

William & Mary Journal of Race, Gender, and Social Justice

Volume 11 (2004-2005)
Issue 3 *William & Mary Journal of Women and
the Law*

Article 5

April 2005

You Make Me Feel Like a Natural Woman: Allowing Parents to Consent to Early Gender Assignment Surgeries for Their Intersexed Infants

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Sara A. Aliabadi, *You Make Me Feel Like a Natural Woman: Allowing Parents to Consent to Early Gender Assignment Surgeries for Their Intersexed Infants*, 11 Wm. & Mary J. Women & L. 427 (2005), <https://scholarship.law.wm.edu/wmjowl/vol11/iss3/5>

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YOU MAKE ME FEEL LIKE A NATURAL WOMAN:¹
ALLOWING PARENTS TO CONSENT TO EARLY GENDER
ASSIGNMENT SURGERIES FOR THEIR
INTERSEXED INFANTS

*The current model of treatment for intersexed infants fails the test for legal informed consent at every step. No matter how well-meaning their intentions, parents are incapable of giving legal informed consent to the performance of genital-normalizing surgery on their infants . . .*²

INTRODUCTION

From the Constitutional Court of Columbia³ to the Intersex Society of North America,⁴ numerous jurists, researchers,⁵ physicians,⁶ and intersex organizations⁷ are engaged in a struggle over the legality of early gender assignment surgeries. Opponents to these procedures charge that they are both needless and harmful to intersexed infants,⁸ and share many of the abhorrent characteristics of female circumcision and sexual abuse.⁹ Advocating the imposition of a legal moratorium on gender assignment surgery, many of these activists argue that parents

1. ARETHA FRANKLIN, *(You Make Me Feel) Like a Natural Woman* on LADY SOUL (Atlantic Records 1967).

2. Kishka-Kamari Ford, Note, "First, Do No Harm" — The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants, 19 YALE L. & POL'Y REV. 469, 488 (2001).

3. The Constitutional Court of Columbia recently held that gender assignment surgery should be postponed until the intersexed child is mature enough to consent. In a related decision, the Court also held that intersexuals comprise a protected minority under the law. For a brief discussion of these decisions, 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, n.92 (2000).

4. See Amicus Brief from the Intersex Society of North America to the Constitutional Court of Colombia (Feb. 7, 1998) [hereinafter Amicus Brief], available at <http://www.isna.org/colombia/brief.htm>.

5. See generally Beh & Diamond, *supra* note 3 (outlining the current research on intersex children).

6. Interview with Galen M. Schauer, M.D., Perinatal and Placental Pathologist, Children's Hospitals and Clinics, in Minneapolis, Minn. (Oct. 25, 2003).

7. Amicus Brief, *supra* note 4.

8. Ford, *supra* note 2, at 469.

9. Julie Cole, *Legal Issues on the Treatment of Children with Intersex Conditions* (Apr. 6, 2003), at http://home.vicnet.net.au/~aissg/legal_issues.htm.

of intersexed infants lack the legal capacity to consent to these surgeries on behalf of their children.¹⁰

Admittedly, these procedures are replete with complications and risks, and often fail to address the true needs and interests of intersexed infants and their families.¹¹ Nevertheless, considerable authority suggests that these surgeries are often both medically and legally appropriate.¹² From a medical standpoint, gender assignment surgeries frequently benefit both intersexed infants and their parents.¹³ From a legal standpoint, a multitude of sources support a parent's ability to provide legal consent for these surgeries on behalf of their intersexed infants.¹⁴ In light of the foregoing evidence and support for parental consent, it would be both unwise and unjust for American lawmakers to impose a legal moratorium on early gender assignment surgeries.

Before debating the merits of a moratorium on gender assignment surgeries, it is imperative to review the development of the traditional surgical model of care for intersexed infants as well as the various medical foundations supporting this model. It is also necessary to examine courts' historical recognition of parental consent on behalf of incompetent minors. After surveying the current state of medical knowledge on intersex conditions and assessing the treatment of the consent doctrine throughout American jurisprudence and academic discourse, this note argues that there is considerable evidence suggesting that parents may legally consent to gender assignment surgeries on behalf of their intersexed infants. At this juncture, the institution of a legal moratorium on gender assignment surgeries would be inappropriate, premature, and potentially harmful to a large number of individuals.¹⁵

10. Ford, *supra* note 2, at 469.

11. *Intersex Babies: Controversy Over Operating to Change Ambiguous Genitalia* (ABC News Television Broadcast, Apr. 19, 2002) [hereinafter *Intersex Babies*].

12. See, e.g., Peter Lee & Philip A. Gruppuso, *Point/Counterpoint: Should Cosmetic Surgery Be Performed on the Genitals of Children Born With Ambiguous Genitals?*, PHYSICIAN'S WKLY, Aug. 16, 1999, available at http://physiciansweekly.com/archive/99/08_16_99/pc.html (last visited Nov. 11, 2003).

13. Interview with Hossein Aliabadi, M.D., Pediatric Urologist, Pediatric Urology Associates, in Minneapolis, Minn. (Oct 25, 2003).

14. See Beh & Diamond, *supra* note 3, at 37-42.

15. See, e.g., Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics & the Law*, 11 ANNALS HEALTH L. 195, 236 (2002). Professor Hermer concludes that:

[c]ontrary to some recommendations . . . a moratorium on cosmetic genital and sex assignment surgeries for infants and children is not warranted. It would swing the pendulum to the other extreme: while such surgeries have previously been recommended and performed with scant, if any, data to support their beneficial effects, a moratorium would similarly cease all such surgeries on the

Part I discusses the legal options currently being pursued by moratorium advocates, offers some background information on intersex conditions and the historical development of the surgical model of care, and highlights the risks, potential drawbacks, and benefits, of gender assignment surgery. Part II examines the framework of the informed consent doctrine and its applicability in the context of parental consent for the medical treatment of minor children. Among the topics Part II discusses are the possibility that the conditions for informed consent are not always met in cases of early gender assignment surgery and the overarching legal tradition of deference to parental wishes regarding the treatment of incompetent minor children. Part III outlines the substituted judgment and best interests tests, explores some of the difficulties with applying these standards to early gender assignment surgery, and suggests that parental involvement in treatment decisions might minimize some of these difficulties. Part IV refutes the allegation that early gender assignment surgery is experimental and merely cosmetic, providing no concrete benefits to the intersexed infant. Part V stresses the reasons why parents and doctors are better decision-makers than the courts and legislatures with respect to early gender assignment surgery, and argues against the imposition of a one-size-fits-all value judgment on all intersexed infants by instituting a moratorium on gender assignment surgery.

BACKGROUND

Legal Options Currently Being Explored By Moratorium Advocates

Numerous intersex activists, doctors, and researchers urge the imposition of a legal moratorium on early gender-assignment surgeries.¹⁶ The precise nature of the desired moratorium, however, remains unclear. Some moratorium advocates choose to encourage the medical community to rethink its approach to intersexed infants by educating its members about the risks and

basis of several small studies and some negative reports from a number of individuals who underwent the surgeries in infancy and childhood.

Id.

16. See generally Beh & Diamond, *supra* note 3, at 1; see also Anne Scheck, *Intersexuality Debate Takes a Conservative Turn*, UROLOGY TIMES, Feb. 1998, at 1 (emphasizing that gender refers to more than just the genitals).

negative outcomes of these procedures.¹⁷ Presumably, these individuals hope to discourage the practice of gender assignment surgery by reducing the number of physicians and surgeons willing to perform such surgery thus instituting a sort of voluntary, supply-driven moratorium.¹⁸ Other opponents of surgery produce news broadcasts,¹⁹ write journal articles,²⁰ design websites,²¹ and pursue other ways of stimulating public discourse about the risks and drawbacks of gender assignment surgery, while promoting the acceptance of intersex individuals in American society. These activists seemingly hope to lessen the demand for gender assignment surgery in the United States and create a voluntary, demand-driven moratorium on surgery by fostering an environment in which the parents of intersexed infants will not feel pressured to surgically alter their children so that their anatomy may resemble those of 'normal,' non-intersexed children. Other activists call for a mandatory moratorium on early gender assignment surgery, presumably imposed through statutes or court decisions.

Background: The Meaning of 'Intersex'

There is no universally-accepted definition of "intersex." One medical professional defines intersexed individuals as "those persons who possess the physical characteristics of both sexes in their gonadal, genital, or reproductive structures or their chromosomal composition."²² Expanding on that definition, other commentators strive to recognize the inherent ambiguities and contradictions of the term:

17. See generally Chanika Phornphutkul et al., *Gender Self-Reassignment in an XY Adolescent Female Born With Ambiguous Genitalia*, 106 PEDIATRICS 135-37 (2000) (discussing an intersexual assigned the female gender at birth but reverted to the male gender during adolescence).

