchell and David Reimer, have the authority to consent to such procedures for their children.²⁴ Neither Mitchell nor Reimer were granted the dignity of making her/his own decision on whether or not to surgically alter her/his body. Parents of intersex children likely consent to genital-normalizing surgeries based on what they believe is in their child's best interest. However, parents are ill-equipped to make a decision that fully encompasses all of the child's future interests because those future interests are in conflict with the parents' interest in having a "normal" child.²⁵ A decision of such fundamental importance should ultimately be left to the child.

In recent years, scholars and intersex activists have called for a moratorium on genital-normalizing surgeries, arguing that the parents of intersex children do not have the authority to consent to such procedures.²⁶ In particular, scholars have argued that consent to genital-normalizing surgery is beyond the scope of parental decision-making authority because genital-normalizing surgeries implicate the child's fundamental rights, including the right to procreate, the right to bodily integrity, the right to sexual gratification, and the right to marriage.²⁷

This Note explores and expands on the potential implications of genital-normalizing surgeries on the fundamental right to marriage, and it ultimately calls for legislative action barring parents from consenting to genital-normalizing surgeries, except in cases of true medical emergencies, until the child is able to make his or her own decision. The dehumanizing effects of genital-normalizing surgeries become particularly apparent when viewed through the lens of marriage; analysis of the impact of genital-

"acknowledged the failure of treatment but theorized that other variables including surgical delay may have caused the child to reject the assigned gender." Beh & Diamond, *supra* note 17, at 9 n.30.

20. Beh & Diamond, *supra* note 14, at 12.

21. *Id.*

22. *Id.* at 7 n.7.

23. *See id.* at 7.

24. *See, e.g., id.* at 8.

25. *See id.* at 7–8.

26. *Id.* at 9.

27. Sara R. Benson, *Hacking the Gender Binary Myth: Recognizing Fundamental Rights for the Intersexed*, 12 CARDOZO J.L. & GENDER 31 (2005) (discussing genital-normalizing surgery and the rights to bodily integrity, personality, sexuality, and gender identity); Kate Haas, *Who Will Make Room for the Intersexed?*, 30 AM. J.L. & MED. 41 (2004) (discussing genital-normalizing surgery and the rights to bodily integrity, procreation, and marriage); Erin Lloyd, Note, *From the Hospital to the Courtroom: A Statutory Proposal for Recognizing and Protecting the Legal Rights of Intersex Children*, 12 CARDOZO J.L. & GENDER 155 (2005) (discussing genital-normalizing surgery and the rights to bodily integrity, sexual gratification, procreation, and marriage).

normalizing surgeries on marriage makes clear that the problem is multifaceted and largely created by society.²⁸

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.²⁹ It is this insistence that pressures parents to consent to genital-normalizing surgeries in the first place. Within the binary gender system, society has created the institution of marriage, which it has largely chosen to limit to "opposite" sex couples.³⁰ Individuals who do not fit neatly within the binary system, such as intersexuals and same-sex couples, expose the fallacies inherent in the binary gender system and in the traditional marital institution that excludes same-sex couples.³¹ The fact that genital-normalizing surgeries have the potential to impact the right to marriage is a problem that society has essentially created. It is a result of both the societal insistence on a binary gender system that fails to recognize intersexuals and the way that society has chosen to define and limit marriage. It is within this context that the impact of genital-normalizing surgeries on the right to marriage is examined.

Part I of this Note explains the current treatment protocol for children born with ambiguous genitalia as well as some of the common criticisms of that approach. Part II discusses the parental right to consent to medical treatment for their children and the limitations on parental decision-making authority when the proposed treatment implicates fundamental rights. Part III begins with a discussion of marriage as a fundamental right as well as the ways that society has chosen to define and limit marriage. Then, it discusses the various ways that courts have defined sex for the purpose of marriage and explores the potential implications that genital-normalizing surgeries could have on this right. Part IV argues that because genital-normalizing surgeries can affect the fundamental right to marriage, parental consent to such procedures should not be allowed. It further argues that judicial oversight will not adequately protect the rights of intersex children and ultimately calls for a legislative ban on genital-normalizing surgeries.

I. THE CURRENT TREATMENT PROTOCOL FOR INTERSEX CHILDREN

John Money's work in the 1960s provided the foundation for the initial treatment of intersex conditions: surgical intervention.³² Under this traditional approach to intersex births, children born with ambiguous genitalia are assigned a sex based on their chromosomal make up and on the presence and size of a phallus.³³ The child then

28. *See infra* Part III.

29. *See* Julie Greenberg, *Legal Aspects of Gender Assignment*, 13 *ENDOCRINOLOGIST* 277, 277 (2003); Jessica Knouse, *Intersexuality and the Social Construction of Anatomical Sex*, 12 *CARDOZO J.L. & GENDER* 135, 135 (2005). "The male/female binary is absolutely pervasive in Western thought, and our culture has no third category to recognize intersex individuals as anything other than deformed males or females." *Id.* at 146.

30. *See* Greenberg, *supra* note 1, at 296–99.

31. *See id.*; *see also* Terry S. Kogan, *Transsexuals, Intersexuals, and Same-Sex Marriage*, 18 *BYU J. PUB. L.* 371 (2004).

32. *See* Dreger, *supra* note 9, at 27.

33. *Id.*

undergoes surgery in order to make the genitalia appear “normal” in an effort to maximize the child’s psychosocial development.³⁴ The surgical approach has come under intense scrutiny in recent years and has led to the development of an alternative treatment paradigm that encourages physicians to consider a broad spectrum of factors before assigning an intersex child a sex and performing any subsequent surgeries.³⁵ Because the surgical approach has served as the dominant approach to intersex births for many decades, it is unlikely that this new treatment protocol will result in an end to genital-normalizing surgeries.³⁶ These two competing treatment paradigms as well as the criticisms of the surgical approach are discussed below.

A. The Surgical Approach

Dr. John Money’s research and theories ushered in what Dr. Alice Dreger, a prominent scholar and activist in the field, describes as “The Age of Surgery” in which “each body [is] allowed only a single true sex, and the medical doctor [is] the determiner or even the creator of it.”³⁷ Intersex children are assigned a sex based on the doctor’s ability to preserve either male sexual functioning or female reproductive capabilities.³⁸ Once a sex is assigned, surgical techniques are used in order to “normalize” the genitalia so that the child can be “raised as [a] girl[] or boy[] with no hint of abnormality.”³⁹ Surgical intervention is seen as a “cure” to the anatomical abnormalities present in an intersex birth that make it difficult for doctors to fit intersexuals into either the male or female category.⁴⁰

Under this approach, intersex births are treated as a “medical and social emergency requiring early surgical intervention.”⁴¹ Proponents of genital-normalizing surgery argue that without surgical intervention, children born with ambiguous genitalia will become victim to teasing from other children and will ultimately be unable to form a gender identity.⁴² With these risks in mind, proponents urge that surgery be performed as soon as possible and that both the parents and the child be told “less than the whole truth about the nature of the condition” in order to maximize the child’s psychological well being and ultimate conformity with the assigned gender.⁴³

In order for a child to be deemed a member of the male sex, the size of the phallus must be “adequate,” or be capable of being made so through surgery or hormone

34. *Id.*

35. See Peter A. Lee, Christopher P. Houk, S. Faisal Ahmed & Ieuan A. Hughes, *Consensus Statement on Management of Intersex Disorders*, 118 PEDIATRICS e488, e491 (2006).

