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Recommended Citation

Noa Ben-Asher, The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties, 29 Harv. J.L. & Gender 51 (2006), <http://digitalcommons.pace.edu/lawfaculty/591/>.

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THE NECESSITY OF SEX CHANGE: A STRUGGLE FOR INTERSEX AND TRANSSEX LIBERTIES

NOA BEN-ASHER*

INTRODUCTION

Transsex individuals often desire the future body that they *should* have,¹ while intersex individuals often mourn the body they *had* before an unwanted normalizing surgery interfered with it.² Thus, Judith Butler,

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¹ The terms “transgender” and “transsexual,” which refer to transsex individuals, are used in various ways in numerous discourses. From a clinical perspective, the current fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* has dropped the term “transsexualism” as a diagnostic category and replaced it with “Gender Identity Disorder.” The definition, however, remains the same. TASK FORCE ON DSM-IV, AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 532–38 (4th ed. 1994). In contrast, “transgender” is not recognized as a diagnostic category, and frequently medical and psychological discourses read it as synonymous to “transsexual.” In reaction to clinical discourses, transsexual- and transgender-identified persons have adopted diverse languages of identification. For example, some view the use of a single “s” spelling of the word “transsexual” as a first step of resistance to medical pathologizing discourses. For an in-depth discussion of such transdiscourses, see JASON CROMWELL, *TRANSMEN AND FTMS: IDENTITIES, BODIES, GENDERS, AND SEXUALITIES* 19–30 (1999).

² The term “intersex” refers to individuals who are not considered by medical experts as “normal” males or females. The intersex category today covers: (1) chromosomal variations, (2) gonadal variations (atypical ovaries or testes), (3) hormonal variations, and (4) external morphologic variations (genitalia that is neither clearly male nor female).

Chromosomal variations are chromosomes other than the common XX and XY patterns. For example, in Klinefelter Syndrome, a mostly phenotypic male typically has two or three extra X chromosomes, and the testes and often the penis are smaller than in other XY individuals. JOHN MONEY, *SEX ERRORS OF THE BODY AND RELATED SYNDROMES: A GUIDE TO COUNSELING CHILDREN, ADOLESCENTS AND THEIR FAMILIES* 13 (2d ed. 1994).

Gonadal variation can be seen, for example, in Turner Syndrome, in which individuals have an XO chromosomal pattern and gonads that are not clearly defined as testes or ovaries. *Id.* at 14.

Hormonal variations occur in syndromes like Androgen Insensitivity Syndrome (AIS) and Congenital Adrenal Hyperplasia (CAH). Individuals with AIS (approximately one out of every 20,000 genetic males) are born with XY chromosomes and typical testes. The body, however, cannot process the androgens, and thus the fetus follows typical female

a dominant feminist-queer theorist who has had a significant role in the shaping of queer theory and politics since the early 1990s, has lately commented that “intersex and transsex sometimes seem to be movements at odds with each other, the first *opposing* unwanted surgery, the second sometimes *calling for* elective surgery”³ This proposition serves as a point of departure for this Article, which explores current legal strategies of the two movements through their complex relations with medical-scientific theories about sex and gender.

Feminist and queer theories are generally concerned with the cohesive effects that gender, as a system of normalization, has on legal subjects. This Article highlights two such harms of gender normalization: the current state of Medicaid coverage of adult transsex surgeries, and the current management of intersex subjects. It proceeds by focusing on the discursive relationships of these two social movements with medical experts and texts, and the translation of medical theories into legal narratives. “Medical necessity,” “cosmetic surgery,” and “experimentation” are terms currently offered in legal narratives by both movements to achieve the two distinct goals of (1) obtaining Medicaid coverage of sex reassignment surgeries and (2) ending normalizing genital surgeries on intersex infants and young children.⁴ This Article examines how we can theorize the legal struggles of the two movements in harmony, to enhance the freedom and happiness of the legal subjects at issue, and to minimize the harms of social stereotyping.