18. See Interview with Galen M. Schauer, *supra* note 6 (discussing the practice of educating other medical professionals about the potential risks and drawbacks of gender assignment surgery).

19. See, e.g., *Intersex Babies*, *supra* note 11.

20. See, e.g., Beh & Diamond, *supra* note 3.

21. For instance, the Intersex Society of North America (ISNA) has developed a web site that helps promote the ISNA's view that gender assignment surgery should be postponed until the intersexed children are mature enough to make their own choices about surgical sex assignments. The ISNA website can be viewed at <http://www.isna.org>.

22. Robert M. Blizzard, *Intersex Issues: A Series of Continuing Conundrums*, 110 PEDIATRICS 616, 619 (2002).

[I]ntersexuality 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 anatomical, behavioral, or philosophical challenges.

Sometimes the phrase "ambiguous genitalia" is substituted for "intersexuality," but this does not solve the problem . . . because we still are left struggling with the question of what must count as "ambiguous." (How small should a baby's penis be before it counts as "ambiguous?")²³

While a thorough examination of the medical aspects and causes of intersex conditions is far beyond the scope of this note, a rudimentary understanding of the genetic and hormonal influences that are responsible for normal genetic development is necessary to appreciate the medical and legal arguments surrounding the issue of parental consent for early gender assignment surgery. One group of physicians explained the process 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.

Male sexual differentiation is initiated by the *SRY* gene on the short arm of the Y chromosome. Under the influence of *SRY*, the undifferentiated gonad forms a testis, which produces the hormonal milieu that results in male sexual differentiation: testosterone stimulates the Wolffian structures (epididymis, vas deferens, and seminal vesicles), and anti-Müllerian hormone suppresses the development of the

23. Alice Dreger, Intersex Society of North America, "Ambiguous Sex" – or Ambivalent Medicine? (1998), at <http://www.isna.org/faq/frequency.html>.

Müllerian structures (fallopian tubes, uterus, and upper vagina). The conversion of testosterone to dihydrotestosterone occurs in the skin of the external genitalia and masculinizes the external genital structures. Most of this male differentiation takes place by about 12 weeks, after which the penis grows and the testes descend into the scrotum. In the absence of *SRY*, female sexual differentiation occurs. An error in genital morphogenesis may occur at any step in this developmental pathway.²⁴

Intersex conditions affect approximately one out of every 2000 babies born, and pediatric surgeons perform between 100 and 200 gender assignment surgeries in the United States each year.²⁵ Most intersex conditions are easily identified through physical examination at birth, although certain conditions — particularly those involving anomalous chromosomal sexes or internal ambiguities — can remain undetected until the child is much older and has undergone thorough testing.²⁶ Among the multitude of intersex conditions, the most common include clitoromegaly (also known as enlarged clitoris), micropenis, hypospadias, Complete Androgen Insensitivity Syndrome (CAIS), Partial Androgen Insensitivity Syndrome (PAIS), True Hermaphroditism, and Congenital Adrenal Hyperplasia (CAH).²⁷

The Surgical Model of Care: Historical Development and Current State of Medical Knowledge

On June 10, 2003, the Gulf News reported that for the first time in the United Arab Emirates (UAE), pediatric surgeons performed gender assignment surgery on a UAE national child born with both ovarian and testicular tissue.²⁸ The surgery took place at the Al Mafraq Hospital in Abu Dabi, at the hands of a

24. American Academy of Pediatrics, Committee on Genetics, *Evaluation of the Newborn With Developmental Anomalies of the External Genitalia*, 106 PEDIATRICS 138, 138-42 (2000) [hereinafter Committee on Genetics].

25. Hermer, *supra* note 15, at 195.

26. *Id.* at 196.

27. Interview with Hossein Aliabadi, *supra* note 13.

28. Barbara Bibbo, *Gender Fixed for Intersex Child*, GULF NEWS, June 10, 2003, available at LEXIS, News & Business.

team headed by Dr. Tony Thoury.²⁹ The child, born with a rare, congenital intersex condition known as true hermaphroditism, was surgically assigned to the female gender.³⁰ Doctors predict that she will "have a fast recovery" and "live a normal life."³¹

Gender assignment surgeries may be novel to those in the UAE, but America has long hosted these now-controversial procedures. For the past forty years,³² pediatric surgeons in the United States have surgically corrected intersexed infants so that their genital and reproductive anatomies resemble that of normal males and females.³³ Only recently, as new medical findings have been revealed and intersexed individuals have begun to speak out against these procedures, has the surgical model of care fallen under widespread attack.³⁴ Before examining a parent's ability to provide legal consent to gender assignment surgery on behalf of her intersexed infant, it is helpful to review how and why the surgical model of care evolved.

Gender assignment surgeries were established as the preferred model of treatment for intersexed infants through the work of Dr. John Money, then a clinical psychologist at Johns Hopkins Hospital in Baltimore, Maryland.³⁵ Dr. Money encountered a case of identical twin baby boys, one of whom had lost his penis during a badly-performed circumcision.³⁶ Relying on a 'nurture' theory of psychosexual identification, Dr. Money recommended that the patient be surgically assigned to the female gender.³⁷ The child would be given female hormones to induce breast growth and other female anatomical development, and would be raised as a girl.³⁸

29. *Id.*

30. *Id.*

31. *Id.*

32. Patricia L. Martin, *Moving Toward an International Standard in Informed Consent: The Impact of Intersexuality and the Internet on the Standard of Care*, 9 DUKE J. GENDER L. & POL'Y 135, 153 (2002).

33. Beh & Diamond, *supra* note 3, at 3.

34. See generally *id.* (attacking the continued performance of gender assignment surgery on intersex infants).

35. *Id.* at 5-6.

36. *Id.* at 6.

37. *Id.* at 5-6.

38. *Id.* at 7-8.

This patient, later dubbed "John/Joan" by researchers and reporters, would soon have her story discussed in medical and psychological journals across the world.³⁹ John/Joan's assignment to the female gender would establish the surgical model of care as the preferred model of treatment for intersexed infants. Years later, it would provide the primary ground on which to attack this model.

Dr. Money's follow-up reports on John/Joan described the 'normal' maturation of a toddler into a well-adjusted, feminine young girl, lending considerable support to Money's contention that infants are psychosexual at birth and capable of adapting, if assigned, to either gender.⁴⁰ Although not born an intersexual, John/Joan effectively served as the human test case for gender assignment surgery on intersexed infants — a case which reportedly "confirmed the apparent efficacy of this treatment as a 'standard of care' for certain infants and contributed to its wide acceptance."⁴¹

Unfortunately, the reality behind the apparent "boy-turned-girl" success story was not nearly as rosy as Dr. Money's reports indicated, and the important discrepancies between fact and fiction were not publicized until years after the surgical model of care had been established in America as the preeminent model of treatment for intersexed infants.⁴² Contrary to the story described in Dr. Money's reports, it was not long after surgery that John/Joan began to show visible signs of rejecting 'her' clinical treatment plan and assigned gender.⁴³ Besides exhibiting "tomboyish traits,"⁴⁴ John/Joan refused to cooperate in Dr. Money's counsel, was often found standing to urinate, ran away from the hospital where she was being treated, and even contemplated suicide.⁴⁵ In 1997, researchers learned that John/Joan had continued to exhibit male-

39. See generally JOHN COLAPINTA, *AS NATURE MADE HIM: THE BOY WHO WAS RAISED AS A GIRL* (2001) (detailing the widespread interest of the medical and psychological fields in the "John/Joan" case).

40. Dreger, *supra* note 23.

41. Beh & Diamond, *supra* note 3, at 9.

42. See generally *id.* (discussing the differences between the publicized success story and the actual failure of John/Joan's operations).

43. *Id.* at 8-11.

44. *Id.* at 8, n.20.