36. Emily A. Bishop, Note, *A Child’s Expertise: Establishing Statutory Protection for Intersexed Children Who Reject Their Gender of Assignment*, 81 N.Y.U. L. REV. 531, 547 (2007).

37. Alice Dormurat Dreger, *A History of Intersex: From the Age of Gonads to the Age of Consent*, in INTERSEX IN THE AGE OF ETHICS, *supra* note 8, at 5, 11.

38. Greenberg, *supra* note 29, at 277. This approach has been criticized as being based on sex-role stereotypes, *id.* at 277, and a “heterosexist framework,” DREGER, *supra* note 12, at 184.

39. Kipnis & Diamond, *supra* note 19, at 177.

40. See *id.* at 177 (analogizing genital-normalizing surgeries to correcting a cleft palate).

41. Greenberg, *supra* note 29, at 279.

42. *Id.*

43. *Id.*

treatments.⁴⁴ If a child has a Y chromosome and is thus a genetic male, then that child will be raised as a male if the length of the stretched phallus is greater than 2.5 centimeters, or one inch.⁴⁵ Surgical procedures and hormone treatments are performed in order to make the phallus look more “believable.”⁴⁶ If, however, the size of the phallus is less than 2.5 centimeters, then the child will be assigned to the female sex, regardless of the presence of a Y chromosome or a phallus.⁴⁷ Once again, this is accomplished through the use of surgery and hormone treatments.⁴⁸ “[S]urgeons refashion phalluses to look like clitorises . . . , build vulvas and vaginas if necessary, and remove any testes. This is done even if it means risking a child’s only real chance at becoming a biological parent, because intersex doctors consider ‘adequate’ penises far more important for boys than potential fertility.”⁴⁹

Intersex children who lack the presence of a Y chromosome are assigned to the female sex.⁵⁰ “This is done chiefly in the interest of preserving these children’s potential feminine reproductive capabilities and in bringing their anatomical appearance and physiological capabilities into line with that reproductive role.”⁵¹ As a result, these children are treated in much the same way as intersexuals born with a Y chromosome and an “inadequate” phallus.⁵² “Vaginas are built or lengthened if necessary, in order to make them big enough to accept average-sized penises. Joined labia are separated, and various other surgical and hormonal treatments are directed at producing a believable and, it is hoped, fertile girl.”⁵³

The ultimate goal of the surgeons is to maintain the reproductive capability of females and to maintain the male sexual prowess by ensuring that a male child will have an “adequate” male phallus.⁵⁴ This entire practice reaffirms the stereotypical gender roles of women as mothers and men as sexual beings and ultimately reaffirms the gender binary system.⁵⁵

B. Criticisms of the Surgical Approach

The widespread publication of David Reimer’s true story and his sad demise has led many to question whether the surgical approach continues to be appropriate.⁵⁶ In recent

44. Dreger, *supra* note 37, at 12 (“If it looks like a believable penis to the doctors, or if they think they can make it look like what they think a penis should look like, the child will be assigned the boy gender.”).

45. *Id.*

46. *Id.* (“Doctors will examine this child at regular intervals and work—using surgical and endocrinological technologies—to make him look like a ‘true’ boy.”).

47. *Id.*

48. *Id.*

49. DREGER, *supra* note 12, at 182.

50. Dreger, *supra* note 37, at 12.

51. Dreger, *supra* note 9, at 28.

52. *Id.*

53. *Id.*

54. See Greenberg, *supra* note 29, at 277.

55. See DREGER, *supra* note 12, at 184.

56. See Dreger, *supra* note 9, at 7. John Money “acknowledged the failure of treatment but theorized that other variables including surgical delay may have caused the child to reject the assigned gender.” Beh & Diamond, *supra* note 17, at 9 n.30.

years, intersex activists have become increasingly vocal, denouncing the surgical approach for a number of reasons.⁵⁷ As Dr. Dreger described: “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.”⁵⁸

One of the main arguments against the dominant treatment protocol for intersex births is that it is dehumanizing and results in both shame and physical and emotional trauma for the parents and patients.⁵⁹ In most cases, the decision to undergo genital-normalizing surgery is not made by the patient, but by doctors and family members who are uncomfortable with the intersex child’s genitalia.⁶⁰ Genital-normalizing surgery may result in scarring, a loss of sexual functioning or the ability to experience sexual pleasure, and a loss of reproductive capabilities.⁶¹ These procedures are performed with very little long-term data showing that the surgeries are actually effective.⁶² Additionally, reports abound showing that the child often rejects the sex chosen by the parents.⁶³ Sadly, these procedures are “essentially irreversible.”⁶⁴

Intersex births are treated as medical emergencies, though few actually require immediate medical attention.⁶⁵ In fact, parents are rarely told that most surgeries can be postponed until the child is capable of making his or her own decision and that surgeries performed later in life are often more successful and more positively received by the patients.⁶⁶ In addition, parents are rarely told that multiple surgeries will be needed.⁶⁷ “Thirty to eighty percent of all children undergoing genital surgery have multiple procedures, ranging from three to five such operations. In many instances it involves complicated upkeep, multiple surgeries, and painful side effects.”⁶⁸

The devastating effects of such surgeries are most apparent in the case of children who have undergone vaginoplasty procedures, a surgical procedure that creates a vagina.⁶⁹ These procedures require a great deal of upkeep, most of which is traumatic to the child.⁷⁰ In order to prevent the newly created cavity from closing, the child’s vagina must be dilated on a daily basis.⁷¹ This task often falls to the child’s parents.⁷²

57. See Greenberg, *supra* note 29, at 279.

58. Dreger, *supra* note 9, at 33.

59. DE MARÍA ARANA, *supra* note 10, at 17–18, 24. It has also been reported that the parents of intersex children “report feeling shame, fear, horror, humiliation, regrets, and ongoing doubt about the choices they may have made for their children.” *Id.* at 22.

60. *Id.* at 18.

61. *Id.* at 19, 21.

62. Kipnis & Diamond, *supra* note 19, at 187.

63. Bruce E. Wilson & William G. Reiner, *Management of Intersex: A Shifting Paradigm*, in INTERSEX IN THE AGE OF ETHICS, *supra* note 8, at 119, 126.

64. DE MARÍA ARANA, *supra* note 10, at 21.

65. Beh & Diamond, *supra* note 17, at 44.

66. See DE MARÍA ARANA, *supra* note 10, at 19, 22. This is because these surgeries are easier to perform on larger anatomy, and “[e]arly childhood surgeries often necessitate revisions to accommodate body growth.” *Id.*

67. *Id.* at 22.