At the core of current conceptualizations of the two movements stands a distinction between sex and gender, a dichotomy that this Article will problematize. “Gender” is often perceived as a social behavior or norm that can be located on an imaginary spectrum connecting hyper-masculinity and hyper-femininity, while “sex” is often perceived as permanent, non-negotiable, and objective.⁵ While gender is often considered to be some-

development and forms external female genitalia and no internal reproductive organs. For more on AIS, see James E. Griffin, *Androgen Resistance: The Clinical and Molecular Spectrum*, 326 NEW ENG. J. MED. 611 (1992).

Finally, external morphologic variations are most commonly caused by Virilizing Congenital Adrenal Hyperplasia (CAH). Genetic XX fetuses with ovaries are prenatally exposed to a high level of androgens. The consequence is “male”-like development of the external genitalia, causing a wide range of results, from a child that looks very much like a typical male, to a child who appears as a typical girl, but whose clitoris is slightly enlarged. For more on CAH, see Perrin C. White & Phyllis W. Speiser, *Congenital Adrenal Hyperplasia Due to 21-Hydroxylase Deficiency*, 21 ENDOCRINE REV. 245 (2000).

In all, approximately 1.7% of all infants are born intersexual *in some form*. This figure represents all chromosomal, anatomical, and hormonal exceptions to the two-sex dimorphic ideal. Melanie Blackless et al., *How Sexually Dimorphic Are We?*, 12 AM. J. HUM. BIOLOGY 151, 161 (2000).

³ JUDITH BUTLER, UNDOING GENDER 6 (2004) (emphasis added).

⁴ While both movements also have other advocacy goals, this Article isolates these two legal goals, as they are central in the struggle for social-legal recognition and intelligibility.

⁵ See BUTLER, *supra* note 3, at 40–43 (2004) (providing a further critical discussion of this view of gender as a norm); see also *id.* at 42 (suggesting that “to assume that gender always

thing that bodies *do*, sex is often considered to be something that bodies *are*.⁶ The Supreme Court has alluded to this distinction, holding in *Price Waterhouse v. Hopkins* that “[i]n the specific context of sex stereotyping, an employer who acts on the basis of a belief that a woman cannot be aggressive, or that she must not be, has acted on the basis of gender.”⁷

Less understood is the notion that sex itself is not fixed, clear, or “objective,” and that sex is *also* a human-made process, often involving a legal process. This Article concentrates on a current state of crisis in scientific expertise regarding the distinction between sex and gender, which corresponds with the claim structure of the two social movements—intersex and transsex—whose determination *turns* on the sex-gender distinction.

This Article is composed of four Parts. The first Part explores two legal struggles for intersex and transsex goals. The main litigation propositions and structures of the two movements are contrasted, especially the meanings that the two movements offer for the terms “medical necessity,” “cosmetic surgery,” and “medical experimentation.” While Part I takes a critical approach to some of the strategies discussed, the main purpose is to describe the mirroring aspects of the two advocacy movements.

The second Part locates these contemporary legal narratives regarding sex change in the broader history of sex change in the twentieth-century United States, emphasizing how these two medicalized identities emerged from increasing medical control of sex, gender, and sexuality.

The historical account outlined in Part II illuminates the argument to follow in Part III: current legal struggles of the two movements are supported by data and experts from two sides of historical and ongoing medical-scientific debates regarding the origins of “gender identity,” often referred to as the nature/nurture debates or biological/psychological debates. In short, transsex advocacy for Medicaid coverage of sex reassignment surgeries

and exclusively means the matrix of the ‘masculine’ and ‘feminine’ is precisely to miss the critical point that the production of that coherent binary is contingent, that it comes at a cost, and that those permutations of gender which do not fit the binary are as much part of gender as its most normative instance. To conflate the definition of gender with its normative expression is inadvertently to reconsolidate the power of the norm to constrain the definition of gender.”).