45. *Id.* at 8-10.

like behaviors throughout childhood⁴⁶ and in 'her' early teen years had actually rejected the female gender.⁴⁷ In the years following his public return to the male gender, John underwent mastectomies to remove the breasts he had developed from the female hormonal supplements he had received, and had penile constructive surgery.⁴⁸ He married a woman and adopted her three children.⁴⁹ Eventually, the two separated, and on May 4, 2004, John committed suicide.⁵⁰

Risks and Drawbacks of Gender Assignment Surgery

Regrettably, a considerable number of recipients of early gender assignment surgery have been dissatisfied with the outcomes.⁵¹ The medical and psychological literature is filled with descriptions of the problems associated with these procedures, including rejection of assigned gender,⁵² loss of reproductive potential, loss of sexual function, loss of sexual sensation, and physical pain during sexual activity.⁵³ Additionally, research conducted by the University College London (UCL) and the Great Ormond Street Hospital for Children in London suggest that clitoral surgery might also compromise a patient's potential to experience sexual pleasure later in life.⁵⁴ Indeed, one study suggests that women who had undergone clitoral surgery suffered a thirty-nine percent greater chance that they would be unable to achieve orgasm.⁵⁵ The seriousness of these problems is heightened because most of these procedures are irreversible: "Tissue removed from the clitoris can never be restored; scarring produced by surgery can never be undone."⁵⁶

46. See Milton Diamond & H. Keith Sigmundson, *Sex Reassignment at Birth: Long-Term Review and Clinical Implications*, 151 ARCH. PEDIATR. ADOLESC. MED. 298, 298-304 (1997).

47. *Id.*

48. Beh & Diamond, *supra* note 3, at 11.

49. Diamond & Sigmundson, *supra* note 46, at 293-304.

50. Mireya Navarro, *When Gender Isn't a Given*, N.Y. Times, Sept. 19, 2004, at Sec. 9, p.1.

51. *Id.*

52. See Pornphutkul et al., *supra* note 17, at 135-37.

53. Claude J. Migeon, M.D. et al., *Ambiguous Genitalia With Perineoscrotal Hypospadias in 46, XY Individuals: Long-Term Medical, Surgical, and Psychosexual Outcome*, 110 PEDIATRICS 31, 31 (2002).

54. Health Newswire Reporters, *"Intersex" Surgery Could Damage Sexual Function*, HEALTH NEWSPAPER CONSUMER, Apr. 11, 2003, available at LEXIS, News & Business.

55. *Id.*

56. See Amicus Brief, *supra* note 4, at 2.

Support for the Surgical Model of Care: Benefits of Gender Assignment Surgery

Both supporters and opponents of early gender assignment surgery are pushing for more comprehensive medical and psychological studies of these procedures, as well as for studies of the related topics of gender identification and development, in the hope of someday devising a more effective treatment model that will put the whole controversy to rest.⁵⁷ In the meantime, however, numerous babies are being born with intersex conditions, and the question remains how to best treat them. Despite the questionable integrity of its origins and the recent public attacks on its legality, many pediatric surgeons, psychologists, and researchers continue to regard gender assignment surgery as an appropriate and effective model of treatment for some intersex conditions.

Although it is impossible to ignore the staggering quantity and severity of complications associated with gender assignment surgery, not to mention the dearth of studies on the long-term physical and psychological effects of these procedures,⁵⁸ many respected professionals nevertheless maintain that early surgery is advisable and the benefits of gender assignment surgery often outweigh the risks.⁵⁹ Dr. A. Barry Belman, who has treated intersex patients in his practice, is one professional who rejects the ISNA argument that surgery should always be postponed until the patient is old enough to provide informed consent.⁶⁰ Cautioning against waiting until the patient reaches maturity, he contends that the question should be "settled [much earlier] for the child's emotional welfare."⁶¹ Dr. Belman also believes that the possibility of rejection has been grossly over-emphasized, pointing out that, in his experience, the stories of protest over early gender assignment surgery by former patients "represent a small group of patients."⁶²

Extending this line of reasoning, many prominent medical professionals appear to agree that a legal moratorium on gender assignment surgery would be "extreme in that the delay will produce as many or more problems for the majority of patients as

57. See, e.g., Ford, *supra* note 2, at 486-88.

58. See Beh & Diamond, *supra* note 3, at 47.

59. Martin, *supra* note 32, at 154 ("Generally, physicians believe that the [intersex] condition should be [surgically] corrected immediately.").

60. Scheck, *supra* note 16, at 2.

61. *Id.*

62. *Id.*

surgery in infancy creates.”⁶³ As some researchers point out, 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.”⁶⁴ Echoing this opinion is Dr. Kenneth I. Glassberg, a pediatric urologist who emphasizes the significant number of intersexuals who are happy with their early surgery and points out the likely possibility that if the law bans gender assignment surgery, intersex children with ambiguous genitalia will “be considered freaks by their classmates.”⁶⁵ Dr. Glassberg opposes the institution of a legal moratorium on these procedures, noting that such a moratorium “is itself experimental, and more of an experiment [than the procedures].”⁶⁶

The British Association of Pediatric Surgeons Working Party on the Surgical Management of Children Born With Ambiguous Genitalia also opposes the imposition of a moratorium on early gender assignment surgery.⁶⁷ Psychologist Heino Meyer-Bahlburg reports that “[m]any patients are quite traditional and are content with their own early surgery.”⁶⁸ Other physicians, including University of Pittsburgh Professor of Pediatrics, Peter Lee, M.D., share this sentiment: “My experience suggests that many, if not most, of the people who had surgery as infants are pleased”⁶⁹

In spite of its many problems and contrary to the assertions of many moratorium opponents, it appears that the surgical model of treatment has enjoyed a substantial measure of success, and is supported by respected empirical studies.⁷⁰ Additionally, evidence exists to suggest that the success rate of gender assignment surgery may increase with the advent of new surgical techniques.⁷¹ Indeed, surgical advances have already rectified some of the problems presently complained of by dissatisfied patients who underwent surgery years ago. “Current techniques that were not possible 30-35 years ago now can maintain nerves and sensitivity of the organs, and some experimental evidence shows that sensitivity may be

63. Blizzard, *supra* note 22, at 618 (internal quotations omitted).

64. *Id.* at 619 (citing Daaboul and Frader).

65. Barron H. Lerner, *If Biology Is Destiny, When Shouldn't It Be?*, N. Y. TIMES, May 27, 2003, available at <http://www.nytimes.com/2003/05/27/health/psychology/27BEHA.html>.

66. *Id.*

67. Blizzard, *supra* note 22 at 618 (reporting the Association's position).

68. *Id.*

69. Lee & Gruppuso, *supra* note 12, at 2.

70. Migeon, *supra* note 53, at 31.

71. Martin, *supra* note 32, at 159-60.

preserved.”⁷² Recognizing the proven and potential merits of early surgery, the American Academy of Pediatrics issued a statement in July 2000 advocating the use of a “team” approach for the treatment of intersexed infants, one that leaves open the possibility of early gender assignment surgery.⁷³

Before surgically assigning a gender to an intersexed infant, pediatric surgeons consider many factors, including the following: the infant’s capacity for normal sexual function, the reproductive potential, endocrine function, potential for malignant change in sexual organs, androgen imprinting of the brain,⁷⁴ and potential to have normal-looking genitalia.⁷⁵ Traditionally, phallus size has also been considered a significant factor when determining the gender to which an intersexed infant should be assigned.⁷⁶ Surgeons, however, are beginning to deemphasize this factor in the process of gender assignment, recognizing that its importance has been largely exaggerated.⁷⁷

INFORMED CONSENT

Informed Consent Doctrine

To escape being labeled a battery, a non-emergency surgical procedure must be performed with the implied or express consent of the patient.⁷⁸ To be legally effective, this consent must be adequately “informed.”⁷⁹ The informed consent doctrine allows a patient to make his or her own medical decisions⁸⁰ and safeguards “the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”⁸¹

72. *Id.*

73. Committee on Genetics, *supra* note 24 at 142.

74. Interview with Hossein Aliabadi, *supra* note 13.

75. *Id.*

76. *Id.*

77. *Id.*

78. See, e.g., *Newmark v. Williams*, 588 A.2d 1108, 1115-16 (Del. 1999) (holding that a doctor who performs surgery under normal circumstances, without the consent of the subject, commits a battery).