68. Benson, *supra* note 27, at 47.

69. See *id.* at 45–46.

70. See *id.*

71. *Id.*

Unsurprisingly, “many intersexuals later describe medical exams and procedures that they were subjected to as children as sexual abuse.”⁷³ Because of the egregious nature of this procedure and other sex-assignment procedures, many activists have called for a moratorium on such surgeries, except in true medical emergencies, until the child is capable of making his or her own decision.⁷⁴

C. Emergence of a New Treatment Protocol

In 2006, the American Academy of Pediatrics adopted a new policy with respect to the treatment of intersex births in which “[t]he birth of an intersex child prompts a long-term management strategy that involves myriad professionals working with the family.”⁷⁵ Unlike the traditional approach, the new policy suggests that physicians consider a variety of factors before determining which sex to assign the child, including the child’s medical “diagnosis, genital appearance, surgical options, need for lifelong replacement therapy, potential for fertility, views of the family, and, sometimes, circumstances relating to cultural practices.”⁷⁶ The new approach emphasizes parental education and advises physicians to spend ample time with parents.⁷⁷

While the new approach makes several advances over the traditional approach, it is far from perfect. It does not advocate that doctors cease performing genital-normalizing surgeries, but instead urges that surgery should maintain a “functional” rather than a “cosmetic” approach.⁷⁸ More importantly, “the creation of new standards of care is not binding on medical providers, and it can take many years for medical practices to change in accordance with new information.”⁷⁹ As a result, the surgical approach remains the dominant approach in many hospitals.⁸⁰

II. INFORMED CONSENT

A. Limitations on Parental Decision-Making Authority

Under the current legal system, parents are afforded a great deal of deference in making decisions for their children and in controlling their children’s upbringing.⁸¹ Included within this decision-making realm is the ability to make medical decisions for

72. *Id.* at 46.

73. *Id.*

74. Greenberg, *supra* note 29, at 279.

75. Lee et al., *supra* note 35, at e488.

76. *Id.* at e491.

77. *Id.* at e490.

78. *Id.* at e491.

79. Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law’s Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER L. & JUST. 59, 78 (2006).

80. *Id.*

81. *See, e.g.*, *Pierce v. Soc’y of the Sisters of the Holy Names of Jesus and Mary*, 268 U.S. 510 (1925) (finding that a law requiring all children to attend public schools “unreasonably interfere[d] with the liberty of parents . . . to direct the upbringing and education of children under their control”); *Meyer v. Nebraska*, 262 U.S. 390 (1923) (holding that the “right of parents to engage [a language instructor for] their children . . . [is] included within the liberty of the [Fourteenth] Amendment”); *see also* Alyssa Connell Lareau, Note, *Who Decides? Genital-Normalizing Surgery on Intersexed Infants*, 92 GEO. L.J. 129, 140 & n.72 (2003).

their minor children.⁸² Parents are granted the authority to consent to medical procedures for their children because it is assumed “that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions . . . [and] that natural bonds of affection lead parents to act in the best interests of their children.”⁸³

This parental right, however, is not absolute and has been limited in a number of instances.⁸⁴ In particular, parents have limited authority to make medical decisions for their children when conflicts of interest (such as a parental desire to avoid raising the child of an incapacitated minor child in the context of sterilization procedures or the desire to avoid parental discomfort or embarrassment in the context of genital-normalizing procedures) make it questionable that parents are acting in the best interests of their child.⁸⁵ Conflicts of this sort are readily visible when the proposed medical procedure implicates the child’s fundamental rights.⁸⁶ Professor Jennifer Rosato refers to such conflicts as “categorical conflicts,” which are said to exist when “the treatment decision [at issue] involves a countervailing constitutional right of the patient that, when exercised, is likely to interfere with the family member’s decision.”⁸⁷ In instances where a proposed treatment creates a “categorical conflict,” blind deference to parental decision-making authority is inappropriate.⁸⁸

Courts have recognized these “categorical conflicts” and have limited parental decision-making authority concerning medical procedures involving fundamental rights in the context of abortion.⁸⁹ In *Planned Parenthood of Central Missouri v. Danforth*, the Supreme Court invalidated a statute that granted parents an “absolute, and possibly arbitrary, veto” over their minor daughter’s fundamental right to seek an abortion.⁹⁰ In *Bellotti v. Baird*, the Court refined its position, holding that in order to appropriately balance the parental right to control the upbringing of their children and the fundamental right to an abortion, statutes that require minors to seek parental consent before receiving an abortion must also “provide an alternative procedure whereby authorization for the abortion can be obtained.”⁹¹ Alternative authorization procedures

82. Jennifer L. Rosato, *Using Bioethics Discourse to Determine when Parents Should Make Health Care Decisions for Their Children: Is Deference Justified?*, 73 TEMP. L. REV. 1, 5–6 (2000).

83. *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

84. *See, e.g., id.* at 603–09.

85. Lareau, *supra* note 81, at 142 (“[D]eference to parental decisionmaking can be overcome if it is shown that the parent decisionmaker has a conflict that has impaired his or her ability to consider the best interests of the child.”).

86. *See* Rosato, *supra* note 82, at 43.

87. *Id.*

88. *See id.*

89. The right to have an abortion is a fundamental right inferred from the liberty interest in the Fifth and Fourteenth Amendments. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

90. 428 U.S. 52, 74 (1976).

91. 443 U.S. 622, 643 (1979). An alternative procedure permits the minor to show by means of judicial or some other proceeding either that she is mature enough to make the decision to abort without parental consent, or that an abortion is in her best interest, regardless of her ability to make an independent decision. *Id.* at 643–44.

that amount to “an absolute, and possibly arbitrary, veto” by a third party are not sufficient.⁹²

Parental decision-making authority has also been limited, perhaps to an even greater extent, in the context of sterilization procedures for children.⁹³ Like the right to an abortion, the right to procreation is fundamental.⁹⁴ Because sterilization procedures directly implicate fundamental rights and have the potential for extreme abuse, most jurisdictions require that parents seek judicial authorization in order to have their child sterilized.⁹⁵ Unlike most other medical procedures, however, sterilization requires judicial authorization regardless of whether or not the parents and the doctor are in agreement.⁹⁶ As with the issue of parental consent requirements for abortion, the fundamental nature of the rights implicated by sterilization procedures justifies limiting parental decision-making authority.⁹⁷

B. Genital-Normalizing Surgeries Create “Categorical Conflicts”

As described above, courts have carved out situations in which parental decision-making authority is limited. Because genital-normalizing surgery implicates the fundamental right to marriage,⁹⁸ it falls within the category of medical procedures for which parents have limited authority to consent.