⁶ Generally, American courts dealing with sex discrimination law are not always coherent in theorizing “sex” and “gender.” For some examples of critical discussions on meanings of sex and gender in the discrimination context, see generally Janet Halley, *Sexuality Harassment*, in *LEFT LEGALISM/LEFT CRITIQUE* 80 (Wendy Brown & Janet Halley eds., 2002) (critiquing a feminist model of discrimination that defines “gender” as the outcome of men using sexuality to make themselves superordinate); Vicky Schultz, *Reconceptualizing Sexual Harassment*, 107 *YALE L.J.* 1683 (1998) (arguing that the focus of harassment law should not be on sexuality as such, but on conduct that consigns people to gendered work roles that do not further their own aspirations or advantage); and Katherine M. Franke, *What’s Wrong with Sexual Harassment?*, 49 *STAN. L. REV.* 691 (1997) (arguing that sexual harassment is wrong because of the gender norms that it reflects and perpetuates).

⁷ *Price Waterhouse v. Hopkins*, 490 U.S. 228, 250 (1989); see also *id.* at 251 (“An employer who objects to aggressiveness in women but whose positions require this trait places women in an intolerable and impermissible catch 22: out of a job if they behave aggressively and out of a job if they do not. Title VII lifts women out of this bind.”).

for lower-income Americans (and support of transsex sex change surgeries in general) historically has been supported by experts like John Money and Richard Green who consider gender a social imprinting of behavioral patterns through the socialization process of the child. By contrast, intersex efforts seeking the termination of unwanted normalizing genital surgeries are ordinarily supported by medical theorists on the opposite end of the nature/nurture binary, who view gender identity as the result of the *biologically* hormonalized sexual brain. This cross-reliance is summarized in the following chart.

	Scientific Approach #1: Biology-Centered Approach	Scientific Approach #2: Socialization-Centered Approach	Transsex and Intersex Civil Rights Activist Approaches
Approach to adult sex reassignment transsex surgery	<i>Negative.</i> <u>Rationale:</u> The true self is in the biological body. Gender disorders must be treated through therapy and not through sex reassignment surgery.	<i>Positive.</i> <u>Rationale:</u> Gender is a process of socialization that occurs in early childhood. In adulthood, gender is immutable, and surgery is the best “treatment” for gender disorders.	<u>Transsex Activism:</u> <i>Positive.</i> Litigation attempts to secure Medicaid coverage for sex reassignment surgeries.
Approach to early normalizing intersex surgery	<i>Negative.</i> <u>Rationale:</u> The true self is in the biological body. Thus, attempts to raise children in the “wrong” sex are doomed to fail.	<i>Positive.</i> <u>Rationale:</u> Gender is a process of socialization that occurs in early childhood. Therefore, genitals should be constructed to “match” gender as early as possible.	<u>Intersex Activism:</u> <i>Negative.</i> Litigation and legislation attempts to stop early intersex surgeries.

The fourth and final Part is a call to de-emphasize the reliance on much-contested medical theories about gender and sex and to concentrate on framing sex-change advocacy in terms of positive and negative liberties. This Article suggests that the legal claim against early intersex surgery can be presented in terms of “negative liberty,” while the legal claim for transsex surgery, based on the Medicaid statute, can be presented as a form of “positive liberty.” In the case of intersex negative liberty, the bodies of intersex infants can be protected from intrusive medical procedures under the theory that state and/or federal law must actively protect the “negative liberty” of the intersex subject from unwanted medical intervention. In the case of transsex positive liberty, the bodies of transsex adults can be transformed by surgery under the theory that state and/or federal law should actively support the “positive liberty” of lower-income transsex subjects to self-determination, which can include the transformation of the body. The Article concludes by suggesting that the civil liberties of socially marginalized intersex and transsex subjects may be enhanced by a reliance on positive and negative liberties, which are less dependent on the scientific debates about gender and which consequently do not locate the two identity groups in a state of unnecessary conflict.

