Gender Assignment Surgery for Intersexed Infants: How the Substantive Due Process Right to Privacy Both Supports and Opposes a Moratorium

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GENDER ASSIGNMENT SURGERY FOR INTERSEXED INFANTS:
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BOTH SUPPORTS AND OPPOSES A MORATORIUM

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I. INTRODUCTION

"Don't try to cut us up or change us or shame us or hide us," cautions intersexed individual Hida Viloria. Viloria is among those Americans who view the practice of performing gender assignment surgery on intersexed infants as unnecessary, physically harmful, and psychologically damaging to its "victims." The procedure of gender assignment surgery, which is traditionally performed on intersexed individuals early in their infancy, is an effort to surgically alter the genitalia of infants born with ambiguous genitalia so that they conform to that of a normal male or female. Many researchers and physicians consider gender assignment surgery to be a valid and appropriate form of treatment for intersexed individuals. However, intersex organizations analogize the surgeries to female circumcision and sexual...
abuse, asserting that the surgery is premature, traumatic, and a form of mutilation. Some propose a moratorium on performing the surgeries on intersexed infants, arguing that such surgeries should be postponed until intersexed individuals are mature enough to consent to the procedures. Others argue that a moratorium would create more problems than it solves by exposing intersexed individuals to psychological harm during their formative years. They suggest that early surgery can help offer intersexuels “emotional closure” with respect to their intersex condition and spare them some of the psychosocial harm that may result from the appearance of their malformed genitalia.

America’s reproductive rights jurisprudence contains extensive discourse on the substantive due process right of privacy that bears directly on the controversial arguments surrounding gender assignment surgery for intersexed infants. However, American legal scholars have yet to conduct a thorough examination of gender assignment surgery through the lens of the privacy doctrine. This gap in the literature may be explained by the fact that American society and its scholars traditionally have analyzed gender assignment surgeries in a medical context, and as a result have deemphasized the civil liberties implicated by these procedures. Specifically, the limited legal scholarship that has been published on gender assignment surgery focuses primarily on issues of medical malpractice, negligence, and informed consent as they relate to the procedure. Media coverage of gender assignment surgeries also focuses on its clinical and ethical, rather than the constitutional, implications. Perhaps most importantly, no American court has yet considered the subject.

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8 Blizzard, supra note 5, at 618.
9 Interview with Hossein Aliabadi, Pediatric Urologist, Pediatric Urology Associates, in Minneapolis, Min. (Oct. 10, 2004).
10 Blizzard, supra note 5, at 619. See also Intersex Babies, supra note 2.
12 However, in 1999, the Constitutional Court of Columbia, the country’s highest court, issued two rulings against gender assignment surgery for intersexed infants. The Court held that the surgery should be postponed until the child is mature enough to consent, and that intersexuels constitute a protected minority. Beh & Diamond, supra note 7, 22 n.92.
Approximately one in every 2,000 children is born with an intersex condition.\(^{13}\) However, virtually no legal work adequately addresses the fundamental privacy issues that underlie gender assignment surgery. This Note attempts to explore this issue. Part II provides an overview of the medical background of intersex conditions. Having established the current medical standard for treatment of intersexed individuals, Part III offers a brief discussion on the current state of the law. Part IV then traces the Supreme Court’s historical recognition of the fundamental right to privacy. Part V applies the privacy doctrine to the debate on whether to impose a moratorium on early gender assignment surgery. It also considers other issues, such as the implications of whether the procedure is deemed to be performed for health or cosmetic reasons, and whether a moratorium on the surgery would be overinclusive and underinclusive. This Note concludes that although the fundamental right of privacy can both support and oppose arguments for a legal moratorium on gender assignment surgery, the imposition of such a moratorium would be premature and unwise at this time in light of the lack of conclusive studies on the subject.

II. MEDICAL BACKGROUND

A. The Meaning of “Intersex”

Even a cursory glance at the academic and medical literature on “intersex” conditions reveals that there is no single, agreed-upon definition of this widely-used term. An ethicist provides a definition of intersexuality that highlights the term’s inherent lack of clarity:

“Intersexuality constitutes a range of anatomical conditions in which an individual’s anatomy mixes key masculine anatomy with key feminine anatomy. One quickly runs into a problem, however, when trying to define “key” or “essential” feminine and masculine anatomy. In fact, any close study of sexual anatomy results in a loss of faith that there is a simple, “natural” sex distinction that will not break down in the face of certain conditions.”

\(^{13}\) Hermer, supra note 11, at 195. See also Beh & Diamond, supra note 7, at 17. Common intersex conditions include clitoromegaly, micropenis, hypospadias, complete androgen insensitivity syndrome (CAIS), partial androgen insensitivity syndrome (PAIS) and congenital adrenal hyperplasia (CAH), the most common intersex condition. Interview with Hossein Aliabadi, Pediatric Urologist, Pediatric Urology Associates, in Minneapolis, Minn. (Oct. 25, 2003). To learn more about intersex conditions, see http://www.isna.org.
anatomical, behavioral, or philosophical challenges. Sometimes the phrase “ambiguous genitalia” is substituted for “intersexuality,” but this does not solve the problem . . . because we are still left struggling with the question of what should count as “ambiguous.” (How small should a baby’s penis be before it counts as “ambiguous?”)\textsuperscript{14}

For the purposes of this Note, the term “intersexed” is used in a broad sense to describe those persons who possess the physical characteristics of both sexes in their gonadal, genital, or reproductive structures or their chromosomal composition.\textsuperscript{15}

A multitude of intersex conditions and corresponding genital abnormalities exist, ranging in scope and severity, and such conditions and abnormalities can arise through many avenues.\textsuperscript{16} A thorough examination of the physical causes and manifestations of intersexuality is beyond the scope of this paper. However, a brief overview of the physiological influences that are responsible for normal genetic development, and of the basic manner in which intersex conditions develop, gives context to how fundamental substantive due process rights doctrine applies to the debate over the surgery.