Some scholars have argued that consent to genital-normalizing surgeries “exceeds parental authority because it unnecessarily forecloses the child’s right to an open future.”⁹⁹ This argument is based on Professor Joel Feinberg’s theory of a child’s right to an open future, which posits that there are certain rights that children, because of their age, are incapable of exercising.¹⁰⁰ These “[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”¹⁰¹ Because these rights cannot be immediately exercised, children entrust these rights to their parents, who have a duty to hold these rights in safekeeping until the child is able to exercise them.¹⁰² These rights “can be violated ‘in advance’ . . . before the child is even in a position to exercise them. [Any] violating conduct guarantees now that when the child is an autonomous adult, certain key options will already be closed to him.”¹⁰³ In other words, the child’s right to an open future may be foreclosed

92. *Id.* at 644 (quoting *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976)).

93. Beh & Diamond, *supra* note 17, at 39.

94. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

95. Tamar-Mattis, *supra* note 79, at 96.

96. Beh & Diamond, *supra* note 17, at 39.

97. *See id.*

98. *See infra* Part III.C.

99. *See, e.g., Benson, supra* note 27, at 32; Beh & Diamond, *supra* note 14, at 5.

100. Joel Feinberg, *The Child’s Right to an Open Future*, in *WHOSE CHILD?* 124, 125 (William Aiken & Hugh LaFollette eds., 1980).

101. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976).

102. *See Feinberg, supra* note 100, at 125–26.

103. *Id.* (emphasis omitted).

by parental conduct that ensures that the child will not be able to exercise certain rights in the future.¹⁰⁴

Included among those rights entrusted by children to their parents for safekeeping is the right to marriage.¹⁰⁵ It is undisputed that an infant is unable to immediately exercise the fundamental right to marriage. It is possible, however, for parents to foreclose their child's future right to marriage by consenting to genital-normalizing surgery.¹⁰⁶ This potential violation of a fundamental right provides one of the reasons why parental decision-making authority should be limited in this context. This concept is further shaped by the way that society has chosen to define and limit marriage to only "opposite" sex couples.

III. INTERSEXUALS AND MARRIAGE

A. The Importance and Limitations of Marriage

As the Supreme Court stated in *Loving v. Virginia*, "[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men."¹⁰⁷ Marriage is a fundamental right,¹⁰⁸ and it plays a central role in our society. The Supreme Court has described marriage as the "most important relation in life,"¹⁰⁹ providing the "foundation of the family and of society, without which there would be neither civilization nor progress."¹¹⁰ Because the institution of marriage is so highly valued by our society, married couples are granted a number of rights and privileges including tax benefits, inheritance and other death benefits, decision-making authority over an incapacitated spouse, and evidentiary privileges.¹¹¹

Although the right to marriage is fundamental, marriage is ultimately a creation of the State and is subject to the definitional limitations placed on it by society. As a result, society has largely chosen to define marriage as a union between a man and a woman, thus limiting marriage to couples of the "opposite" sex. From this perspective, only the right to an "opposite sex" marriage is fundamental.

In 1996, Congress enacted the Defense of Marriage Act (DOMA), which defines "marriage" as a "legal union between one man and one woman as husband and wife" and defines "spouse" as "a person of the opposite sex who is a husband or a wife."¹¹² DOMA further recognizes the authority of the states under the Full Faith and Credit Clause to choose whether or not to recognize a same-sex marriage license issued by another state.¹¹³ A number of states have passed similar statutes and constitutional amendments limiting marriage to male and female couples, and "[e]ven in states in which no legislation exists, the assumption of the courts is that a valid marriage

104. *Id.* at 126.

105. *See id.* at 126–27.

106. *See infra* Part III.C.

107. 388 U.S. 1, 12 (1967).

108. *Zablocki v. Redhail*, 434 U.S. 374, 383–86 (1978).

109. *Maynard v. Hill*, 125 U.S. 190, 205 (1888).

110. *Id.* at 211.

111. Cass R. Sunstein, *The Right to Marry*, 26 CARDOZO L. REV. 2081, 2090–92 (2005).

112. 1 U.S.C. § 7 (2006).

113. 28 U.S.C. § 1738C (2006).

requires a union of one man and one woman.”¹¹⁴ Currently, only five states issue marriage licenses to same-sex couples wishing to marry.¹¹⁵

Because of the way that society has chosen to define and limit marriage, a person’s sex is an important aspect of determining whether or not that person is entering into a valid heterosexual marriage. This issue becomes even more important for intersexuals who do not fit neatly into either the male or female category.¹¹⁶

B. Legal Determinations of Sex for the Purpose of Marriage

Despite the fact that a majority of states, as well as the federal government, have chosen to define marriage as a union between a man and a woman, none have actually defined what constitutes a man or a woman for that purpose.¹¹⁷ As a result, this task has largely been left to the judiciary.¹¹⁸ While no American courts have discussed the mechanics of determining the sex of an intersexual for the purpose of marriage, both Australia¹¹⁹ and England¹²⁰ have reviewed the validity of a marriage where one member of the marriage is an intersexual. A number of American courts have assessed the validity of a marriage in which one spouse is a postoperative transsexual—a transgendered individual who has undergone sex reassignment surgery.¹²¹ These cases provide a useful starting point because postoperative transsexuals, like intersexuals, do not fit neatly within the binary gender system.

The courts that have addressed the issue have taken a number of different approaches. Some courts determine an individual’s sex by looking only to biological factors, while other courts are willing to look to psychological factors in addition to biological factors. The common thread among all of these cases is the court’s determination of an individual’s “true sex” for the purpose of marriage, a concept that is relevant solely to ensure that the marriage is between members of the “opposite” sex, thus comporting with the definitional limitations that society has placed on marriage.

1. An Emphasis on Biological Factors

Courts that focus on biological factors determine sex by looking to an individual’s chromosomal and hormonal composition and, perhaps more importantly, that individual’s anatomy at birth. Gender identity is not considered. This approach was

114. Greenberg, *supra* note 1, at 296.

115. Same-sex marriages are legal in Connecticut, Iowa, Massachusetts, New Hampshire, and Vermont. Freedom to Marry, Where Can Gay Couples Get Married?, <http://www.freedomtomarry.org/states.php>.

116. Randi E. Frankle, Note, *Does a Marriage Really Need Sex?: A Critical Analysis of the Gender Restriction on Marriage*, 30 FORDHAM URB. L.J. 2007, 2026 (2003) (“If marriage is a fundamental right, limited to opposite sex, or apparently heterosexual couples, classifying an intersex person becomes extremely important.”).

117. Greenberg, *supra* note 1, at 297–98.

118. *Id.* at 298.

119. *See infra* Part III.B.3.

120. *See infra* Part III.B.1–2.