I. LEGAL POSITIONS: TRANSSEX ARGUMENTS *FOR* SEX CHANGE SURGERY AND INTERSEX ARGUMENTS *AGAINST* SEX CHANGE SURGERY

This Part will demonstrate how transsex and intersex advocacy adopt mirroring approaches regarding the need for surgery. For litigation purposes, advocates of sex change surgery for transsex adults portray the surgery as medically necessary and neither cosmetic nor experimental, while intersex advocates and allies, taking the exact opposite approach in the case of intersex children, assert that sex change is medically unnecessary and both cosmetic and experimental.

A. *Transsex Medicaid Advocacy: Genital Surgery Is Medically Necessary, Not Cosmetic or Experimental*

A claim for Medicaid coverage of transsex surgery is based on the notion that sex change is a medical necessity and the main form of treatment for the transsex individual who seeks it. While this proposition is often debated by medical experts, one thing remains certain: the shape of genitals often does determine legal sex, and this, in many cases, makes sex change necessary for legal recognition. Courts generally will not recognize a transgender person’s chosen sex or gender without the undergoing of sex change surgery, and preoperative transgender individuals are sometimes precluded from legal name change as well.⁸ The significance of legal sex

⁸ See, e.g., Jerry L. Dasti, *Advocating a Broader Understanding of the Necessity of Sex-*

emerges in a variety of legal fields, such as inmate treatment, birth-certificate amendment, and, of course, marriage.⁹ The high costs of sex change surgery, which may exceed \$100,000,¹⁰ turn the Medicaid program into a gatekeeper of the legal recognition of transsexuals.

Medicaid, a federal-state program created by Congress in 1965,¹¹ funds a health insurance scheme for lower income Americans using federal and state money; the program is administered at the state level.¹² Although state participation in the system is not mandatory, if a state decides to participate, it faces statutory and regulatory requirements.¹³ There is a distinction in Medicaid regulations between two types of “neediness”: categorical and medical. While states must cover the “categorically needy,” such as the elderly, the disabled, and children,¹⁴ they may cover at their discretion “medically needy” individuals—those who do not fall under the “categorically needy” category, but lack financial resources to obtain necessary medical care.¹⁵ The Supreme Court held that states can determine which procedures meet the standard of “medical necessity” and which do not, and that courts should generally defer to rational definitions of those categories.¹⁶ However, there is a limit on state discretion: a state cannot

Reassignment Surgery under Medicaid, 77 N.Y.U. L. REV. 1738, 1742 (2002) (noting that fraud is the main consideration in such decisions); *In re Rivera*, 627 N.Y.S.2d 241, 244 (N.Y. Civ. Ct. 1995) (granting a preoperative transsexual’s request for name change as long as she did not use it as evidence that she had successfully completed sex-reassignment surgery); *In re Anonymous*, 587 N.Y.S.2d 548, 548 (N.Y. Civ. Ct. 1992) (noting the court’s responsibility to weigh possibility of fraud in granting name change applications); *In re Anonymous*, 293 N.Y.S.2d 834, 838 (N.Y. Civ. Ct. 1968) (finding that concerns of fraud are not realized when name change is sought by postoperative, as opposed to preoperative, transsexuals); *In re Harris*, 707 A.2d 225, 228 (Pa. Super. Ct. 1997) (evaluating petitioner’s commitment to living full-time as a woman before granting name change); *In re Dickinson*, 4 Pa. D. & C.3d 678, 679–90 (Pa. Ct. Com. Pl. 1978) (granting transsexual’s request to change name and sex designation on birth certificate “where [she] has acquired an emotional, psychological and physiological change from one sex to another”); *In re Dowdrick*, 4 Pa. D. & C.3d 681, 684–85 (Pa. Ct. Com. Pl. 1978) (denying preoperative transsexual’s petition for name change, in part because it would not comport with “fairness” to the public), criticized by *In re McIntyre*, 715 A.2d 400, 402 (Pa. 1998) (calling it “an arbitrary determination” to refuse to grant name change until after operation and overruling trial court, which relied on decisions like *Dowdrick*).