79. See *Keogan v. Holy Family Hosp.*, 622 P.2d 1246, 1252 (Wash. 1980).

80. See *Beh & Diamond*, *supra* note 3, at 34 (internal citations omitted).

81. *Cruzan v. Director, Missouri Department of Health et al.*, 497 U.S. 261, 269 (1990) quoting *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

Informed consent doctrine requires physicians to actively involve the patient in the consent process⁸² and to disclose information that is relevant to the patient's medical treatment.⁸³ Generally, a physician "must fully explain the proposed procedure, the expected short-term risks and long-term consequences, the available alternatives and their risks and benefits and the consequences of declining or delaying treatment."⁸⁴ As one legal scholar explained:

[I]nformed consent includes an obligation to provide relevant information concerning alternatives to the proposed treatment, including "material risks incident to abstention from treatment." Although some courts continue to follow an older physician-oriented standard and measure the adequacy of disclosure with reference to the custom and standard within the medical community, the decisional trend over the past two decades has been toward a patient-oriented standard, with reference to "what a reasonable person objectively needs to hear from his or her physician to allow the patient to make an informed and intelligent decision regarding proposed medical treatment."⁸⁵

In addition to the duty of disclosure, informed consent doctrine imposes a duty on physicians to ensure that the consent for medical treatment is being received from an individual legally capable of giving consent. To be considered legally capable of giving informed consent to a particular treatment, the individual must have the capacity to appreciate all of the treatment's important aspects, including its potential consequences.⁸⁶ In cases involving incompetent minors, public policy usually demands that

82. J. Steven Svoboda et al., *Informed Consent for Neonatal Circumcision: An Ethical and Legal Conundrum*, 17 J. CONTEMP. HEALTH L. & POL'Y 61, 65 (2000).

83. Courts have reluctantly recognized some exceptions to the disclosure requirement, such as waiver and therapeutic privilege. See generally *Canturbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

84. Svoboda et al., *supra* note 82, at 67 n.34.

85. Beh & Diamond, *supra* note 3, at 35 (internal citations omitted). See also Ross Povenmire, *Do Parents Have the Legal Authority to Consent to the Surgical Amputation of Normal, Healthy Tissue From Their Infant Children?: The Practice of Circumcision in the United States*, 7 AM. U. J. GENDER SOC. POL'Y & L. 87, 99 (1998/1999) (stating "courts measure informed consent either by the disclosure that would have been given by a reasonable physician, typically measured by the customary practices of physicians in the locality, or by a standard based upon disclosure of information which the patient would deem relevant in reaching a decision. The latter 'patient-based' rule reflects the trend towards a healthy skepticism of medical authority, and the increasing recognition of patients' right to control their own treatment"(internal citations omitted)).

86. Svoboda et al., *supra* note 82, at 70-71.

medical professionals obtain consent from the minor patient's parent or guardian before administering treatment.⁸⁷

Additionally, physicians have a duty to ensure that consent is given voluntarily. To be voluntary, a patient's decision concerning whether to pursue a given form of medical treatment should be free of coercion, manipulation, and improper influences.⁸⁸ Numerous factors can interfere with the voluntariness of a patient's treatment decision, including the natural power imbalance between physician and patient, the physician's tendencies to highlight treatments that follow his personal preferences while downplaying those that do not, and the poor timing of the physician's disclosure of treatment considerations.⁸⁹

Suggestions That the Conditions for Informed Consent May Not Always Be Met in Cases of Early Gender Assignment Surgery: Fatal to the Surgical Model of Care?

Barriers to informed consent often exist when "[a]ctivists and others who have examined the issue note that cosmetic and sex assignment surgeries on intersex children are frequently performed without adequate disclosure, and under rushed circumstances which are not conducive to careful or thoughtful deliberation."⁹⁰ Based on such reports, opponents of gender assignment surgery often argue that the likelihood that certain elements of informed consent have not been met warrants a moratorium.⁹¹ One author writes that "[t]he questionable theoretical bases for early genital-normalizing surgery are rarely, if ever, disclosed to the parents of intersexed infants."⁹² The failure to disclose these bases, together with other deceptions by doctors who routinely advocate

87. *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941).

88. Svoboda et al., *supra* note 82, at 71.

89. *Id.* at 71-72.

90. Hermer, *supra* note 15, at 220.

91. Ford, *supra* note 2, at 488.

92. *Id.* at 486.

early genital-normalizing surgery,⁹³ ostensibly renders it impossible for parents to give legal informed consent to gender assignment surgery.⁹⁴ These critics of surgery contend that because there have been relatively few scientific studies on the long-term effects of gender assignment surgery, "the potential risks of genital-normalizing surgery *cannot* be communicated to the parents of intersexed infants."⁹⁵ Additionally, surgical critics claim that a doctor's tendency to identify the course of treatment that he believes is in the best interests of the infant might constitute "coercion" if the parents are guided by this advice.⁹⁶ Furthermore, these critics counsel that the sense of vulnerability and devastation that parents sometimes experience after the birth of an intersexed child would make it virtually impossible for them to comprehend the information necessary for them to grant informed consent to gender assignment surgery.⁹⁷

It is undoubtedly true that "physicians need to present the options available to parents [of intersexed infants] in a neutral and inclusive fashion,"⁹⁸ and "parents need early psychological counseling and support."⁹⁹ The unwillingness or inability of some physicians to properly inform the parents of intersexed children of the benefits and risks of gender assignment surgery, however, and the inability of some parents to adequately appreciate the ramifications of early surgery, should *not* be used to prove that informed consent is *impossible* and that a moratorium on gender assignment surgery is the *only* solution. Concerns that could be addressed by increasing the information given to the parents of intersexed infants and referring them to family counseling should not be addressed with a moratorium on the surgeries. Phrased

93. Hermer, *supra* note 15, at 222-23. Hermer writes:

[H]ealth care providers often convey an aura of urgency regarding sex assignment and cosmetic genital surgeries that is not medically or surgically justified. Information concerning the surgeries is frequently incomplete, particularly issues concerning the cosmetic outcome and potential effects of scarring on future sexual sensation. Secrecy concerning the surgeries has been fostered in the past, particularly with respect to what the intersex child does or does not know about them. [Researchers] also note that physicians have frequently failed to disclose the possibility that the child will ultimately reject the sex to which the surgery will assign him or her

Id.

94. Ford, *supra* note 2, at 486.

95. *Id.* at 487 (emphasis added). See also Martin, *supra* note 32, at 161-62 (adding that follow-up studies of intersexuals have not been conducted).

96. Ford, *supra* note 2, at 487.

97. *Id.* at 488.

98. Hermer, *supra* note 15, at 231.

99. *Id.* at 232-33.

differently, there is no need to use a tourniquet when a band-aid would stop the bleeding. As one scholar pointed out:

There undoubtedly have been, and may still be, serious informed consent issues with many intersex surgeries on infants. This is not, however, a basis on which one can reasonably call for a moratorium on the surgeries, particularly when one can take the less drastic step of offering more complete information (e.g., indicating gaps in information, such as those concerning long-term outcomes).¹⁰⁰

Additionally, those opposed to allowing families to make medical decisions for incompetent patients often point out that families may inappropriately choose or deny treatment options out of their own desire to be relieved of the emotional and social burdens of coping with an ailing relative.¹⁰¹ Not surprisingly, these arguments have been extended to the arena of early gender assignment surgery.¹⁰²

If a parent's aim in providing consent for early gender assignment surgery was only to obtain relief from the emotional and social burdens of coping with an intersexed child, there would be a much faster, albeit harsher, solution available: adoption. The parents of an intersexed infant *always* have the option of effectively "walking away" from the entire situation, leaving their infant to the care of someone more able or willing to manage the complications associated with an intersexed child.¹⁰³ It follows that, when parents provide consent to gender assignment surgery, after being informed of the various risks and benefits of surgery as well as the different medical and psychological aspects of their infant's particular intersex condition, they do so out of concern for their child, in an attempt to safeguard their child's *best interests*.

100. *Id.* at 223.

101. Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 VILL. L. REV. 103, 152-53 (1993).

102. See Ford, *supra* note 2, at 488.

103. Hamann, *supra* note 101, at 153 (noting that "if the family's goal in terminating treatment is to be relieved of the financial and emotional hardships associated with the person's illness, they have a much easier way out. They can just walk away. (For example, Mr. and Mrs. Cruzan could have deserted their daughter like Nancy's husband did . . . When a family tries to terminate treatment, they do it out of love)").

Legal Tradition of Deference to Parents in the Treatment of Their Incompetent Minor Children

Courts have long stressed that "the parental right is sacred which can be invaded for only the most compelling reasons."¹⁰⁴ Consequently, parents are widely respected as being in the best position to make decisions involving the education and upbringing of their children,¹⁰⁵ and America enjoys a strong tradition of deference to parental wishes in the context of medical care for minor children.¹⁰⁶ This tradition is premised on the notion that "parents, as the natural guardians of their children, are best situated and best able to make important decisions on their behalf."¹⁰⁷ Protected by statute in many states, the parental ability to consent to medical treatment on behalf of their minor children has long been supported by the Supreme Court, and it remains in effect even when medical treatment imposes risks on the child. As the Court stated in *Parham v. J.R.*, "[s]imply because the decision of a parent is not agreeable to a child or because it involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state Parents can and must make those judgments."¹⁰⁸ The law generally assumes that parents typically act to protect their children's welfare, and it allows broad parental discretion in treatment decisions, absent a termination of parental rights or a particular showing that the treatment will be detrimental to the child.¹⁰⁹ Explaining the

104. *Newmark v. Williams*, 588 A.2d 1108, 1115 (Del. 1991). *See also In re Burns*, 519 A.2d 638, 645 (Del. 1986) (holding due process needs to be satisfied with termination of parental rights); *Daber v. Div. of Child Protective Serv.*, 470 A.2d 723, 726 (Del. 1983) (holding that clear and convincing evidence is needed for parental right termination).