121. *See infra* Part III.B.1–2.

utilized by the English court in *Corbett v. Corbett*,¹²² the first case to address the issue of determining a person's sex in order to assess the validity of a marriage.¹²³ In *Corbett*, the court considered whether Ashley Corbett, a postoperative male-to-female transsexual, could legally marry a man.¹²⁴ The court determined that there were four factors that might be considered when determining an individual's sex: (1) chromosomal factors, (2) gonadal factors, (3) genital factors, and (4) psychological factors.¹²⁵ The court added that two additional factors—hormonal factors and secondary sex characteristics, such as breasts or physique—may also be relevant.¹²⁶

In finding that the marriage was invalid, the court held that a person's sex is fixed at birth and that Ashley Corbett's sex-change operation did not alter her "true sex," which was male.¹²⁷ The court further held that only the first three factors—chromosomal factors, gonadal factors, and genital factors—are controlling, so long as they are congruent, when determining an individual's sex for the purpose of marriage.¹²⁸ The court declined consideration of Ashley Corbett's gender identity because it considered marriage to be "a relationship which depends on sex and not on gender."¹²⁹ The court noted that "[t]he only cases where the term 'change of sex' is appropriate are those in which a mistake as to sex is made at birth and subsequently revealed by further medical investigation."¹³⁰

Most American courts have followed the approach established by the *Corbett* court.¹³¹ In *Littleton v. Prange*, the Texas Court of Appeals addressed what it considered to be the fundamental issue in the case: whether "a physician [can] change the gender of a person with a scalpel, drugs and counseling, or [whether] a person's gender [is] immutably fixed by our Creator at birth."¹³² The issue in *Littleton* was whether Christie Littleton, a postoperative male-to-female transsexual, could enter into marriage as a woman and later sue for the wrongful death of her husband.¹³³

Against the background of what the court considered the "wide spread" "opposition to same-sex marriages,"¹³⁴ the court found that Christie Littleton's marriage to Jonathon Littleton was invalid:

At the time of birth, Christie was a male, both anatomically and genetically. The facts contained in the original birth certificate were true and accurate, and the words contained in the amended certificate are not binding on this court.

122. *Corbett v. Corbett (otherwise Ashley)*, [1971] P. 83, 83.

123. Greenberg, *supra* note 1, at 299.

124. *Id.*

125. *Id.* at 100.

126. *Id.*

127. *Id.* at 106.

128. *Id.*

129. *Id.* at 107. Courts tend to use the terms "sex" and "gender" interchangeably.

130. *Id.* at 104.

131. P.L. Chau & Jonathan Herring, *Defining, Assigning, and Designing Sex*, 16 INT'L J.L. POL'Y & FAM. 327, 346 (2002).

132. 9 S.W.3d 223, 224 (Tex. App. 1999).

133. *Id.* at 225 ("In order to have standing to sue under the wrongful death and survival statutes [sic], Christie must be Jonathon's surviving spouse.").

134. *Id.* at 225–26.

There are some things we cannot will into being. They just are.¹³⁵

Refusing to rely on Christie Littleton's sex-change operation, her amended birth certificate, or her gender identity, the court instead focused on her chromosomal composition and lack of female internal sex organs.¹³⁶ Ultimately, the court's decision rested entirely on chromosomes: "The male chromosomes do not change with either hormonal treatment or sex reassignment surgery. Biologically a post-operative female transsexual is still a male."¹³⁷

The Probate Court of Stark County, Ohio, placed a similar emphasis on the "true" birth sex noted on the original birth certificate in *In re Ladrach*.¹³⁸ In denying a marriage license to a postoperative male-to-female transsexual, the court stated that "[i]t is generally accepted that a person's sex is determined at birth by an anatomical examination by the birth attendant. This results in a declaration on the birth certificate of either 'boy' or 'girl' This then becomes a person's true sex," which cannot be altered by a sex change operation.¹³⁹ As in *Littleton*, the court emphasized that there was no mistake on the original birth certificate.¹⁴⁰

More recently, the Kansas Supreme Court addressed the issue in *In re Estate of Gardiner*.¹⁴¹ Following in the footsteps of *Corbett*, *Littleton*, and *In re Ladrach*, the court relied on biological factors to find that an individual's sex is fixed at birth.¹⁴² As with its predecessors, the *Gardiner* court emphasized that its decision had to be made against the backdrop of the public policy against same-sex marriages.¹⁴³

The words "sex," "male," and "female" in everyday understanding do not encompass transsexuals. The plain, ordinary meaning of "persons of the opposite sex" contemplates a biological man and a biological woman and not persons who are experiencing gender dysphoria. A male-to-female post-operative transsexual does not fit the definition of a female. The male organs have been removed, but the ability to "produce ova and bear offspring" does not and never did exist. There is no womb, cervix, or ovaries, nor is there any change in his chromosomes.¹⁴⁴

Therefore, in Kansas, sex is determined by our common understanding of what it means to be "male" or "female," which in turn is largely determined by looking at biological and reproductive capabilities.

135. *Id.* at 231.

136. *See id.* at 230–31.

137. *Id.* at 230; *see also* Michael L. Rosin, *Intersexuality and Universal Marriage*, 14 *LAW & SEXUALITY* 51, 68–70 (2005) ("Chief Justice Hardberger's opinion relies on just a single factor: the sex chromosomes.").

138. 513 N.E.2d 828 (Ohio Prob. Ct. 1987).

139. *Id.* at 832.

140. *Id.*

141. 42 P.3d 120 (Kan. 2002).

142. *See id.* at 135–36.

143. *Id.* Kansas defines marriage by statute as "a civil contract between two parties who are of opposite sex." *Id.* at 125.

144. *Id.* at 135.

2. Consideration of Psychological Factors

Courts that consider psychological factors, on the other hand, are willing to consider an individual's gender identity as an additional factor in determining an individual's sex for the purpose of marriage. While the English court declined consideration of psychological factors in determining the sex of a postoperative transsexual in *Corbett v. Corbett*,¹⁴⁵ the court held that psychological factors are relevant in determining the sex of an intersexual in *W v. W*.¹⁴⁶

In *Corbett*, the court went to great lengths to distinguish Ashley Corbett's status as a transsexual from that of an intersexual.¹⁴⁷ In hypothesizing about how it might determine the sex of an intersexual seeking to marry, the court stated:

This question does not arise in the present case and I must not anticipate, but it would seem to me to follow from what I have said that greater weight would probably be given to the genital criteria than to the other two. This problem and, in particular, the question of the effect of surgical operations in such cases of physical inter-sex, must be left until it comes for decision.¹⁴⁸

The English court had the opportunity to visit this issue in *W v. W*.¹⁴⁹ In that case, the court was asked to nullify a marriage between a male and an intersexual female on the grounds that it constituted a same-sex marriage.¹⁵⁰ The wife was born with male chromosomes, male gonads, and sufficiently ambiguous genitalia, such that her sex could not be readily determined at birth.¹⁵¹ Doctors gave the wife's parents the option of choosing her sex, and her parents decided to register the wife as a male and raise her as a boy.¹⁵² The wife began developing breasts as a teenager and ultimately identified with the female gender.¹⁵³ She eventually underwent surgery in order to attain "normal" female genitalia.¹⁵⁴ Prior to the surgery, she was unable to have sex as either a male or a female.¹⁵⁵

The court declined to adhere to the solution it posited in *Corbett*, and instead held that all six factors posed by the *Corbett* court—chromosomal, gonadal, genital, psychological, hormonal, and secondary sex characteristics—are relevant in determining an intersexual's sex for the purpose of marriage.¹⁵⁶ The court relied heavily on the wife's desire to live as a woman, and on the fact that as a result of that desire, she underwent surgery that enabled her to consummate her marriage as a

145. See *Corbett v. Corbett (otherwise Ashley)*, [1971] P. 83, 106.

146. *W v. W*, [2001] Fam. 111, 111.