⁹ See, e.g., Julie A. Greenberg, *When Is a Man a Man, and When Is a Woman a Woman?*, 52 FLA. L. REV. 745, 746 (2000) (discussing *Littleton v. Prange*, 9 S.W.3d 223 (Tex. App. 1999)).

¹⁰ The full cost of sex-reassignment surgery—including the psychoanalytic treatment required to obtain a recommendation for surgery and life-long hormone treatments—is, for many, a prohibitively high expense, often exceeding \$100,000. The cost of surgery alone is approximately \$37,000 for male-to-female transsexuals, and approximately \$77,000 for female-to-male transsexuals. See, e.g., Rachel Gordon, *S.F. Set to Add Change Benefits*, S.F. CHRON., Feb. 16, 2001, at A1.

¹¹ Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C. § 1396 (2000)).

¹² See, e.g., *Smith v. Rasmussen*, 249 F.3d 755, 757 (8th Cir. 2001).

¹³ *Id.*

¹⁴ 42 U.S.C. § 1396a(a)(10)(A) (2000).

¹⁵ 42 U.S.C. § 1396a(a)(10)(C) (2000).

¹⁶ *Beal v. Doe*, 432 U.S. 438, 440–41 (1977). The federal Medicaid statute does not

discriminate by denying or reducing the scope of a service based on the type of diagnosis, condition, or illness.¹⁷

Since Medicaid coverage for procedures requires a “medical necessity” determination, and the statute does not provide coverage for “optional” services, “transsexual” is narrowly defined in Medicaid litigation as a “very complex medical and psychological problem,”¹⁸ and as a severe form of “gender identity disorder” (GID).¹⁹ Courts generally have adopted this psychiatric definition of GID, and explained transsexual identities through medical terminology.²⁰

Theorists and advocates for transsexual rights have expressed discomfort with this medicalization of transsexual identities in legal and medical discourses. As recently articulated by Dean Spade of the Sylvia Rivera Law Project:

For most of us, negotiating medical standards—whether we are seeking to change our bodies or identity documents, or seeking to enforce our rights—is fraught with difficulty. The medical approach to our gender identities forces us to rigidly conform ourselves to medical providers’ opinions about what “real masculinity” and “real femininity” mean, and to produce narratives of struggle around those identities that mirror the diagnostic criteria of GID.²¹

provide for coverage of “optional” services, even if they may be medically beneficial. 42 U.S.C. § 1396d(a)(6)-(17) (2000).

¹⁷ 42 C.F.R. § 440.230(c) (2002) (a state “may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition”).

¹⁸ *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) (quoting *Doe v. Minn. Dep’t of Pub. Welfare*, 257 N.W.2d 816, 819 (Minn. 1977)); see also *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 184 (D. Mass. 2002) (“It is undisputed that Kosilek has a gender identity disorder, which is a rare, medically recognized, major mental illness.”).

¹⁹ *Smith v. Rasmussen*, 249 F.3d 755, 756–57 n.3 (8th Cir. 2001) (citing the diagnostic criteria for GID from TASK FORCE ON DSM-IV, AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 537–38 (4th ed. 1994): “A. A strong and persistent cross gender identification (not merely a desire for any perceived cultural advantages of being the other sex). B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. C. The disturbance is not concurrent with a physical intersex condition. D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.”).

²⁰ See, e.g., *J.L.S. v. D.K.S.*, 943 S.W.2d 766 (Mo. Ct. App. 1997) (detailing a transsexual parent’s medical history and condition in the context of custody case); *Daly v. Daly*, 715 P.2d 56 (Nev. 1986) (same); *Maffei v. Kolaeton Indus., Inc.*, 626 N.Y.S.2d 391, 393 (Sup. Ct. 1995) (giving medical definitions of transsexualism in an employment discrimination case); *In re Rivera*, 627 N.Y.S.2d at 244 (describing, at name change hearing, petitioner’s treatment by physicians); *In re Harris*, 707 A.2d at 225–26 (detailing petitioner’s medical history in name change hearing); *In re Dickinson*, 4 Pa. D. & C.3d at 679 (same).