105. *See, e.g., Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972) (upholding the right of Amish parents to control the education and upbringing of their children); *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 532-33 (1925) (recognizing parental right to control education and religious teaching of their children). *See also 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, 4 (2000) (discussing the constitutional right of parents to make health care decisions for their children).

106. *See, e.g., Parham v. J.R.*, 442 U.S. 584 (1979). *See also Bryan Shartle, Comment, Proposed Legislation for Safely Regulating the Increasing Number of Living Organ and Tissue Donations by Minors*, 61 LA. L. REV. 433 (2001) (stating the need for legislation in organ donations by minors).

107. *Ford, supra* note 2, at 478 (citations omitted); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.").

108. *Parham v. J. R.*, 442 U.S. 584, 603 (1979).

109. *Id.* at 602.

rationale behind this respect of parental authority, the *Parham* Court declared:

The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has been recognized that natural bonds of affection lead parents to act in the best interests of their children.¹¹⁰

This deference to parents, well-grounded in reason and tradition, has since formed the basis for judicial recognition of the parents' right to consent to medical procedures on behalf of their minor children.

Parental Consent for Minor Children

Infants are inherently incapable of personally providing legal consent to gender assignment surgeries because of their inability to weigh the benefits and risks of various forms of medical treatment and comprehend the ramifications of surgical procedures.¹¹¹ Consequently, if an infant is to undergo a gender assignment procedure, informed consent will have to be provided by an individual other than the infant patient. Usually, the parent or guardian provides this consent.¹¹² When determining whether parental consent is legally sufficient to allow an incompetent minor child to undergo a surgical procedure, American courts typically rely on the "substituted judgment" standard,¹¹³ the "best interests" standard,¹¹⁴ or some combination of the two.

SUBSTITUTED JUDGMENT AND BEST INTERESTS TESTS

The Substituted Judgment Standard

The substituted judgment standard, first employed in a 'right-to-die' case,¹¹⁵ is a subjective test that purportedly takes into account "each individual person's desires and personal value system. The goal of substituted judgment is to determine, insofar as possible, what the incompetent person would have decided if

110. *Id.*

111. Ford, *supra* note 2, at 477-78.

112. *Id.*

113. Hart v. Brown, 289 A.2d 386, 387-90 (Conn. Super. Ct. 1972).

114. *In re Richardson*, 284 So.2d 185, 187 (La. Ct. App. 1973).

115. Hamann, *supra* note 101, at 111.

he were competent."¹¹⁶ The doctrine of substituted judgment allows a third party, such as a parent, to legally advocate the course of action that is in the best interest of the incompetent minor.¹¹⁷ A minor patient's parents, as surrogates for the patient, must "decide not on the basis of how *they* want the patient to be treated, but rather on the basis of how *the patient* would choose to be treated if he or she were capable of choosing."¹¹⁸

The difficulty with applying the substituted judgment standard to cases involving intersexed infants is that infants are incapable of expressing their treatment preferences in any dependable and meaningful way. Indeed, infants have never once been capable of expressing treatment preferences. Consequently, it is virtually impossible to predict whether a particular intersexed infant would have chosen gender assignment surgery had he or she been competent.¹¹⁹ Some commentators have avoided this philosophical dilemma by suggesting that, in cases where there is little evidence of how the patient would choose to be treated if he or she were capable of choosing, as in the case of an intersexed infant, the substituted judgment standard calls on the surrogate to make the treatment decision on the basis of how a rational patient would choose to be treated under the totality of the circumstances.¹²⁰ Under this reasoning, the subjective "substituted judgment" standard seems to meld into the more objective "best interests" standard¹²¹ that courts often use when evaluating parents' decisions concerning the medical treatment of incompetent minors.¹²²

116. *Id.*

117. Ford, *supra* note 2, at 477-78.

118. Svoboda et al., *supra* note 82, at 76.

119. Hamann, *supra* note 101, at 112-13 (noting the great difficulty in applying the substituted judgment standard to patients "who were never able to express a preference, namely minors and the mentally handicapped").

120. Svoboda et al., *supra* note 82, at 77.

121. The overlap between the two standards is apparent: acting on behalf of the patient, the parent surrogate chooses the treatment decision that a rational patient would choose under the circumstances (substituted judgment analysis), which presumably is the treatment that would best serve the patient's interests (best interests analysis).

122. See *Custody of a Minor*, 375 Mass. 733, 753 (Mass. District 1978). The court recognized that "[i]n a case . . . involving a child who is incompetent by reason of his tender years, we think that the substituted judgment doctrine is consistent with the 'best interests of the child' test . . . As a practical matter, the criteria to be examined and the basic applicable reasoning are the same." *Id.*

The Best Interests Standard

Most courts employ the objective best interests standard when outlining the scope of medical treatments for which parents may legally consent on behalf of their incompetent minor children.¹²³ Under the best interests approach, a parent's capacity to make decisions for the welfare of the child may be limited when those decisions adversely affect the child's health and well-being.¹²⁴ A parent may only consent to those procedures that are objectively in the child's best interests.¹²⁵ These interests have been defined as those involving "relief from suffering, preservation or restoration of functioning, and quality and extent of sustained life."¹²⁶ "Although the court in such determinations considers both the attendant risks and benefits of various alternatives, personal preferences do not weigh heavily, if at all, in a best interests determination."¹²⁷ Under the best interests standard, courts perform a balancing test that weighs the costs and risks of the proposed treatment against its likely benefits.¹²⁸

Difficulties With Applying the Substituted Judgment and Best Interest Standards to Cases of Early Gender Assignment Surgery, and Arguments for Why Parental Involvement in Treatment Decisions Might Minimize These Difficulties

As identified in the preceding section, one main difficulty in applying the substituted judgment standard to cases involving early gender assignment surgery is that infants are unable to express a treatment preference. Indeed, it is doubtful whether infants are able to express *any* sort of feelings or tendencies to help indicate which treatment decision they might make if they were competent. Even in jurisdictions that do not explicitly adopt a best interests approach to cases involving medical care for incompetent minors, the substituted judgment standard strongly resembles the best

123. Teena-Ann V. Sankoorikal, *Using Scientific Advances to Conceive the "Perfect" Donor: The Pandora's Box of Creating Child Donors for the Purpose of Saving Ailing Family Members*, 32 SETON HALL L. REV. 583, 606 (2002) ("The American legal system subsequently adopted the 'best interests' standard, which 'remains the governing principle for adjudicating cases involving minors.'") (internal citations omitted).

124. *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944) (holding that parents are not "free . . . to make martyrs of their children").

125. *Bonner v. Moran*, 126 F.2d 121, 123 (D.C. Cir. 1941).

126. *In re Estate of Longeway*, 549 N.E.2d 292, 299 (Ill. 1989) (internal citations omitted).

127. Sankoorikal, *supra* note 123, at 606 (internal citations omitted).

128. *See, e.g., In re Storar*, 420 N.E.2d 64, 73 (N.Y. 1981).

interests standard. Accordingly, treatment decisions for intersexed infants should be made on the assumption that an intersexed infant would have chosen the treatment option best promoting his or her interests.

The primary problem with using this approach in situations involving intersexed infants, is that the medical community has not developed one correct medical model for the treatment of these infants.¹²⁹ There is grave uncertainty as to which form of treatment most effectively promotes the intersexed infant's best interests. The longstanding, predominant surgical model of care has been widely criticized for its dubious scientific foundation. Nevertheless, no other model has yet been established to take its place. Anecdotal evidence certainly suggests that intersexed infants can grow into happy, psychologically well-adjusted individuals *without* undergoing early surgery.¹³⁰ There is also considerable evidence to suggest that the surgical model of care *is* an effective and valuable treatment model, and that the recipients of early surgery are generally happy with their results.¹³¹ An 'objective' best interests standard presupposes a consensus in society on the issue of whether an intersexed infant should undergo gender assignment surgery, when in fact there is great controversy surrounding the matter.