147. *Corbett*, [1971] P. at 98–100, 106.

148. *Id.* at 106.

149. *W*, [2001] Fam. at 111.

150. *Id.* at 112. This Note will refer to the intersexual female in this case as the "wife." The husband in this case sought to have the marriage nullified so he could remarry in the Church. *Id.* at 115.

151. *Id.* at 113, 120.

152. *Id.* at 113.

153. *Id.* at 113–14.

154. *Id.* at 114.

155. *Id.* at 121.

156. *Id.* at 146.

female.¹⁵⁷ The court continued to rely on external genitalia as a factor, but unlike *Corbett*, the court looked at the characteristics of the wife's genitalia at the time she entered into marriage rather than at the time of her birth.¹⁵⁸ The court also recognized the difficulty in choosing a sex for a child and suggested that in "cases where a decision as to the sex or gender in which a child should be brought up [is left] to be made by doctors and others," a "wait and see" approach might be appropriate.¹⁵⁹

The Superior Court of New Jersey took a similar multifactor approach to determining an individual's sex for the purpose of marriage in *M.T. v. J.T.*,¹⁶⁰ a case involving the marriage of a postoperative male-to-female transsexual. Like the court in *W v. W*, the *M.T. v. J.T.* court departed from the *Corbett* approach, which limited its analysis solely to biological factors, and instead considered psychological factors as relevant to the determination of an individual's sex for the purpose of marriage.¹⁶¹ While the court recognized gender identity as a relevant factor, external genitalia and sexual capacity were of paramount importance.¹⁶² Under this approach, psychological factors become relevant because "[s]exual capacity . . . requires the coalescence of both the physical ability and the psychological and emotional orientation to engage in sexual intercourse as either a male or a female."¹⁶³ Therefore, a court that follows *M.T. v. J.T.* will consider psychological factors, but only if the external genitalia are made to conform to the psychological sex.¹⁶⁴

3. Intersexuals Have No Sex

The final approach taken by courts to determine the sex of an intersexual for the purpose of marriage produces the harshest results. Under this approach, intersexuals cannot be characterized as male or female because they possess characteristics of both sexes.¹⁶⁵ Because of the ban on same-sex marriages, intersexuals are unable to marry anyone because of their inability to marry a member of the "opposite" sex.¹⁶⁶

This is the approach taken by the first court to ever consider the marriage of an intersexual, *In the Marriage of C. and D.*, which involved a marriage between an intersexual male and a female.¹⁶⁷ The husband was unaware of his status as an intersexual until he began to develop breasts and "have a monthly loss of blood."¹⁶⁸ His

157. *See id.*

158. Kogan, *supra* note 31, at 406.

159. *W*, [2001] Fam. at 146.

160. 355 A.2d 204 (N.J. Super. Ct. App. Div. 1976).

161. *Id.* at 209–11 ("[W]e must disagree with the conclusion reached in *Corbett* that for purposes of marriage sex is somehow irrevocably cast at the moment of birth, and that for adjudging the capacity to enter marriage, sex in its biological sense should be the exclusive standard.").

162. *See id.* at 209.

163. *Id.*

164. *See id.* at 210.

165. *In the Marriage of C. and D. (falsely called C.)* (1979) 28 A.L.R. 524 (Austl.); *see also* Greenberg, *supra* note 1, at 304.

166. *See id.* at 528.

167. *Id.* at 524. This Note will refer to the intersexual male in this case as the "husband."

168. *Id.* at 525.

doctors later discovered the presence of an ovary and uterus during an operation for abdominal pains.¹⁶⁹ The husband subsequently underwent surgery to remove his breasts and “to correct his external sex organs.”¹⁷⁰ Though he possessed female chromosomes, the “surgery . . . [was performed] to confirm the recognition that he was born a male and had been reared as a male.”¹⁷¹ The court invalidated the marriage, finding that the husband was neither a man nor a woman, and thus could not marry a member of the “opposite” sex.¹⁷² The position taken by the court in this case is considered quite extreme and has been subject to a great deal of negative criticism for obvious reasons.¹⁷³ It is doubtful that any court would elect to follow the holding because, regardless of whether or not genital-normalizing surgeries are performed, intersexuals would be denied the right to marry anyone.¹⁷⁴

C. Legal Sex for the Intersexed and the Effects of Genital-Normalizing Surgery

American courts have not addressed the issue of how to determine the sex of an intersexual for the purpose of marriage, and it is unclear which of the approaches discussed above might be adopted by courts in the event that such a marriage is presented for review. Because of the wide array of legal tests employed by courts and the lack of cases involving intersexual marriages, a great deal of ambiguity remains over what impact, if any, genital-normalizing surgeries will have on the determination of an individual’s legal sex. While courts may choose to rely on international case law and analogize from cases involving postoperative transsexuals, they remain in uncharted waters. What is important for purposes of this discussion, however, is that genital-normalizing surgeries could have a profound impact on how courts view the sex of an intersexual, and ultimately on the fundamental right of intersexuals to marry.¹⁷⁵ As a result, the parents of intersexed children should not be able to interfere with the process by being allowed to consent to such surgeries.

1. Courts that Consider Psychological Factors

Courts that take psychological factors into account will likely reach a different result from those that only consider biological factors. Even courts that consider psychological factors, however, still heavily emphasize the necessity of genitalia that is capable of consummating a marriage.¹⁷⁶ Under an analysis like *W v. W*, a court would look to an individual’s desire to live as a member of a given sex, as exemplified by his or her willingness to conform his or her genitalia to be able to function sexually as a member of that sex.¹⁷⁷ The same could be said for an approach like *M.T. v. J.T.*, in

169. *Id.*

170. *Id.* at 525–26.

171. *Id.* at 526.

172. *Id.* at 528.

173. Greenberg, *supra* note 29, at 282 tbl.1. This holding was ultimately overruled. *See In re Kevin* (2003) 30 Fam. L.R. 1, 41 (Austl.).

174. *See* Frankle, *supra* note 116, at 2027–28.

175. *See* Haas, *supra* note 27, at 60–61; Lloyd, *supra* note 27, at 187.

176. *See* *M.T. v. J.T.*, 355 A.2d 204, 209–11 (N.J. Super. Ct. App. Div. 1976).

177. *See* *W v. W*, [2001] Fam. 111, 111.

which the court considers gender identity, but only if the external genitalia are made to agree with the gender identity.

If parents elect to have their child's genitalia "normalized," and the child ultimately identifies with a different gender, then that child would be unable to marry without undergoing additional surgery to reverse the previous surgeries performed on him or her as a child.¹⁷⁸ This process, if medically possible, would likely be both expensive and traumatic, and "may prohibit some, otherwise qualified, intersexuals from marrying."¹⁷⁹ By consenting to genital-normalizing surgery, the intersexual child's parents have virtually decided the sex of the person that their child may marry by altering their child's genitalia and ultimately determining how their child will consummate his or her future marriage.