One group of medical professionals explained the process of genetic development as it affects intersex infants as follows:

Before about 6 weeks’ gestation, male and female embryos develop undifferentiated gonadal tissue and have primordial structures with the potential to produce either male or female genitalia. The genital appearance of the newborn is largely determined by the presence or absence of genetic and hormonal influences responsible for the active process of male differentiation. The fetus tends to develop as a female in the absence of these male influences. Intersex conditions arise because of an abnormality along the male pathway that interferes with complete masculinization or, in the case of a
genetic female, some virilizing influence that acts on the developing embryo.\textsuperscript{17}

The ambiguous genitalia of intersexed individuals are usually identified through physical examination; however, some intersex conditions, particularly those involving anomalous chromosomal sexes or internal ambiguities, do not become apparent until the child is much older and has undergone thorough testing.\textsuperscript{18}

\textbf{B. The Development of the Surgical Model}

Having established the definition of "intersex" and how intersexed conditions arise, a discussion of the type of medical treatment intersexed individuals have traditionally received is appropriate before turning to the arguments for and against a moratorium on the treatment. The surgical model of care for intersexed infants developed approximately forty years ago.\textsuperscript{19} The model gained widespread acceptance in the medical community by the 1970s due to the clinical "findings" of John Money, a psychologist from Johns Hopkins Hospital.\textsuperscript{20} Money played a pivotal role in the medical care of patient David Reimer, known in the psychological and medical literature as "John/Joan" or "J/J."\textsuperscript{21} Although J/J was not born an intersexed individual, his case helped set the precedent for the surgical treatment of intersexed infants in the United States.

The infamous John/Joan case is widely recognized as the story of two identical twin boys, one of whom (J/J) experienced the traumatic loss of his penis at the tender age of 8 months.\textsuperscript{22} Based on a theory that infants are psychosexually neutral at birth,\textsuperscript{23} Money made the following recommendations: J/J's anatomy should be surgically refashioned to resemble that of a female, J/J should be given female hormonal supplements, and J/J should be raised as a normal female by his family.\textsuperscript{24}

\textsuperscript{18} Hermer, \textit{supra} note 11, at 196, 206, 208.
\textsuperscript{19} Beh & Diamond, \textit{supra} note 7, at 2-3.
\textsuperscript{20} \textit{Id.} at 6, 16.
\textsuperscript{21} \textit{Id.} at 7 n.15.
\textsuperscript{22} \textit{Id.} at 6.
\textsuperscript{24} Beh & Diamond, \textit{supra} note 7, at 7-8.
J/J’s parents consented to Money’s recommended course of action and for the next several years they attempted to raise their “daughter” in accordance with the prescribed treatment plan.\(^{25}\) J/J’s care was left to a group of psychiatrists practicing in his geographic area, but Money personally followed the child’s development for several years, making progress reports at least once a year.\(^{26}\) According to Money’s reports, J/J satisfactorily matured as a normal girl – a seemingly perfect success story.\(^{27}\)

J/J’s existence as a girl seemed to prove Money’s nurture theory that intersexed infants could adapt to either gender assignment. Money’s groundbreaking work thus helped sculpt the surgical model of care for intersexed infants. As law professor Hazel G. Beh and anatomy and reproductive biology professor Milton Diamond put it, “... the significance of the early reports of J/J’s supposedly successful sex change confirmed the apparent efficacy of this treatment as a ‘standard of care’ for certain infants and contributed to its wide acceptance.”\(^{28}\)

Money’s model remained largely unquestioned until researchers uncovered the disturbing truth behind his “findings” in the late 1990s. In 1997, years after the physicians of America had accepted the surgical model of care, and years after J/J had seemingly been “lost to follow up,”\(^{29}\) the remarkable story of the boy-turned-girl was reintroduced in the public arena – this time, to reveal a shocking, and largely unpredicted, twist. As Diamond and Sigmundson, a doctor associated with the Department of Psychiatric Services at the Ministry of Health in Victoria, British Columbia, reported in 1997, Money’s reports were not only incomplete, but also misrepresentative of J/J’s true story.\(^{30}\) Instead of seamlessly adapting to the female gender, as Money had testified, J/J had rejected “her” assigned sex as a teenager, and was living in Canada as a married man and the adoptive father of three children.\(^{31}\) J/J’s long journey back to his self-identified gender, and the reality behind Money’s previously acclaimed “success story” of gender assignment surgery, is at once disturbing and disheartening.

\(^{25}\) Id. at 7.

\(^{26}\) Id.

\(^{27}\) Id. at 7-8.

\(^{28}\) Id. at 9.

\(^{29}\) Id. at 4.

\(^{30}\) Diamond & Sigmundson, supra note 23, at 298-304.

\(^{31}\) Id. at 300; Hermer, supra note 11, at 197, 203.
In contrast to Money’s positive reports, while still young, J/J often exhibited typical male behavior and denounced typical female behavior. "Joan refused ‘girl’ toys, had little interest in girl activities, and refused to wear dresses. . . . In her prepubescent years, Joan ‘thought she was a freak or something’ and eventually ‘figured [she] was a guy’ but ‘didn’t want to wind up opening a can of worms.’ She . . . contemplated suicide." In her early teenage years, Joan was often caught standing to urinate in the girls’ bathroom. Finally, at age 14, Joan made the choice to start living as a boy who is referred to in medical literature as the pseudonym John. Shortly thereafter, John’s father told John about his tumultuous medical history and the traumatic genital injury he had suffered in infancy. John later underwent mastectomies to excise the hormone-induced breasts he had grown as a result of Money’s treatment plan, as well as penile reconstructive surgery. Because his testicles were removed during his gender assignment surgery, John had to take male hormone replacements for the remainder of his life. He committed suicide on May 4, 2004, allegedly depressed after separating from his wife and losing a job.

J/J’s true story shocked the American public. It was the subject of publications ranging from the Archives of Pediatrics & Adolescent Medicine to a New York Times Bestseller, As Nature Made Him: The Boy Who Was Raised As A Girl. In the last few years, many researchers and physicians have reexamined whether the surgical model is the best, or even an acceptable, model of treatment for intersexed infants. Nevertheless, Money’s surgical model of care, in which an intersexed infant’s genitalia is surgically altered to conform to the

32 Beh & Diamond, supra note 7, at 10 (alterations in the original) (citations omitted).
33 Id.
34 Id. at 11.
35 Id.
36 Id.
37 Id.
39 Diamond & Sigmundson, supra note 23.
41 See, e.g., Chanika Phomphutkul, et. al., Gender Self-Reassignment in an XY Adolescent Female Born With Ambiguous Genitalia, 106 PEDIATRICS 135-37 (2000).
gender the child will be raised as, is still generally accepted in medical communities across the nation.\textsuperscript{42}