²¹ Dean Spade, *Resisting Medicine, Re/modeling Gender*, 18 BERKELEY WOMEN’S L.J. 15, 28–29 (2003).

In particular, the classification of transsexual identified individuals as people “suffering” from GID is characterized by Spade as a double-edged sword.²² While GID is perhaps useful for achieving local relief, it promotes a regime of binary gender regulation:

[I]f I have to find a “diagnosable condition,” I have to rely on GID to make my claims. I do not want to make trans rights dependent upon GID diagnoses, because such diagnoses are not accessible to many low income people; because I believe that the diagnostic and treatment processes for GID are regulatory and promote a regime of coercive binary gender; and because I believe that GID is still being misused by some mental health practitioners as a basis for involuntary psychiatric treatment for gender transgressive people. I do not want to legitimize those practices through my reliance on the medical approach to gender nonconformity.²³

This classification of transsexual individuals as suffering from GID is the basis for the “medical necessity” argument in the context of Medicaid coverage of reassignment surgery. Since the 1950s and 1960s, some physicians, researchers, surgeons, and endocrinologists have promoted sex reassignment as a favorite, successful treatment of GID in adults. As they helped individuals define their sex by performing sex change surgeries, they were also producing the medicalized identities of transsexuals.²⁴ Through categories such as “gender dysphoria” and “gender identity disorder,” medical experts exercised the power of naming and control. This is the historical double-edged sword articulated by Spade: on the one hand, medical doctors were allies who could help one change sex; on the other, the payoff for this sex change was to play along in the medical-pathological naming game that today takes the form of GID.²⁵ The medical naming of GID persuaded many courts that surgeries are “medically necessary” in the treatment of transsexuals.²⁶ Accordingly, in states that have statutory or regulatory bans on Medicaid coverage of sex reassignment surgery,²⁷

²² *Id.*

²³ *Id.* at 34–35; see also Dasti, *supra* note 8, at 1763 (discussing commentators and scholars who have argued that success in a case in which Medicaid coverage for sex reassignment surgery is claimed based on medical necessity may be a “Pyrrhic victory” for transsexuals, as it relies on the “pathologization of nonconforming gender identities”).

²⁴ See *infra* Part II.

²⁵ For a discussion of the *DSM-IV* definition of GID, see *supra* note 1.

²⁶ See, e.g., *Richards v. U.S. Tennis Ass’n*, 400 N.Y.S.2d 267, 271 (N.Y. County Sup. Ct. 1977) (“Medical Science has not found any organic cause or cure (other than sex reassignment surgery and hormone therapy) for transsexualism, nor has psychotherapy been successful in altering the transsexual’s identification with the other sex or his desire for surgical change.”).

²⁷ E.g., ALASKA ADMIN. CODE tit. 7, § 43.385 (1997); ARIZ. ADMIN. CODE § R9-27-203 (1997); ILL. ADMIN. CODE tit. 89, § 140.6 (1998); 130 MASS CODE REGS. 410.405,

courts may invalidate denials of coverage and find the bans to be inconsistent with the federal regulations prohibiting discrimination based on diagnosis.²⁸