On the other hand, it is not entirely clear whether an individual in the position of the wife in *W v. W* would have been able to marry without having genital-normalizing surgery performed because of her inability to have sex as either a male or a female.¹⁸⁰ While the courts in *W v. W* and *M.T. v. J.T.* emphasized the ability to function sexually, it is doubtful that a court would force an individual to undergo surgery as a prerequisite to marriage.¹⁸¹ In any event, a "wait and see" approach like the one proposed by the court in *W v. W* is best because, even if forced to undergo surgery, it is the intersexual, and not the parent, who will make the decision.

2. Courts that Only Consider Biological Factors

Applying a purely biological test to an intersexual that has undergone genital-normalizing surgery is difficult and could lead to a number of different results. This problem flows directly from the insistence on finding an individual's "true sex," which must be either male or female. Intersexuals, however, do not fit neatly into either category.¹⁸² A court could find that, regardless of whether or not genital-normalizing surgery has been performed, intersexuals do not have a "true sex" because they possess both male and female characteristics.¹⁸³ This result, however, is highly unlikely since it would deprive an entire group of citizens of the right to marry.¹⁸⁴ Therefore, courts are left with the impossible task of ferreting out an individual's "true sex" and forcing intersexuals to fit into the binary gender system, all for the ultimate purpose of determining whether the contemplated marriage is one of "opposite" sexes.

The difficulties posed by the notion of finding an individual's "true sex" were recognized in Justice Angelini's concurring opinion in *Littleton*, in which she stated "that 'real difficulties . . . will occur if these three criteria [chromosomal, gonadal and genital tests] are not congruent.' We must recognize the fact that, even when biological factors are considered, there are those individuals whose sex may be ambiguous."¹⁸⁵

178. See Haas, *supra* note 27, at 61.

179. *Id.*

180. See Kogan, *supra* note 31, at 411–14.

181. See *id.* at 403.

182. Knouse, *supra* note 29.

183. See *supra* Part III.B.3.

184. See Frankle, *supra* note 116, at 207–28.

185. *Littleton v. Prange*, 9 S.W.3d 223, 232 (Tex. App. 1999) (Angelini, J., concurring) (alterations in original) (citation omitted) (quoting *Corbett v. Corbett (otherwise Ashley)*, [1971]

This statement reveals that the *Littleton* court had the plight of the intersexual in mind when it rendered its decision, yet it still advanced a test that relied almost entirely on chromosomes.¹⁸⁶ While Justice Angelini expressed no opinion as to how the court would or should handle a marriage involving an intersexual, her concurrence shows that the court had an opportunity to carve out an exception allowing for consideration of psychological factors when determining the “true sex” of intersexuals, but chose not to.¹⁸⁷

The question then becomes, how does one define an intersexual’s “true sex”? If an individual’s “true sex” is based entirely on chromosomes, as the court presumed in *Littleton*, then genital-normalizing surgery will have no effect on an intersexual’s ability to enter into marriage because surgery cannot change an individual’s chromosomes. If “true sex” is based on whether or not an individual has the ability to bear or beget offspring as the court held in *Gardiner*, then this too cannot be altered by surgery.¹⁸⁸ In both *Littleton* and *Gardiner*, the courts discussed and rejected man-made anatomical characteristics.¹⁸⁹ It remains to be seen, however, whether such courts would consider genital-normalizing surgery as creating man-made genitalia, or as restoring genitalia to the condition they would have been it had it not been for an anatomical anomaly. If a court were to view genital-normalizing surgery as a “cure” for ambiguous genitalia, as much of the medical profession does,¹⁹⁰ then it might find that an individual’s “true sex” is the one carved from the surgeon’s knife. Having established a “true sex,” the intersexual would be unable to alter it in the future, and may not be able to marry as a result.

The analysis becomes even more complicated with the concept of birth sex, which the court in *In re Ladrach* considered to be the “true sex.”¹⁹¹ The court defined birth sex as the sex determined by the birth attendant after examination.¹⁹² In both *Littleton* and *In re Ladrach*, the courts noted that mistakes could be made in assigning a sex at birth and implied that this would not affect an individual’s “true sex” for the purpose of marriage.¹⁹³ Prior to having genital-normalizing surgery, intersexuals can change their legal sex by petitioning the court and showing that they have ambiguous genitalia and that they identify with the opposite sex.¹⁹⁴ Once genital-normalizing surgery is performed, however, an intersexual no longer has ambiguous genitalia, and his or her legal sex cannot be changed without subsequent surgeries.¹⁹⁵ From this perspective, “genital reconstruction surgically defines an intersexed person as male or female, thus, prohibiting them from marriage to a person of their ‘same’ gender.”¹⁹⁶

P. 83).

186. *See id.* at 230–32.

187. *See id.* at 232.

188. Greenberg, *supra* note 29, at 281–82.

189. *See Littleton*, 9 S.W.3d at 231 (“Her female anatomy, however, is all man-made. The body that Christie inhabits is a male body in all aspects other than what the physicians have supplied.”).

190. *See supra* Part I.A.

191. *See* 513 N.E.2d 828, 832 (Ohio Prob. Ct. 1987).

192. *Id.*

193. *See Littleton*, 9 S.W.3d at 231; *In re Ladrach*, 513 N.E.2d at 831.

194. Haas, *supra* note 27, at 60–61.

195. *Id.* at 61.

196. *Id.* at 60.

Because of the difficulties presented by a purely biological test, Professor Terry Kogan argues that courts would be forced to look at psychological factors when determining the “true sex” of intersexuals because of the biological incongruities present in intersexuals.¹⁹⁷ Professor Kogan bases his argument on the transition from the *Corbett* court, which theorized that genital factors would be controlling in the case of intersexuals, to the court in *W v. W*, which found that all six factors posed by the *Corbett* court, including psychological factors, need to be considered.¹⁹⁸ Under this approach, a court would always look to psychological factors in determining the sex of an intersexual for marriage, even if that same court would ignore psychological factors when determining a postoperative transsexual’s sex for the purpose of marriage.

While Professor Kogan’s argument might hold true for intersexuals who have not undergone genital-normalizing surgery,¹⁹⁹ it may not apply to individuals who have been subject to such procedures. This is so because the mere fact that genital-normalizing surgery has been performed might change a court’s view of whether or not biological incongruities are present. If Professor Kogan is correct, then a court would, regardless of whether or not genital-normalizing surgery has been performed, consider psychological factors and likely apply a test similar to *W v. W*. On the other hand, a court might find that once an individual has undergone genital-normalizing surgery, his or her sex is “surgically define[d] . . . as male or female,”²⁰⁰ thus removing genital ambiguity as well as the need to look to psychological factors.²⁰¹ Under the latter approach, the mere fact that genital-normalizing surgery has been performed could lead a court to apply a biological test that ignores gender identity as a factor when it might otherwise have deferred to gender identity as the defining factor.