\textbf{C. The Surgical Model Under Attack}

Currently, the factors that pediatric surgeons consider when determining an intersexed infant's gender -- which, under the surgical model of care, is synonymous with the infant's surgically assigned sex -- include: (1) the infant's reproductive potential, (2) capacity for normal sexual function, (3) phallus size, (4) endocrine function, (5) potential for malignant change in sexual organs, and (6) androgen imprinting of the brain.\textsuperscript{43} Additionally, the infant's potential to have normal-looking genitalia is an important factor in medical decisions.\textsuperscript{44} New findings and studies on the topic are constantly being published that influence the manner in which parents and physicians balance these considerations. They help shape the treatment model for these infants by educating those most responsible for applying it to real-life situations.\textsuperscript{45}

Unfortunately, even when surgeons pay close attention to these factors, early gender reassignment surgery does not always secure a positive, or even a satisfactory, result. In fact, some recent studies suggest that gender assignment surgery can often do more harm than good for its recipient.\textsuperscript{46} As moratorium advocates point out, the problems faced by recipients of gender assignment surgery are both abundant and serious. Numerous reports describe intersexed individuals who were assigned as females, and later declared themselves male.\textsuperscript{47} In addition to rejecting their assigned gender in adulthood, surgically-assigned intersexed individuals also can experience loss of sexual sensation, loss of sexual function, loss of reproductive potential, and physical pain during sexual activity.\textsuperscript{48}

Although researchers and physicians acknowledge that gender assignment surgery does not always insure a favorable, or even a

\textsuperscript{42} Beh & Diamond, \textit{supra} note 7, at 9, 12.
\textsuperscript{43} American Academy of Pediatrics, \textit{supra} note 17, at 140-41.
\textsuperscript{44} Interview with Hossein Aliabadi, \textit{supra} note 13.
\textsuperscript{45} For instance, some pediatric urologists no longer assign XY individuals with micropenis as females, at least not on a routine basis. \textit{See}, \textit{e.g.}, \textit{id}.
\textsuperscript{46} \textit{See, e.g.}, Diamond & Sigmundson, \textit{supra} note 23, at 298-304.
\textsuperscript{47} \textit{See, e.g.}, Phomphutkul, \textit{supra} note 41.
satisfactory, outcome, academics nevertheless maintain that the imposition of a moratorium on early gender assignment surgeries is “extreme in that the delay will produce as many or more problems for the majority of patients as surgery in infancy creates.” In addition, they routinely argue that gender assignment is worthwhile, citing gender assignment successes. Based on these arguments, academics insist that reassignment surgery should remain a viable form of treatment for intersexed infants. Sharing this opinion, the American Academy of Pediatrics published a recommendation in April 1996 supporting early surgical intervention. Although the Board later modified its position in recognition of the substantial debate over early gender assignment surgery, it continues to approve of the surgical model of care.

Other researchers state that a broad moratorium on early surgery “ignores the potential for psychosocial harm to intersex children when years pass before decision-making is finalized, and ignores the strong deference in our culture to parental discretion in decisions for and about their children.” Indeed, a considerable number of recipients of gender assignment surgery may be quite satisfied with their surgeries. At least

49 They further admit that certain influences, such as androgen imprinting of the brain, have not always been given sufficient attention when assigning genders to intersexed infants; this can result in disastrous consequences for the intersexed recipient of gender assignment surgery, including rejection of the assigned sex when the individual reaches adulthood. Interview with Hossein Aliabadi, supra note 13.
50 Blizzard, supra note 5, at 618.
53 American Academy of Pediatrics, supra note 17, at 141. The Board issued a statement in July 2000 advocating the use of a “team” approach for the treatment of intersexed infants that leaves open the possibility of early gender-assignment surgery. The surgical model of care has received international support. The British Association of Paediatric Surgeons Working Party on the Surgical Management of Children Born With Ambiguous Genitalia recently stated that a blanket policy of delaying surgery until the patient is old enough to consent for himself or herself would be overly restrictive, although it acknowledged that parents of intersexed infants should be informed that nonoperative management of intersex conditions is a viable alternative to surgery. Blizzard, supra note 5, at 618.
54 Blizzard, supra note 5, at 619, (citing Jorge Daaboul and Joel Frader, Ethics and the Management of the Patient with Intersex: a Middle Way, 14 J. PEDIATRIC ENDOCRINOLOGY & METABOLISM, 1575-83 (2001)).
one physician has said, "My experience suggests that many, if not most, of the people who had surgery as infants are pleased..."55

III. CURRENT STATUS OF THE LAW

A. Avenues Presently Being Pursued by Moratorium Advocates

Approximately 100 to 200 pediatric surgical sex reassignments are performed in America every year.56 Decrying the traditional surgical model as rooted in questionable science, many physicians, attorneys, researchers and intersexed individuals are calling for a moratorium on gender assignment surgeries performed on intersexed infants.57 Given the devastating side effects that are sometimes associated with gender assignment surgery, and all that remains unknown about how the influences of nature and nurture actually interact to affect an infant’s sexual identity, moratorium advocates argue that gender assignment surgery should be postponed until the individual himself can consent to the procedure. In addition to allowing the intersexed individual to avoid the destructive medical and sexual side effects described above, delaying surgery might save intersexed individuals who later reject their assigned sex from the distress of having genitals that do not comport with their self-identified gender.58

While they have identified the numerous problems that can result from early gender assignment surgery, these impassioned moratorium advocates have not yet established a unified, precise mechanism for imposing such a moratorium, nor have they agreed upon the most appropriate and effective type of moratorium for their cause. Some supporters of the moratorium concentrate their efforts on educating members of the medical community about the negative, long-term outcomes of these surgeries, as well as their risks and drawbacks.59 These individuals hope that education will curtail the practice of gender assignment surgeries by inspiring self-motivated, “self-policing” within

55 Lee & Gruppuso, supra note 5.
56 Beh & Diamond, supra note 7, at 17.
57 See, e.g., id. at 59. See also Intersex Babies, supra note 2; Lee & Gruppuso, supra note 5.
59 See, e.g., Phornphutkul, supra note 41, at 135-37.
the medical community. That is, that education will decrease the pool of medical professionals willing to perform or recommend such surgeries.\textsuperscript{60}

In contrast, other advocates focus on promoting public awareness of intersex issues through the use of news broadcasts,\textsuperscript{61} journal articles,\textsuperscript{62} websites\textsuperscript{63} and other avenues of popular media. This form of education, which is aimed at society rather than the medical community, endeavors to bring an end to gender assignment surgery by promoting acceptance of individuals who do not conform to society's gender and sexual norms. Presumably, such an attitudinal shift will ensure that parents of intersexed individuals don't feel societal pressure to surgically "fix" their children, and intersexed children won't grow up feeling societal pressure or stigma for failing to conform to traditional anatomical appearances or gender roles.