In response, some states have attempted to classify sex reassignment surgeries as “cosmetic,” which is by definition not “medically necessary.” This has not always proved effective. For example, in two cases before the California Court of Appeals, the court rejected the argument that sex reassignment surgery was “merely cosmetic” and not medically necessary, drawing a distinction between the alteration of genitals and the alteration of other parts of the body, such as the nose.²⁹ In a different context, in *Kosilek v. Maloney*, a male to female transsexual inmate sued the Commissioner of the Massachusetts Department of Corrections, alleging that under a policy of “freezing a transsexual in the condition he was in when incarcerated,” she was being denied adequate medical care for her GID in violation of the Eighth Amendment’s prohibition of cruel and unusual punishment.³⁰ Following the diagnosis of two experts, the court recognized that in cases of “severe” GID such as the plaintiff’s, a serious medical need arises that demands adequate care.³¹ The court concluded that “if psychotherapy, hormones, possibly psychopharmacology are not sufficient to reduce the anguish caused by Kosilek’s gender identity disorder to the point that there is no longer a substantial risk of serious harm to him, sex reassignment surgery might be deemed medically necessary.”³²

Another denial strategy is to label sex reassignment surgery “experimental.” Courts have typically required state Medicaid administrations to provide rational justifications for doing this. For example, the Fifth Circuit in *Rush v. Parham* held that a state denying coverage had the burden of demonstrating that this denial was “reasonable.”³³ Regarding the balance

405.418, 415.408, 423.415, 433.404, 433.440 (1998); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2 (1998); OHIO ADMIN. CODE 5101:3-13-05 (1998); OR. ADMIN. R. 410-120-1200 (1996); 55 PA. CODE § 1163.59 (1998); WIS. ADMIN. CODE [Dep’t Health & Family Servs.] § 107.03 (1997).

²⁸ E.g., *Pinneke v. Preisser*, 623 F.2d at 549–50 (finding that “a state plan absolutely excluding the only available treatment known . . . for a particular disease must be considered an arbitrary denial of benefits based solely on the ‘diagnosis, type of illness, or condition’”).

²⁹ *G.B. v. Lackner*, 145 Cal. Rptr. 555, 558 (Cal. Ct. App. 1978) (“Surely, castration and penectomy cannot be considered surgical procedures to alter the texture and configuration of the skin and the skin’s relationship with contiguous structures of the body. Male genitals have to be considered more than just skin, one would think.”); *Doe v. Lackner*, 145 Cal. Rptr. 570, 572 (Cal. Ct. App. 1978) (finding transsex surgery to be “medically reasonable and necessary”).

³⁰ *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 159–60 (D. Mass. 2002).

³¹ *Id.* at 184–88.

³² *Id.* at 195. The court held that, although plaintiff proved that she was not provided adequate care, she did not prove that this was a result of “deliberate indifference,” and thus the plaintiff did not prove the defendant had violated the Eighth Amendment. *Id.*

³³ *Rush v. Parham*, 625 F.2d 1150, 1156–57 (5th Cir. 1980) (remanding to allow the State to show either that sex-reassignment surgery is actually experimental or that it is not appropriate for the plaintiff).

between the medical profession and state administration, the court held that states have freedom to tailor Medicaid to their own particular requirements, so long as they do not interfere unduly with a physician's determination of medical necessity.³⁴ Likewise, contrary to the assertion of the state Department of Health and Human Services, a state administrative law judge in New Jersey found that the phalloplasty sought by a transsexual was not experimental, distinguishing a medical procedure that is in its "refining" stage from an experimental one whose "safety and efficiency are unknown."³⁵

In recent years, however, courts have been considerably hesitant to recognize the medical necessity in sex reassignment.³⁶ The Eighth Circuit, for example, reversed an earlier ruling in favor of Medicaid coverage, based on an outcome study that concluded that due to "a lack of consensus in the medical community and the availability of other treatment options, the Department should not fund sex reassignment surgery."³⁷ This rising uncertainty regarding the necessity of surgery was also reflected in 1993 when the American Psychiatric Association concluded at its annual conference that "well-adjusted" transgender people should not be automatically diagnosed as having a medical disorder.³⁸

In summary, advocates for Medicaid coverage today must show that sex change surgery is not "experimental" or "cosmetic." They must demonstrate the GID of clients and argue that sex change surgery is the best and only form of "treatment" for individuals "suffering" from GID. They must do all of this because, given the current expense of sex change surgery, the opposite movement of de-medicalization may turn basic legal rights that are today attached to legal sex into a luxury of the wealthy.