In the clear absence of a 'best' form of treatment, *any* treatment decision made for an intersexed infant will necessarily reflect the decision-maker's value system. The decision-maker must first take all of the available evidence into account, weighing the physical, emotional, psychological, and social risks of early surgery against its potential physical, emotional, psychological, and social benefits. The decision-maker must *then* decide whether gender assignment surgery is appropriate in the particular case before him. Given the relative lack of long-term evidence about intersexed individuals who were not surgically altered in their early years, the decision *not* to operate is as much a treatment decision and an 'experiment' as the decision *to* operate — if not more so. The

129. See Beh and Diamond, *supra* note 3, at 34-42.

130. See *Intersex Babies*, *supra* note 11.

131. See Lerner, *supra* note 65.

experiment is simply cultural in nature, rather than surgical.¹³² As two notable scholars explained,

there is very little data suggesting that parents can (or, for that matter, cannot) raise children with ambiguous genitalia unambiguously in one gender. There is similarly little data concerning how well intersex children interact with their peers during adolescence, when ambiguities are likely to come to light in gym class and elsewhere (if they have not already done so). Children are particularly hard on those whom they perceive to be different.¹³³

Rather than take this difficult decision away from the parents and physicians through the imposition of a legal moratorium on gender assignment surgeries, it would seem more prudent to allow those closest to the infant to make the decision that appears most likely to benefit the infant overall. The parents of an intersexed infant, together with the infant's family and physicians, have the greatest knowledge about the particular intersex condition from which the infant suffers, the specific cultural and religious environment in which the infant will be raised, the social community in which the infant will develop, and other relevant factors. Therefore, parents are in the best position to determine what treatment, if any, the intersexed infant would have chosen, as well as the treatment option that is in the overall best interests of the infant. To the extent that personal values *are* reflected in this difficult treatment decision, the decision should reflect the individualized values of those *closest* to the infant — those who will have the primary responsibility for the infant's upbringing and

132. Hermer, *supra* note 15, at 228. Hermer writes:

It must be recognized that, if we choose the latter course [of delaying surgery or bypassing it altogether], we will again have used intersex individuals as guinea pigs of sorts, this time in a cultural experiment. However much any of us may wish to see [this latter course of delaying surgery] prevail, the outcome is not certain. Thus, a physician cannot, in good conscience, assure the parents of an intersex infant that they ought not to choose cosmetic or sex assignment surgery for their child, on the ground that the unaltered child, along with his/her intersexual forebears and brethren, will (over time) alter our present sex and gender systems to make space for those who do not conform to the present norms. Given our present state of knowledge concerning the long-term outcomes of intersex individuals (both those who have and have not had surgery), and given our current sex and gender systems and the fact that intersex individuals have no choice but to cope with them one way or another, there can presently be no reasonably certain "right" answer for physicians and parents of intersex children with respect to surgery.

Id.

133. *Id.* at 233.

value system — as opposed to the impersonal “value” that a uniform, blanket moratorium would impose.

BENEFITS OF EARLY GENDER ASSIGNMENT SURGERY

Early Gender Assignment Surgery as Experimental and Not Medically Indicated: Whom Does Surgery Benefit?

In general, “[m]ost courts . . . defer to parental discretion within a broad spectrum of situations ranging from those which are medically necessary, to those which do not threaten the health of the child.”¹³⁴ When parents seek to provide consent on behalf of their children for treatments that appear experimental or outside the realm of medical indication, however, courts often intervene if the desired treatment does not appear to confer an independent benefit on the child.¹³⁵ Advocates of a moratorium on gender assignment surgery allege that parental consent is not sufficient for early gender assignment surgeries because these surgeries involve “experimental techniques which must not be imposed without the patient’s full informed consent.”¹³⁶ Emphasizing the strong American tradition against subjecting involuntary human subjects to experimental medical procedures, organizations such as the Intersex Society of North America (ISNA) argue that the experimental nature of gender assignment surgeries prohibits their performance on intersexed infants.¹³⁷

These opponents of gender assignment surgeries allege that such procedures are unrelated to the health of an intersexed child and unnecessary for the child’s survival or function.¹³⁸ Arguing that these surgeries fail to meet the requirement that an experimental treatment offer independent benefit to the patient,¹³⁹ moratorium advocates contend that the only real benefits of early surgery are realized by the parents of intersexed infants, and not by the infants themselves.¹⁴⁰ Considering the flexible manner in which the courts have previously measured “independent benefit,” however, it appears that the potential psychological and cultural

134. Povenmire, *supra* note 85, at 105-06.

135. See generally, *Bonner v. Moran*, 126 F.2d 121, 123 (D.C. Cir. 1941) (recognizing the “basic consideration” that an operation performed on a minor provide some benefit to the minor himself).

136. Amicus Brief, *supra* note 4. See also Ford, *supra* note 2, at 486-88.

137. Amicus Brief, *supra* note 4.

138. See *id.*

139. Ford, *supra* note 2, at 480-82.

140. Amicus Brief, *supra* note 4.

benefits offered by gender assignment surgery warrant its inclusion among the surgical procedures offering independent benefit to the patient. In addition to the direct psychological benefits that may accompany gender assignment procedures, surgery may also bring intersexuals, their families, and their peers closer together, allowing intersexuals to grow up in happier home and cultural environments.¹⁴¹ "[I]f surgery permits those parents to better relate to their child, then both the parents and the child will have benefited from it, notwithstanding any ill effects the surgery may ultimately have on the child him/herself."¹⁴² Clearly, sufficient evidence exists to suggest that intersexed infants *can* receive independent benefit from gender assignment surgery, and often do. Accordingly, courts should recognize parents as having the legal capacity to consent to early surgery on behalf of their intersexed infants.

In *Strunk v. Strunk*, the Supreme Court of Kentucky modified the substituted judgment standard to uphold parents' right to consent to their twenty-seven-year-old, mentally-disabled son's donation of a kidney to his brother. The court reasoned that the boy would probably be more traumatized by losing his brother than by undergoing a kidney transplant procedure.¹⁴³ Using comparable analysis, the Superior Court of Connecticut upheld the right of parents to consent to their daughter's donation of a kidney to her twin sister in *Hart v. Brown*. The court noted that "the donor would enjoy a better future life if her ailing twin sister were kept alive"¹⁴⁴ and declared that the parents "have the right . . . to give their consent to the operations on both minor children."¹⁴⁵ Similarly, in *Little v. Little*, the Texas Court of Appeals sanctioned the removal of a kidney from an incompetent individual suffering from Down's Syndrome, basing its decision on the "strong evidence . . . that [the donor] will receive substantial

141. See Hermer, *supra* note 15, at 230 (suggesting that delaying surgery may cause parents and peers to bond poorly with an intersex child, due to the child's malformed genitals).

142. *Id.* at 235.

143. *Strunk v. Strunk*, 445 S.W.2d 145, 146 (Ky. 1969); see also Sankoorikal, *supra* note 123, at 609 (reporting the court's statement as, "[u]nder a strict reading of the 'substituted judgment' standard, considerations of benefit to the incompetent are not appropriate"). It cited *Strunk* as an example of a case in which a court, under the auspices of a substituted judgment standard, reached a decision based partly on the objective benefit to the patient and thus modified the substituted judgment standard to resemble the best interests standard. *Id.*

144. *Hart v. Brown*, 289 A.2d 386, 390 (Conn. Super. Ct. 1972).

145. *Id.* at 391.

psychological benefits from [the procedure]."¹⁴⁶ Even with all the medical risks inherent to organ donation procedures, the courts in these cases reasoned that the kidney donors would probably suffer less harm in undergoing the surgeries than they would in losing their siblings.¹⁴⁷ While emphasizing the importance of minimizing the expected harm to minor children undergoing medical treatment, the *Strunk* and *Hart* courts remained flexible in outlining the factors considered when measuring the harm and benefit to the child.¹⁴⁸ Employing a broad view of "harm," the courts placed great emphasis on the child's potential to suffer psychological damage and the psychological value of the child's personal relationships.¹⁴⁹

The argument that gender assignment surgery is "unrelated to an intersexed infant's health"¹⁵⁰ reflects a severely limited understanding of human "health," and ignores the courts' longstanding liberal treatment of the term. For decades, courts have employed reasoning similar to that used in the *Strunk* and *Hart* decisions, incorporating psychological and emotional factors when analyzing the effects of surgical procedures on an individual's health and well-being. In so doing, these courts acknowledged that the term "health" is not limited to the physical and physiological workings of an individual's body, but includes the individual's mental health and development as well.