\textbf{B. Tiptoeing Into the Legal Arena, and Into the Province of Fundamental Rights}

As the dialogue over gender assignment surgery widens to include the opinions and research of those outside the medical sphere, it is likely that the issue of gender assignment will be increasingly framed in a legal context. When legal scholars add their perspectives to those of physicians, legislators and lay persons, those opposing gender assignment surgeries will likely begin to demand legal remedies with greater frequency.

One such remedy might be a state or federal statute that bans gender assignment surgeries on intersexed infants, or a statute that creates a presumption that such surgeries are improper and raise questions of civil liability.\textsuperscript{64} Additionally, amicus briefs submitted to cases involving gender assignment surgeries might promote a federal ruling outlawing gender assignment surgery on intersexed infants entirely. Moratorium advocates also might try persuading courts to apply a "reasonable person standard" rather than the currently-applied "reasonable professional" standard to cases involving gender assignment surgery.\textsuperscript{65} In determining

\textsuperscript{60} Interview with Galen M. Schauer, Pediatric Pathologist, Children's Hospitals and Clinics in Minneapolis, Min. (Oct. 25, 2003).
\textsuperscript{61} See, e.g., Intersex Babies, supra note 2.
\textsuperscript{62} See, e.g., Beh & Diamond, supra note 7.
\textsuperscript{63} See, e.g., ISNA, supra note 3.
\textsuperscript{64} Interview with Galen M. Schauer, supra note 60.
\textsuperscript{65} Hermer, supra note 11, at 217-20. The author states, however, that while changing the standard of care could lead to some positive changes, it would be inadequate to resolve some of the more troubling aspects of treating intersexed children.
whether a doctor has acted negligently under the reasonable professional standard, the courts compare the doctors' behavior to the behavior of other doctors operating on similar conditions; thus, under the reasonable professional standard, the medical community establishes its own standards. However, under the reasonable person standard, the courts consider whether a reasonable lay person would find the doctor's treatment to be reasonable. Use of this reasonable person standard might weaken the case for gender assignment surgery by emphasizing the opinions and experiences of patients over those of their doctors, holding medical professionals accountable to the ideas and beliefs of those outside the medical system, and encouraging the medical community to reexamine whether gender assignment surgery truly is a permissible treatment model.

Moratorium opponents, by contrast, will likely attempt to quash efforts to pass statutes that ban or limit gender assignment surgery on intersexed infants. Indeed, these opponents may even advocate for judicial or statutory protection of a parent's right to seek gender assignment surgery for their intersexed infants, or seek to strengthen the common judicial practice of applying a reasonable professional standard of care to medical treatment cases. Indeed, the legal arguments and avenues on both sides of the debate seem virtually endless.

Regardless of the position taken, the debate on gender assignment surgery is complicated by the fact that there is a lack of conclusive medical studies on the topic. Although activists on both sides are lobbying for further medical and psychological research, much remains unknown about the causes of intersex conditions and the effects of early gender assignment surgery on intersexed children and adults. As a result, it will be difficult to devise a recommended medical model of care that will minimize deficiencies with gender assignment surgery while promoting the overall future health and happiness of intersexed infants. Additional research may resolve many of the issues surrounding gender assignment surgery.

66 Id. at 215.
67 Id.
68 Blizzard, supra note 5, at 620.
69 See Beh & Diamond, supra note 7, at 47.
70 The following findings might bear significantly on whether gender assignment surgery is an acceptable, reasonable, and ultimately, constitutional form of medical treatment: whether the surgery is primarily cosmetic or health-related in nature; whether the surgery can be performed with a minimal negative impact on the intersexed
IV. HISTORICAL RECOGNITION OF FUNDAMENTAL RIGHTS

A. General Background

While more research may resolve issues involving gender assignment surgery, until such research becomes available, activists on both sides of the debate would benefit from examining the Supreme Court's reproductive rights jurisprudence, and particularly discourse on the substantive due process right of privacy, and considering how it may be applied to the current debate over gender assignment surgery.

The phrase "substantive due process" might appear to be a misnomer because due process is, as the words might suggest, process-oriented. That is, due process guarantees that the government will use proper procedures when it denies a citizen life, liberty, or property. A variety of court decisions, however, support the idea that certain substantive, fundamental rights are embedded in the due process clauses of the Fifth and Fourteenth Amendments. These decisions hold that those rights that are important to our nation deserve the full force of constitutional protection, even though they are not explicitly enumerated in the Constitution. Unfortunately, it is not always easy to determine precisely what these rights are, or how far they extend.

Courts apply a variety of approaches when they determine which non-enumerated rights receive protection as fundamental rights. The Supreme Court's emphasis on history and tradition is the most prominent approach to identifying fundamental non-textual rights, yet it is far from the only approach. Some legal scholars suggest that courts' individual's sexual function and capacity for sexual pleasure; the likely sexual identification of individuals with various intersex conditions; the role of external anatomy, hormones, and "nurture" in influencing an infant's sexual identification; and the extent to which an intersexed child who grows up "uncorrected" will experience psychological difficulties in childhood and adulthood.

71 See, e.g., Griswold v. Connecticut, 381 U.S. 479 (1965) (holding that the privacy right encompasses the right to buy and use contraceptives); Roe v. Wade, 410 U.S. 113 (1973) (basing a woman's right to choose to terminate her pregnancy on the due process right of privacy); Washington v. Glucksberg, 521 U.S. 702 (1997) (holding that the state of Washington's ban on assisted suicide did not violate the Fourteenth Amendment because of its relation to a legitimate government interest).

72 See, e.g., Glucksberg, 521 U.S. at 720.

73 Indeed, some commentators argue that history and tradition are ineffective for use in identifying fundamental due process rights because the fundamental rights in need of constitutional protection are precisely those that history and tradition have not usually protected. In his dissenting opinion in Michael H. v. Gerald D., Justice Brennan stated: "By describing the decisive question as whether [plaintiffs'] interest is one that has been traditionally protected by our society . . . and by suggesting that our sole function is to
most important role is to ensure that the political process runs smoothly and that all views are appropriately represented. These scholars would identify non-textual rights as fundamental only if they strengthened courts' commitment to "representation reinforcement." Other authorities suggest that courts should use natural law principles when identifying fundamental rights.