D. Different Jurisdictions, Different Definitions

Because of the numerous approaches taken by courts in addressing marriages with postoperative transsexuals, as well as the variety of ways that those courts may in turn evaluate intersexual marriages, “the intersex adult’s ability to marry a person of the opposite sex may very well depend on his or her state of residence.”²⁰² These tests all make clear the problems that arise from the law’s deep reliance on anatomy for determining an individual’s “true sex.”²⁰³ There would not be an issue if the law developed in such a way as to allow individuals to establish a legal sex based

197. Kogan, *supra* note 31, at 403 (arguing that intersexuals are at an advantage over transsexuals because courts will be forced to consider psychological factors when determining the sex of an intersexual). This situation is precisely what happened in England in the transition from *Corbett* to *W v. W*. *Id.* at 404–05. While the *Corbett* court initially theorized that genital factors would be controlling, the court in *W v. W* found that all six factors posed by the *Corbett* court need to be considered. *Id.* at 405.

198. *Id.* at 404–05.

199. *See id.* at 403–11.

200. Haas, *supra* note 27, at 60.

201. *See* Kogan, *supra* note 31, at 403–11.

202. *See* Lloyd, *supra* note 27, at 187.

203. *See* Greenberg, *supra* note 1.

completely on their gender identity, regardless of the appearance of their genitalia or their chromosomal make up.²⁰⁴ Unfortunately, however, this does not seem likely.

The problem could be solved on a more fundamental level by legislation that recognizes same-sex marriages.²⁰⁵ In the six states that issue same-sex marriage licenses, there is no need to determine an individual's "true sex" because individuals may marry whomever they please, regardless of sex.²⁰⁶ In these states, an intersexual's fundamental right to marriage is not threatened by genital-normalizing surgery. Because of DOMA, however, a marriage recognized as valid in one state does not have to be recognized as valid in another.²⁰⁷ Therefore, until all fifty states expand their definition of marriage to include same-sex couples, the rights of intersexuals to marry will continue to be threatened by genital-normalizing surgeries. This analysis makes clear that the problem has been largely created by the way that society views sex and gender and by the way that society has chosen to define and limit marriage.

IV. A CALL FOR LEGISLATIVE PROTECTION

Because of the dehumanizing nature of genital-normalizing surgeries and the fundamental importance of the rights implicated by such surgeries, it is vital that the legislature step in to give a voice to intersex children whose voices are not heard during the decision-making process. In particular, the legislature should enact a moratorium on such procedures, except in the case of a real medical emergency, until the child is capable of making his or her own decision on whether or not to submit to surgery.²⁰⁸

Numerous physicians and scholars have argued for a higher level of informed consent to better protect intersex children and to make sure that parents have all of the relevant information necessary to make an informed decision.²⁰⁹ But this heightened level of informed consent does nothing to protect the child's fundamental right to marriage, nor any of the other fundamental rights implicated by genital-normalizing surgeries. In addition, a heightened standard of informed consent still leaves the intersexual out of the decision-making process. For this reason, as well as the potential effects of genital-normalizing surgery on marriage, judicial oversight is an equally insufficient method of protecting the rights of intersex children.²¹⁰

Case law makes clear that governmental oversight over genital-normalizing surgeries is appropriate. In *Parham v. J.R.*, the Supreme Court evaluated the constitutionality of a Georgia statute that enabled parents to institutionalize their minor

204. See Kogan, *supra* note 31, at 416.

205. *Id.* at 417–18.

206. See *id.*

207. See *supra* notes 112–13 and accompanying text.

208. See Intersex Soc'y of N. Am., What Does ISNA Recommend for Children With Intersex?, <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.")

209. See Beh & Diamond, *supra* note 14, at 20–21.

210. See *supra* Part III.C.

child despite the child's liberty interest in not being hospitalized.²¹¹ Because the child was exercising a fundamental right, the Court held that it was necessary for someone to "exercise independent judgment as to the child's need for confinement."²¹² The Court found that a staff physician is sufficient to serve in that role, "so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment."²¹³

With genital-normalizing surgeries, however, parents have absolute control over the decision to subject their child to surgery. In *Parham*, the Court found that the parents did not actually have absolute control over the decision to institutionalize their child because a staff physician had to exercise independent judgment regarding whether or not hospitalization was an appropriate form of treatment.²¹⁴ This, however, is not the case with genital-normalizing surgeries. The dominant treatment protocol for children born with ambiguous genitalia is genital-normalizing surgery, so a physician's independent judgment will always be the same: if the child has ambiguous genitalia, then surgery is appropriate.²¹⁵ This judgment is not independent. It is a rubber stamp.

Even if independent judicial review were required, the result would likely be the same. "It is unusual that anyone champions the interest of the child when the treating physician and parents agree on treatment, even though the child may have competing interests."²¹⁶ This is precisely the issue recognized by legislators who have crafted additional protections with regard to the sterilization of minors and mentally impaired individuals.²¹⁷ A legislative ban on genital-normalizing surgeries is needed to protect intersex children, perhaps to an even greater extent than with sterilization, because genital-normalizing surgeries affect not only the child's fundamental right to marriage, but also his or her rights to procreation, bodily integrity, and privacy.²¹⁸

CONCLUSION

Genital-normalizing surgeries are dehumanizing, and their implications for the fundamental rights of intersexuals to marry provide only one of many reasons that the practice should be ceased immediately.²¹⁹ Fortunately, the problems for the right to marriage that are posed by genital-normalizing surgeries are largely caused by the way that society has chosen to define and limit marriage. These problems can be solved by

211. 442 U.S. 584 (1979).

212. *Id.* at 604 (concluding that "the child's rights and the nature of the commitment decision are such that parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized").

213. *Id.* at 607.

214. *Id.*

215. *See supra* Part I.A.

216. Beh & Diamond, *supra* note 17, at 39.

217. *Id.* at 39–40.

218. *See* Benson, *supra* note 27 (discussing genital-normalizing surgery and the rights to bodily integrity, personality, sexuality, and gender identity); Haas, *supra* note 27 (discussing genital-normalizing surgery and the rights to bodily integrity, procreation, marriage); Lloyd, *supra* note 27 (discussing genital-normalizing surgery and the rights to bodily integrity, sexual gratification, procreation, and marriage).

219. DE MARÍA ARANA, *supra* note 10.

expanding the scope of marriage to include same-sex couples.²²⁰ However, this solution still does not solve the underlying problem that genital-normalizing surgeries are inhumane and are performed on children without their consent or consideration.²²¹ The fact that genital-normalizing surgeries are performed at all reflects society's reliance on a binary gender system that is deeply flawed and that leads parents to think that such surgeries are necessary. The rights of intersex children will continue to be threatened until society fundamentally changes the way it views sex and gender and the way it defines and limits marriage. Until that day, it is incumbent upon the legislature to protect the rights of this class of citizens whose voices are not heard.

220. *See supra* Part III.D.

221. *See id.*