One famous example of a liberal judicial view of health is found in the landmark case of *Roe v. Wade*, in which the Supreme Court broadly construed the term "health" to incorporate an individual's psychological and emotional well-being.¹⁵¹ The Court stated, "[m]aternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent.

146. *Little v. Little*, 576 S.W.2d 493, 500 (Tex. Civ. App. 1979).

147. See cases cited *supra* notes 143-45.

148. The judicial conception of "benefit" is often further relaxed in situations in which considerable debate exists in the medical community about the efficacy and appropriateness of various medical treatments. For instance, in cases of minors caught in a persistent vegetative state, courts usually trust parents to make decisions about removing life-sustaining treatment. The more tenuous the judgment call, the more likely a minor's parents will be allowed to make that call free of legal constraints. Indeed, parents will almost always be allowed to make "wrenching health care decisions when there is no social consensus as to appropriate treatment." Rosato, *supra* note 105, at 65.

149. Notably, several courts have looked to the impact of surgery on a minor's emotional and mental health when upholding the sterilization of minor children. See, e.g., *In re C.D.M.*, 627 P.2d 607, 612 (Alaska 1981); see also *In re Romero*, 790 P.2d 819, 822 (Colo. 1990) (holding that clear and convincing evidence did not establish the ward's incompetency).

150. See Amicus Brief, *supra* note 4.

151. *Roe v. Wade*, 410 U.S. 113 (1973).

Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child.¹⁵² The Supreme Court's emphasis on the mental health and distress of the mother outlines an expansive definition of health; one that places great importance on the emotional well-being of the individual. Under this view, it is apparent that early gender assignment surgery, with its potential to improve a patient's emotional wellness and happiness,¹⁵³ can offer significant health benefits to an intersexed individual and should not be banned through the imposition of a legal moratorium.

Gender Assignment Surgery as Merely 'Cosmetic?'

Labeling a childhood surgery 'cosmetic' does not automatically place it outside the bounds for which parents may lawfully consent.¹⁵⁴ Nevertheless, characterizing gender assignment surgery as 'cosmetic'¹⁵⁵ can trivialize this intensely significant procedure. That label ignores the immense impact that gender assignment surgery can have on an intersexed infant's psychological and emotional health, as well as the infant's mental development and process of gender-identification. Furthermore, labeling these surgeries as 'cosmetic' threatens to mischaracterize a procedure that falls well within the Supreme Court's conception of 'health' and medically-indicated surgeries. This opinion is echoed by Dr. Peter Lee, who argues that gender assignment surgery should properly be considered *corrective* surgery, and not *cosmetic* surgery.¹⁵⁶ He admits that the distinction between the two can often be subtle, but stresses its importance.¹⁵⁷ According to Dr. Lee, cosmetic surgery is surgery that is performed "just so that the organ has a more pleasing appearance," such as mammoplasty to make a 'normally'-

152. *Id.* at 153 (1973). This focus on psychological and emotional harm was echoed in *Planned Parenthood v. Casey*, 505 U.S. 833, 852 (1992) (stating that "[t]he mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear").

153. Martin, *supra* note 32, at 168 (Parents of intersexed infants "should be warned about the repercussions of waiting until [puberty]" for gender assignment surgery and "parents should also know that untreated ambiguous genitalia may create problems for children when they attend school, resulting in serious psychological repercussions").

154. For instance, in the case of circumcision, parents are "presumed to have the power to consent . . . despite the mounting evidence of the procedure's deleterious effects." Povenmire, *supra* note 85, at 106.

155. See Intersex Society of North America, at <http://www.isna.org>; see also Lee & Gruppuso, *supra* note 12 (describing the difference between cosmetic and corrective surgery).

156. Lee & Gruppuso, *supra* note 12.

157. *Id.*

developed woman's breasts more symmetrical.¹⁵⁸ In contrast, mammoplasty for a young man with persistent gynecomastia¹⁵⁹ is better characterized as corrective surgery,¹⁶⁰ similar to the way that a cleft palate is corrected both to improve function as well as to minimize the abnormal appearance of the condition.

In *In re Kevin Sampson*, the Court of Appeals of New York directed and authorized surgery and blood transfusions on a fifteen-year-old child over his mother's religious objections, even though surgery was not required to improve the physical health or life of the child or the public.¹⁶¹ The child suffered from Von Recklinghausen's disease, which caused a "massive deformity of the right side of his face and neck" that the court described as "a large fold or flap of an overgrowth of facial tissue which causes the whole cheek, the corner of his mouth and right ear to drop down giving him an appearance which can only be described as grotesque and repulsive."¹⁶² The court recognized that the condition posed no immediate threat to the boy's sight and hearing, and that the main, and perhaps the only, benefit that surgery would offer was psychological and cultural.¹⁶³ Nevertheless, the court found that this benefit was great enough to justify surgery. The court stated,

there is . . . no need for treatment of either his eyes or his ears. However, the massive deformity of the entire right side of his face and neck is patently so gross and so disfiguring that it must inevitably exert a most negative effect upon his personality development, his opportunity for education and later employment and upon every phase of his relationship with his peers and others.¹⁶⁴

The treating psychologist reported that the child showed "no evidence of any thinking disorder and . . . failed to show any

158. *Id.*

159. Gynecomastia is a medical condition that results in "abnormally large breasts on men," Merle James Yost, *Gynecomastia in Men: What is Gynecomastia?*, at <http://www.gynecomastia.org/content/general/gynart.shtml> (last visited Feb. 2, 2005). Potential causes of gynecomastia include: puberty, steroid abuse, obesity, tumors, genetic disorders, chronic liver disease, marijuana use, castration, Klinefelter Syndrome, Gilbert's Syndrome, and aging. *Id.*

160. *Id.* (stating that often the best solution is surgery).

161. *In re Sampson*, 317 N.Y.S.2d 641 (Fam. Ct. 1970).

162. *Id.* at 643.

163. *See id.*

164. *Id.* at 644.

outstanding personality aberration."¹⁶⁵ One of the attending surgeons described the procedure as "dangerous" and testified that it involved "considerable risk."¹⁶⁶ Nevertheless, the court determined that the possibility of normalizing the child's appearance through surgery would have a profound effect on the child's psychological and emotional well-being.¹⁶⁷ The court stated that "the conclusion is inescapable that the marked facial disfigurement from which this boy suffers constitutes such an overriding limiting factor militating against his future development that unless some constructive steps are taken to alleviate his condition," he would have less chance of successfully pursuing a "normal, useful life."¹⁶⁸ Claiming broad authority to "help safeguard [children's] physical, mental, and emotional well-being," the court ordered risky, corrective medical treatment for the child.¹⁶⁹ The court understood that the beneficial effect that this 'cosmetic' surgery might have on the child's mental and emotional health was important enough to not just *sanction* the procedure in accordance with the parent's wishes, but indeed to *order* the procedure against the parent's wishes.¹⁷⁰

Similar to the aesthetic correction of the child's deformity in *Sampson*, gender assignment surgery affords intersexed infants the opportunity to benefit psychologically from corrective surgery, potentially increasing their "chances for a normal, useful life."¹⁷¹ Under this view, which is consistent with the broad judicial conception of health exemplified by *Roe*, gender assignment surgery is not merely cosmetic, but is integrally related to the individual's health and medical interests, and should be treated accordingly.

PARENTAL/MEDICAL VS. JUDICIAL/LEGAL DECISION MAKING

Parents and Doctors Are Often Better Able to Make Medical Decisions than Courts and Legislatures

165. *Id.*

166. *Id.* at 645.

167. *Id.* at 644.

168. *Id.*

169. *Id.* at 647 (quoting FAM. CT. ACT. §1011).

170. In *In re Sampson*, the child's mother actually authorized the corrective surgery, but refused to authorize the blood transfusions without which the surgery would be so risky that it could not be performed. *Id.* at 643. See also *In re Seiferth*, 309 N.Y. 80 (1955) (recognizing the court's authority to direct surgery on a child's cleft palate and harelip, based on its authority to protect the child's general welfare, when the primary health benefits of surgery were psychological and mental in nature).

171. *In re Sampson*, 317 N.Y.S.2d at 644.