In Washington v. Glucksberg, the Supreme Court articulated the basic legal framework for identifying which practices qualify as substantive due process rights. The Court recognized two important features of practices deserving protection under a substantive due process analysis: (1) the practice is "deeply rooted in this Nation's history and tradition" and "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [it] were sacrificed," and (2) there exists a "careful description" of the liberty interest being claimed. The Glucksberg standard arguably receives the most attention in modern legal circles.

B. The Fundamental Right to Privacy

The substantive due process right most pertinent to the debate over gender assignment surgery is the right to privacy. In American jurisprudence, privacy is generally accepted as a liberty sufficiently important to be regarded as fundamental even though it is not specifically enumerated in the Constitution. Although certain legal authorities, including Justice Douglas, describe privacy as emanating from the "penumbras" of the First, Third, Fourth and Fifth amendments, courts generally have treated the right of privacy as a substantive due process right. The right is an important focus in reproductive jurisprudence, and in particular in abortion jurisprudence;
this paper will explore how the arguments made in those cases can be applied to the gender assignment surgery debate.

"As an abstract principle, privacy’s logical limits forbid State interference into the ‘most basic decisions about family and parenthood, as well as bodily integrity.’ Numerous court decisions support the general contention that on a fundamental level, the right to privacy protects an individual’s right to be free from unwanted invasion of his or her person. Particularly in the context of reproductive rights, the right of privacy often has been used to protect individuals’ bodies from outside invasion. While the courts have historically protected the right of privacy as a substantive due process right, the proper scope of the right is still hotly debated in legal and judicial circles.

Although the privacy right is generally considered fundamental in Supreme Court jurisprudence, what specific actions it protects is less clear. When determining which actions fall under the umbrella of a fundamental right, courts often struggle with questions concerning the degree of abstraction at which the right should be stated. If a substantive due process right is stated broadly, a wide variety of actions fall within its protection. In contrast, if the right is stated narrowly, few actions will be protected.

First explicitly relied upon in Meyer v. Nebraska, the right of privacy has been interpreted to include the right of parents to “establish a home and bring up children,” and “to control the education of their own.” The right of privacy also has been extended to include a multitude of other, more specific rights, many of which are implicated in the controversy over early gender assignment surgery. Some of the most prominent of these rights lie in the legal arena of procreation.

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82 See, e.g., Roe, 410 U.S. at 152-53.
84 For a judicial commentary on the ways that the level of abstraction at which a right is defined can influence whether it is protected as “fundamental,” see Michael H. v. Gerald D., 491 U.S. at 127 n.6.
85 Moore v. City of East Cleveland, 431 U.S. 494, 502-03 (1977) (in which the Court ruled that defining family rights to only include the protection of the nuclear family would be too narrow a construction).
86 262 U.S. 390, 399 (1923).
87 Id. at 401.
C. Individual v. Associational Rights

The Supreme Court has discussed the right of privacy, including the right to control procreation, as both an individual right and an associational right. The former describes a right that is separately vested in each individual person, whereas the latter describes a shared right that arises from a close relationship between individuals. The following cases illustrate some of the primary differences between these two views of the privacy right.

   Privacy as an Individual Right

In *Skinner v. Oklahoma*, the Supreme Court struck down a state act that allowed courts to order the involuntary sterilization of criminals convicted on two or more counts of "felonies involving moral turpitude." Although *Skinner* is an equal protection case, the Court spoke broadly about the right to procreate, characterizing it as a fundamental due process right:

> We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. The power to sterilize, if exercised, may have subtle, far-reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to whither and disappear.\(^8^9\)

*Skinner* describes reproductive rights as positive rights – the right to reproduce\(^9^0\) – and it strengthens the notion that the right of privacy encompasses the right of an individual to exercise affirmative procreative choice and to be free from procedures that improperly infringe on a person's "basic civil right" to procreate.\(^9^1\) Additionally, *Skinner* illustrates that the privacy right of procreation is an *individual* right that is held by every person under the law, as opposed to an *associational* right that is created out of a marital relationship. The *Skinner* Court says, "There is no redemption for the individual whom the

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\(^8^8\) 316 U.S. 535, 536 (1942).

\(^8^9\) Id. at 541.

\(^9^0\) This is in contrast to cases like *Roe v. Wade*, 410 U.S. 113, and *Planned Parenthood v. Casey*, 505 U.S. 833, which paint reproductive rights as negative rights – i.e., the right not to reproduce.

\(^9^1\) *Skinner*, 316 U.S. at 535-37.
[sterilization] law touches . . . He is forever deprived of a basic liberty."\(^9\)

_Eisenstadt v. Baird_ confirmed the interpretation of _Skinner_ as establishing an individual, affirmative privacy right to procreate.\(^9\) The _Eisenstadt_ Court struck down a Massachusetts law that prohibited the sale and distribution of contraceptives to unmarried people.\(^9\) The Court stated that reproductive rights "must be the same for the unmarried and the married alike" and that, "[i]f the right of privacy means anything it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."\(^9\) By recognizing that the privacy right to buy and use contraceptives was not an associational right, _Eisenstadt_ framed the right as one by which individuals can make personal decisions about procreation. While _Eisenstadt_ is an equal protection case and not a substantive due process case, it influenced privacy rights jurisprudence by extending the privacy right to include the right to be free from governmental intrusion into matters affecting the decision about whether to have children.\(^9\)

2. _Griswold v. Connecticut_: Privacy as an Associational Right

In contrast to _Skinner_ and _Eisenstadt_, the Court has established a line of cases that construe the privacy right as an associational right, not an individual right. In _Griswold v. Connecticut_, the Court extended the privacy right to encompass the right to buy and use contraceptives.\(^9\)

\(^9\) Id. at 541. One should note that _Skinner_ is an equal protection case, not a substantive due process case, but nonetheless the Court spoke of the right to procreate as a fundamental right. The case does not rely significantly on tradition or cultural norms when identifying the affirmative, individual privacy right to procreate. This lack of reliance suggests that history and culture are not the only ways to identify a right that receives substantive due process protective status. American society has a traditional, binary system of gender and forty years of history in performing gender assignment surgery on intersexed infants. Under the standard described in _Glucksberg_, courts probably would find that tradition and history do not support the "right" of intersexed infants to avoid gender assignment surgery in the hope that they may someday procreate, and therefore this "right" would not be given substantive due process protective status under the standard. Under the _Skinner_ standard, however, tradition and history do not appear to be central to determining privacy rights, and _Skinner_'s focus on the individual make it more likely that under it courts would find intersexed infants have a substantive due process right to not have gender assignment surgeries.