Ardath A. Hamann is a critic of society's reluctance to allow families to withhold life-sustaining treatment from incompetent adult relatives. He writes:

Society justifies interference with family decisionmaking on the basis that children must be protected . . . or under the theory that family members have a conflict of interest . . . Instead, society concludes, the omniscient and impartial outsider should make the decision. This conclusion is fundamentally flawed. Only God is omniscient and there is no absolute truth . . . There are only individual preferences based in individual morality.¹⁷²

Legislators and judges are often no more impartial than family members in making medical decisions on behalf of incompetent patients, and they are frequently less qualified to make these decisions.¹⁷³ Therefore, although society does not always agree with every medical decision made by a patient's family, one could infer that families are generally better decisionmakers than the existing alternatives.¹⁷⁴ As one scholar pointed out:

Some of the common concerns with judges as decision-makers are that the judicial process takes too long, judges do not know the patient or her situation well enough, and they possess their own set of biases. Even more significantly, judges cannot weigh the moral and ethical considerations that are integral to these decisions¹⁷⁵

These concerns are easily extended to legislators and to virtually anyone outside of the patient's immediate circle of contact: hospital administrative boards, ethical committees, and the like. Admittedly, these 'outside' individuals and organizations might be sufficiently knowledgeable and impartial to play an influential role in the decisionmaking process. It would be horribly

172. Hamann, *supra* note 101, at 139-40.

173. Sankoorikal, *supra* note 123, at 602. Sankoorikal writes:

With respect to the legal system, in particular, judicial intervention in parental decisions has often been criticized on the theory that courts and judges lack the time or knowledge needed to render an informed decision in the child's best interests. In addition, these non-familial decision-makers are often unable to weigh non-quantifiable factors such as the myriad moral and ethical considerations that may affect a particular family.

Id. (internal citations omitted).

174. See Rosato, *supra* note 105, at 42.

175. *Id.*

inappropriate, however, to allow them to rob the parents of intersexed infants of any participation in the decision regarding gender assignment surgery by instituting a legal moratorium on such surgery.

Another consideration weighing against a moratorium is that "[m]edical decisionmaking for an incompetent person should rest with the person's family because no one loves the person more than his own family."¹⁷⁶ An intersexed infant typically receives the most concern from his or her family: family members spend time with the infant, assist with the infant's care and comfort, and advocate on the infant's behalf.¹⁷⁷ Additionally, the parents of intersexed infants will themselves have to live with the treatment decisions made on behalf of their child,¹⁷⁸ and they are usually in the best position to understand and help their child face the unique difficulties and challenges that accompany his or her intersex condition and treatment. These and many other reasons often warrant deference to parents.¹⁷⁹

As discussed earlier, the substituted judgment test was created in an effort to arrive at an outcome consistent with an incompetent patient's wishes.¹⁸⁰ Obviously, an intersexed infant lacks the cognitive ability to form preferences regarding medical treatment, much less to communicate them in a dependable fashion. Nevertheless, an intersexed infant's parents would probably be familiar and sensitive to the environment and considerations that would control the infant's treatment preferences. To the extent that the substituted judgment or best interests standards are appropriate for these cases, society should allow the informed and involved parent — and not the uninformed and uninvolved force of the law — to make the uniquely personal surgical decision for the intersexed infant.¹⁸¹

Different Children, Different Needs

The need for parental deference in treatment decisions for incompetent minors is particularly acute in cases where the

176. Hamann, *supra* note 101, at 160.

177. *Id.* at 162 (discussing in terms of "families" and "patients").

178. *Id.*

179. Rosato, *supra* note 105, at 51.

180. Hamann, *supra* note 101, at 164.

181. See Rosato, *supra* note 105, at 42-44 (stating that the moral authority of parents to make fundamental health care decisions for their infant children "directly serves the patient's interests, as long as the interests of a patient whose family does not reflect this reality is adequately protected").

patient's treatment preference is unknown or unknowable, and medical opinion is divided.¹⁸² As one scholar explained:

[T]he decision-maker must not only 'do good' in a general sense, but must do the particular 'patient's' good. This task is made increasingly difficult when the patient has not articulated her desires clearly or at all, and when there is a lack of moral consensus over what constitutes a person's good in a pluralistic and secular society.¹⁸³

Early gender assignment surgery easily fits into the category explained above. Medical professionals differ greatly on the appropriate model of care for intersexed infants, and the debate over gender assignment surgery has recently sparked an explosion of legal and moral controversy. In order to ensure that the "particular 'patient's' good"¹⁸⁴ is advanced, and that the best interests of the particular intersexed infant are promoted, courts and legislatures should defer to the judgment of parents and physicians in the decision over early gender assignment surgery. A legal moratorium on such surgery would be inappropriate and over-inclusive, treating all intersexed infants as having the same environment, perspective, and interests, when, in fact, these factors may vary greatly with each individual case.

A moratorium on gender assignment surgery would require all intersexed infants to live through their formative years without the psychological and medical benefits that gender assignment surgery can bring, by forcing *all* intersexuals to forgo surgery until they attain the age of maturity and may themselves opt to undergo the procedure. This avenue may be in the best interests of *some* intersexed infants, but there is no indication that it is in the best interests of *all* of them. Indeed, the medical community remains divided on the subject, with many medical

182. See *State v. Perricone*, 181 A.2d 751 (N.J. 1962). In upholding an order to administer needed blood transfusions to a minor over the objection of the minor's parents, the Supreme Court of New Jersey suggested that deference may be given to parental treatment preferences in situations when there is debate in the medical community over the appropriate medical treatment for a minor child:

[M]edicine and surgery are not yet exact sciences and the result of any given operation or treatment cannot be foretold with complete accuracy. However, courts can be guided only by the prevailing medical opinion. Had there been a relevant and substantial difference of medical opinion about the efficacy of the proposed treatment . . . a strong argument could be made in favor of appellants' position.

Id. at 760.

183. Rosato, *supra* note 105, at 34.

184. *Id.*

professionals and intersexed individuals supporting the practice of early gender assignment surgery.

There are certainly some infants who, as a result of their particular personalities, cultural environment, proclivity to succumb to peer pressure, and family belief system, might benefit emotionally and mentally from early surgery. Supporting this contention are reports suggesting that numerous intersexuals are quite satisfied with the results of their early gender assignment surgeries.¹⁸⁵ By denying all intersexed infants the opportunity to undergo gender assignment surgery, irrespective of their individual circumstances, moratorium advocates blatantly ignore the significant benefits that surgery recipients can receive by growing up with genitalia that comport with their assigned gender. These advocates assume that preserving one's choice of gender is the overriding concern of all intersexed individuals, severely downplaying the serious psychological, social, and physical difficulties that may confront a child bearing ambiguous genitalia.

Admittedly, some intersexuals might experience little or no difficulty living a life in which their genitalia opposes their assigned sex, and may not be troubled when facing a society that is not always kind to individuals who fall outside its scope of traditional gender norms. These individuals, by virtue of their innate personalities or personal upbringing, might suffer no confusion over gender identification, endure no ridicule from their peers, feel no embarrassment in the locker room, and develop no body image complexes. In these cases, it might be better to postpone gender assignment surgery until the intersexed child is mature enough to provide direct consent.

Other individuals, however, on account of their particular intersex conditions, personal characteristics, religious surroundings, or familial environment, might experience *extreme* hardship when coping with the difficulties associated with growing up as intersexuals. These individuals might be particularly sensitive to the social ridicule, gender-identification and psychological issues, locker-room banter, social discrimination, and moral judgments that they will encounter due to their intersexual conditions. In *these* cases, the intersexed children might benefit greatly from early gender assignment surgery — and correspondingly, might be harmed by a moratorium on the surgery. Allowing parents to

185. See, e.g., Susan J. Bradley et al., *Experiment of Nurture: Ablatio Penis at 2 Months, Sex Reassignment at 7 Months, and a Psychosexual Follow-up in Young Adulthood*, 102 PEDIATRICS 9 (1998), available at <http://www.pediatrics.org/cgi/content/full/102/1/eq>.

provide consent to gender assignment surgery may be the optimum way to safeguard the overall best interests of these children. A blanket moratorium on such surgery would deprive all infants of that treatment option — perhaps promoting the best interests of some, but also compromising the best interests of others.¹⁸⁶

CONCLUSION

Absent any demonstrable conflict between the interests of the family and the interests of the patient, and assuming that the medical decision made by the family for the infant is within the range of reasonableness, society should exhibit deference to parents in the context of gender assignment surgery. Legislators and courts should refrain from instituting a legal moratorium on gender assignment surgery and recognize the legal capacity of parents to consent to surgery on behalf of their intersexed infants.

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186. This concern that blanket regulations may be appropriate for some members of a class but inappropriate for other members of the class is evidenced in Chief Justice Stone's concurrence in *Skinner v. Oklahoma*. *Skinner v. Oklahoma*, 316 U.S. 535, 544 (1942). Chief Justice Stone wrote:

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 such 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.

Id.

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