\(^9\) Id. at 453.
\(^9\) Id.
\(^9\) Id. at 445-53.
\(^9\) 381 U.S 479, 485.
Rather than framing this right as an individual right to make reproductive choices, as the Court did in Skinner, in Griswold the Court framed the issue as one of marital privacy and privacy in the bedroom. Here, the Griswold Court described the privacy right of procreation as one that arises from a close relationship and not as one that inherently resides in an individual.98

Despite the strong arguments in favor of familial privacy, the Court has firmly established that the privacy right of the family unit has its limits. In Prince v. Massachusetts,99 the Court upheld the application of child labor laws to a young girl who had been soliciting on behalf of Jehovah’s Witnesses at the behest of her parents. While acknowledging the existence of a “private realm of family life which the state cannot enter,”100 the Court insisted that “family itself is not beyond regulation in the public interest . . . Acting to guard the general interest in youth’s well being, the state as parens patriae may restrict the parent’s control by requiring school attendance, regulating or prohibiting the child’s labor and in many other ways.”101 Even in Wisconsin v. Yoder, a First Amendment case which has often been cited for its fervent protection of private decisions made within the family unit, the majority was careful to note that the holding did not apply to situations in which there was evidence of “any harm to the physical or mental health of the child or to the public safety, peace, order, or welfare.”102 In situations where there is evidence of such harm, the state is clearly empowered, and some might even argue, obligated, to intrude upon the family unit in the interests of the child.

V. APPLICATION OF SUBSTANTIVE DUE PROCESS TO THE MORATORIUM DEBATE

As previously noted, both those who oppose and those who support a moratorium on gender assignment surgery on intersexed infants can find support in the Court’s substantive due process jurisprudence. The following section applies substantive due process doctrine to the debate over the moratorium, first detailing what arguments moratorium
advocates can make, and then explaining what arguments moratorium opponents can make.

A. Moratorium Advocates’ Arguments

As discussed, under the Glucksberg standard the Court considers two important features in determining whether a practice qualifies as a substantive due process right: (1) the practice is “deeply rooted in this Nation’s history and tradition” and “implicit in the concept of ordered liberty,” such that “neither liberty nor justice would exist if [it] were sacrificed,” and (2) there exists a “careful description” of the liberty interest being claimed. In the context of gender assignment surgery, a court’s determination of whether these two important features are present or absent depends in large part on how broadly the courts choose to define the substantive due process right.

A broadly defined substantive due process approach likely would lead a court to conclude that intersex infants do have a substantive due process right to be free from gender assignment surgery, and that a moratorium on gender assignment surgery should be imposed. If the right at issue were framed in very broad terms, such as “the individual’s right to be free from unsolicited invasions of his body,” then the first feature of the Glucksberg standard would certainly be present: America does enjoy a long tradition of respecting an individual’s right to be free of such invasions. Describing the right in broad terms would be in line with the Court’s recent trend in substantive due process jurisprudence. However, phrasing the right in such broad terms may or may not allow a court to identify the second feature of the Glucksberg inquiry, depending on whether a “careful description” of such a right could be articulated.

Indeed, the Court’s opinion in Lawrence v. Texas seems to reflect a broad judicial approach to the description of substantive due process rights. In Lawrence, the Court considered the right of privacy as a broad, individual right that encompasses a person’s privacy of sexuality and sexual expression. The Court stated:

103 Glucksberg, 521 U.S. at 721.
104 See, e.g., Glucksberg, 521 U.S. at 720 (in which the Court includes the right to “bodily integrity” in a list of privacy interests protected by the Due Process Clause.
105 See, e.g., Lawrence, 539 U.S. at 566-68 (in which the Court acknowledged that it construed the liberty interest too narrowly in Bowers v. Hardwick, 478 U.S. 186 (1986), and overruled the case).
The laws involved in *Bowers* and here are, to be sure, statutes that purport to do no more than prohibit a particular sexual act. Their penalties and purposes, though, have more far-reaching consequences, touching upon the most private human conduct, sexual behavior, and in the most private of places, the home. The statutes do seek to control a personal relationship that, whether or not entitled to formal recognition in the law, is within the liberty of persons to choose without being punished as criminals. 106

By defining the right as one concerning “private human conduct, sexual behavior” instead of a right to engage in “a particular sexual act,” the Court defined the right at issue in broad terms, making it easy to determine that the right fell within the liberty protected by the substantive due process clause of the Fourteenth Amendment.

Besides emphasizing the Court’s broad approach to substantive due process analysis in *Lawrence*, moratorium advocates also might argue that *Lawrence* solidifies the right of privacy as an individual, not associational, right. By acknowledging that “[t]he liberty protected by the Constitution allows homosexual persons the right to make this choice,” the Court recognized the right to privacy as one rooted in the individual person, and not in a relationship. 107 Moratorium advocates might assert that *Lawrence* also signifies a judicial willingness to protect an individual’s choice to pursue unpopular sexual practices and make unpopular sexual decisions, even in the face of societal and familial pressures to do otherwise. This notion lends credence to the contention that intersexed infants should be allowed to make their own decisions regarding sexuality, including the decision of whether to undergo gender assignment surgery, and consequently supports the imposition of a moratorium on gender assignment surgery.

Finally, moratorium advocates should note that the Supreme Court has acknowledged that an individual’s minority status does not bar him from asserting the privacy right of procreation. As the Court stated in *Bellotti v. Baird* (*Bellotti II*): “[a] child, merely on account of his minority, is not beyond the protection of the Constitution.” 108 Although the Court has asserted that “the constitutional rights of children cannot

106 *Lawrence*, 539 U.S. at 567.
107 Id. (emphasis added).
be equated with those of adults," applying the Court’s language to the issue at hand, it is clear that while intersexed infants may not enjoy the full legal status of adults, they do possess some reproductive rights deserving of constitutional protection.

B. Moratorium Opponents’ Arguments

In contrast to moratorium advocates who should present the privacy right at issue broadly, those opposing a moratorium on early gender assignment surgery should present the right narrowly. A narrowly defined substantive due process right would likely lead a court to conclude that intersex infants do not have a substantive due process right to be free of gender assignment surgery, and that a moratorium on gender assignment surgery should not be imposed. If the right at issue were described in very narrow terms, such as “an intersex baby’s right to be free of gender assignment surgery,” the description would probably be “careful” enough to satisfy the second prong of the Glucksberg analysis. However, the first prong of the Glucksberg inquiry would probably not be met, for the right to be free from gender assignment surgery is decidedly not “deeply rooted in this Nation’s history and tradition” (indeed, up until recently the standard of care has been to perform such surgeries on intersexed infants).

In addition to construing the right of privacy in narrow terms, those opposing a moratorium on early gender assignment surgery can support their opposition by framing the issue in terms of the privacy right to procreate, but construing the privacy right to procreate as an associational right. This associational approach has important implications for the issue at hand. By conceptualizing the privacy right to procreate as one arising from a personal relationship, and not one that is vested in individuals, the Griswold decision lends support to moratorium opponents by drawing the privacy right away from the intersexed infant and giving the right to the applicable close relationship – that between the infant and his or her parents. Indeed, the right of privacy has been extended to protect not just the intimate marital arena that Griswold sheltered from undue state interference, but also the autonomy of the family unit as well.110

With this shift in focus from the privacy of the individual to the privacy of the relationship, it is easier to argue that the parent of an

109 Id. at 634.
110 See, e.g., Yoder, 406 U.S. 205.
intersexed infant – being an integral part of the infant-parent relationship from which the privacy right of procreation springs under Griswold’s associational model111 – should have decisionmaking power with respect to surgeries that might adversely affect his or her intersexed infant’s reproductive potential. In the face of controversial medical treatment models that still require testing for their overall effectiveness, potential side effects, and risks to the patient, the privacy right of the parents to make decisions concerning the infant’s private life may reign supreme.

In addition, critics might argue that the privacy right to procreate, even though established in due process jurisprudence, is inapplicable to the context of early gender assignment surgeries because intersexed infants do not yet possess reproductive rights due to their minority status. In Bellotti II, in which the Court stated that children are not beyond the protection of the Constitution merely because they are minors, the Court acknowledged the difficulties inherent in reconciling the reduced legal status of pregnant minors – still under the control of their parents – with the rights to bodily privacy recognized by cases such as Roe v. Wade112 and Planned Parenthood v. Casey.113 Settling on a balancing test, the Court identified three reasons why “the constitutional rights of children cannot be equated with those of adults: the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing.”114

The reasons the Court identified in Belloti II as to why children’s constitutional rights cannot be equated with adults can be used by moratorium opponents to argue that the decision over gender assignment surgery should not be left until intersexed individuals are old enough to consent to surgery. By emphasizing the Belloti II Court’s recognition of the differences between children and adults under the Constitution, moratorium opponents can argue that an intersexed infant’s right to bodily integrity and procreative liberty may not be equal to the rights of adults, and therefore might not demand the same application of Roe, Planned Parenthood, and Griswold. Given “the inability” of children “to make critical decisions in an informed, mature manner,” moratorium

111 See Griswold, 381 U.S. at 479-86.
112 Roe, 410 U.S. 113 (basing a woman’s right to choose to terminate her pregnancy on the due process right of privacy).
113 Casey, 505 U.S. 833 (holding that a provision of a Pennsylvania statute that required a married woman to notify her husband before having an abortion was invalid).
114 Bellotti II, 443 U.S. at 634.
opponents might argue that the medical decisions affecting the rights to procreation (such as the decision concerning gender assignment surgery) should be properly left to the parents, who play such an “important role” in “child rearing.”

C. Additional Considerations

In addition to the concerns addressed above, the debate over gender assignment surgery often involves heated discussion about whether such surgery is performed for cosmetic reasons or health reasons. Ordinarily, those supporting early gender assignment surgeries portray it as solving health concerns, while those opposing the surgeries portray it as unnecessary and cosmetic. However, even if gender assignment surgery is portrayed as being performed for health reasons, moratorium advocates can make arguments to support their position. In Roe v. Wade, perhaps the most celebrated and reviled privacy decision of the 20th century, the Court held that the right of privacy “is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy,” but was careful to add that this right must be balanced against the important state interests in the potential life of the fetus and the mother’s health. Moratorium advocates might emphasize that Roe lends support to the argument that the state may regulate or outlaw medical procedures in order to protect an individual’s health. Thus, the state can regulate gender assignment surgery in order to protect the infant’s future health. Such regulation could include a moratorium on performing gender assignment surgeries on infants.

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115 See, e.g., Lee & Gruppuso, supra note 5.
116 See e.g., id.
117 Roe, 410 U.S. at 161-62.
118 Id. at 162. In ruling that the mother’s right to privacy in the abortion context is circumscribed by the state’s interest in the mother’s health, the Court demonstrated that society, through the arm of the State, is empowered to protect an individual’s health based on its own standards and definition of “health,” and not based on the individual’s personal conception of the terms.
119 As previously noted, gender assignment surgery can result in a loss of sexual sensation, loss of sexual function, loss of reproductive potential, and physical pain during sexual activity. Ford, supra note 4, at 483; Haas, supra note 48, at 42-43.
120 Moratorium opponents, on the other hand, may argue that gender assignment surgery promotes the state’s interest in protecting the health of intersexed infants. They might use Roe to bolster their argument by emphasizing that the Roe Court’s definition of “health” is not limited to an individual’s physical well being. The Roe Court acknowledged that the term “health” can include a person’s mental and emotional health as well: “[m]aternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the
On the other hand, moratorium opponents might be more likely to prevail on their arguments that the decision is best left to the private realm of the infant’s family and physicians, rather than to an overbroad moratorium, by also framing the decision in a medical, health-related context. As one scholar wrote when discussing the Court’s historical treatment of the abortion right:

The cases vacillate between characterizing the [abortion] decision as medical or moral... the more the Court characterizes the decision as medical, the more it belongs to doctors, and the stronger the protection likely to be given to the right. The more the decision is cast in moral terms, the more it belongs to society, and the weaker the protection given against restrictions and burdens designed to influence the woman’s decision...

Against the backdrop of the Roe decision, then, it appears that the more that early gender-assignment surgery is framed as a medical, “health” procedure, the more control and discretion physicians and family members might have over the decision.

Another concern that moratorium opponents could point out is that a moratorium on such surgery may not actually help the individuals it aims to protect. While gender assignment surgery has the potential to trample on the privacy rights of intersexed infants and modern privacy jurisprudence helps moratorium advocates by construing the privacy right as an individual right, those supporting the practice of gender assignment surgery could argue that the imposition of a blanket moratorium would undoubtedly be both overinclusive and underinclusive. Moratorium advocates often rely on the following logic: since physicians cannot always accurately predict the gender with which an intersexed infant will identify, and since gender assignment surgery often carries with it undesirable side effects and risks, surgeons should always refrain from performing gender assignment surgery until the individuals are old enough to provide their own consent to it. In

unwanted child.” Roe, 410 U.S. at 153. This attention to the mental health of the individual exhibits a broad judicial view that takes into account the emotional distress and future happiness of an individual. Since some moratorium opponents assert that delaying gender assignment surgery may result in psychosocial harm to intersexed individuals, they may argue that the surgery promotes the state’s interest in protecting the health of intersexed individuals.

Reilly, supra note 81, at 773.
addition, some intersexed individuals, because of their particular medical condition, personality, and familial situation, might easily identify with a gender and be unaffected by peer pressure and their conspicuous nonconformity with sexual norms. These individuals might prefer to be spared gender assignment surgery until they are mature enough to make a gender choice for themselves.

Nevertheless, a moratorium on surgery would be grossly overinclusive because it would deny all intersexed infants the opportunity to undergo surgery until they were old enough to competently choose surgery for themselves—including those infants who, because of their particular psychological compositions, family environments, communities, and sensitivities to peer pressure, would have benefited psychologically and physically from early surgery. In contrast to those individuals who would have preferred to wait to have gender assignment surgery, there are those individuals who are happy to have undergone the surgery in infancy. For these individuals, at least, early surgery was the appropriate, and perhaps best, response to their intersex condition. Hence, a moratorium on gender assignment surgery would be overinclusive because it would impose a value judgment on all intersexed infants—that growing up without surgery is better than growing up with it. It would presuppose that every intersexed individual would choose to grow up as closely as possible to the way nature made him or her, regardless of the psychological and physical difficulties and social mores he or she might encounter by having ambiguous genitalia. A moratorium on gender assignment surgery would treat all intersexed individuals as having the same desires and needs when, in fact, they may have very different ones. Some intersexed individuals might view their right of privacy as one that they share with their parents, which their parents may exercise on their behalf to elect surgery. A

122 Lee & Gruppuso, supra note 5.
123 This concern that a regulation may be overinclusive is reflected in Chief Justice Stone’s concurrence in Skinner: “Moreover, if we must presume that the legislature knows—what science has been unable to ascertain—that the criminal tendencies of any class of habitual offenders are transmissible regardless of the varying mental characteristics of its individuals, I should suppose that we must likewise presume that the legislature, in its wisdom, knows that the criminal tendencies of some classes of offenders are more likely to be transmitted than those of others. And so I think the real question we have to consider is . . . whether the wholesale condemnation of a class to an invasion of personal liberty, without opportunity to any individual to show that his is not the type of case which would justify resort to it, satisfies the demands of due process.” Skinner, 316 U.S. at 544. (Stone, J., concurring).
moratorium would prevent individuals who would benefit from early surgery from receiving it – and might therefore do more harm than good.

A moratorium on gender assignment surgery would be not only overinclusive, but also underinclusive, because it could not cover all of the individuals it seeks to protect. One of the main concerns among moratorium advocates is that a surgically-assigned child will reject his or her gender as an adult. However, this possibility is not limited to intersexed individuals. Many people born without a medically-detected intersex condition later declare that the sex they were born into does not adequately reflect their self-identified gender. Some of these people even choose to undergo sex-assignment surgery in order to make their outward appearance comport with their self-identified gender. A moratorium on gender assignment surgeries for intersexed infants would do nothing to address these concerns, and would therefore be limited in its effectiveness.

Finally, the debate over early surgery brings up additional concerns that have not yet been addressed in the Court's privacy jurisprudence. Yoder and Griswold describe circumstances in which the wishes of the familial unit conflict with societal norms that the state is trying to protect. A moratorium on early gender assignment surgeries, by contrast, involves a situation where both family wishes and societal norms may support gender assignment surgery, but the privacy rights of the intersexed infant are said to be in need of separate Constitutional protection. In Yoder and Griswold, there is one conflict at issue: traditional societal values clashing with privacy rights, whether individual or associational. In the case of a moratorium, the same conflict is present, but there is an additional element: the conflict between individual and associational rights. A court must examine both the tension between the views of the state and the privacy rights of the family unit, as well as the tension between the associational privacy rights of the family and the individual privacy rights of the intersexed infant. This additional element serves to further complicate the application of privacy jurisprudence.

VI. CONCLUSION

A "natural parent's desire for and right to the companionship, care, custody and management of his or her children is an interest far more
precious than any property right.” As much as the right to privacy can bolster the arguments of moratorium advocates, it also supports the arguments that favor gender assignment surgery.

The historic utilization of the surgical model of care, a binary conception of gender, and the legitimate concerns that individuals raised with “uncorrected” ambiguous genitalia might have growing up all seem to oppose a moratorium on gender assignment surgery. In addition, the medical literature and the Supreme Court’s substantive due process and privacy decisions appear to oppose a legal imposition of a moratorium on gender assignment surgery. Given the numerous anecdotes that have been gathered from intersexed adults who have experienced positive outcomes from their gender assignment surgery, it would be premature for a court or legislature to decide, in the absence of conclusive findings, that gender assignment surgery is detrimental to intersexed infants and that a moratorium on early gender assignment surgery is warranted. It is simply too extreme to declare, at this point in time, that the privacy rights of intersexed infants require that their parents raise them with ambiguous genitalia, no matter how the infants’ families or surgeons feel about that decision and no matter what the sexual norms are of society.

However, the predominant surgical model of treatment might require revision, as it fails to meet the needs of many intersexed individuals. Only by exploring and examining privacy arguments will society be able to develop a strong and effective treatment model for infants born with intersex conditions – a model that fully integrates both the medical and legal aspects of gender assignment surgery, and is consistent with America’s substantive due process jurisprudence concerning the right of privacy.

Regardless of whether the arguments of moratorium opponents or proponents appear the most legitimate at this juncture, both should incorporate substantive due process arguments and privacy rights jurisprudence into their dialogue. As the debate over early gender assignment surgery moves into the legal arena, both sides must work to understand the substantive due process and privacy considerations that surround the surgery. Only then will they be equipped to fully comprehend the legal implications of the surgery and devise a model of care that adequately addresses the concerns of intersexed infants and their families.