B. Intersex Advocacy: Genital Surgery Is Medically Unnecessary, Cosmetic, and Experimental

Unlike transsex identities that are portrayed in Medicaid litigation as a medicalized psychological condition, intersex conditions are characterized by current dominant medical standards as a physical anomaly that demand surgical intervention.

The practice of genital surgeries for "corrective" purposes has become, since the 1950s, a prominent course of treatment for intersexed in-

³⁴ *Id.* at 1155–56 ("This [holding] does not remove from the private physician the primary responsibility of determining what treatment should be made available to his patients.").

³⁵ *M.K. v. Div. of Med. Assistance & Health Servs.*, 92 N.J. Admin. 2d (DMA) 38 (May 7, 1992), 1992 WL 280789.

³⁶ See also *Dasti*, *supra* note 8, at 1764–68 (discussing this as a "backlash" in Medicaid litigation).

³⁷ *Smith v. Rasmussen*, 249 F.3d 755, 760 (8th Cir. 2001).

³⁸ This resulted in the removal of transexualism from *DSM-IV*, and its replacement with GID. See *supra* note 1.

fants. Current pediatric guidelines advise that, “[i]n full-term newborns the stretched penile length should measure at least 2 cm” (about one inch).³⁹ Because the size of male genitals and the potential for development are considered “of paramount importance when one is considering the male sex of rearing,”⁴⁰ if a newborn displays a penis that is *less than two centimeters* in length, “a trial of testosterone injections should be given in equivocal cases and the infant raised as a boy only when there is a very good response.”⁴¹ Accordingly, the guidelines instruct that “testes should be removed soon after birth in infants with partial androgen insensitivity or testicular dysgenesis in whom a very small penis mandates a female sex of rearing.”⁴² In other words, male genitals must be considered “adequate” in size to justify rearing a child as a boy.⁴³

This mode of treatment is based on a psychosocial gender identity theory, established in the 1950s, which alleges that gender identity is “fixed” early in life, and thus “standard” anatomy must match that gender identity to facilitate development.⁴⁴

While in intersex genetic males the focus is on the “adequate phallus,” in intersexed genetic females the guidelines prescribe the preservation of reproductive capabilities.⁴⁵ Alongside the significance of reproduction, guidelines advise that “infants raised as girls will usually require clitoral reduction.”⁴⁶ Medical standards do not allow clitorises larger than 0.9 centimeters at birth (about 3/8 of an inch).⁴⁷ An enlarged clitoris is typically reduced so that it will not look “masculine” or “offensive,” and vaginas are built or lengthened to enable intercourse involving average-sized penises.⁴⁸ Joined labia are separated, and various other surgical and hormonal treatments are applied to produce a fertile girl.⁴⁹

Adults who have undergone normalizing surgery as young children and their allies are often displeased with this forced medical intervention

³⁹ American Academy of Pediatrics, *Evaluation of the Newborn With Developmental Anomalies of the External Genitalia*, 106 PEDIATRICS 138, 139 (2000).

⁴⁰ *Id.* at 141.

⁴¹ *Id.*

⁴² *Id.*

⁴³ For a more detailed discussion of medical standards and evaluations of infant genitals, see SUZANNE J. KESSLER, LESSONS FROM THE INTERSEXED 33–52 (1998).

⁴⁴ This Article will elaborate further this theory. Academy of Pediatrics, *Timing of Elective Surgery on the Genitalia of Male Children with Particular Reference to the Risks, Benefits, and Psychological Effects of Surgery and Anesthesia*, 97 PEDIATRICS 590 (1996).

⁴⁵ American Academy of Pediatrics, *supra* note 39, at 141 (“All female infants virilized because of CAH or maternal androgens are potentially fertile and should therefore be raised as girls.”).

⁴⁶ *Id.*

⁴⁷ KESSLER, *supra* note 43, at 42–44. However, not all pediatric surgeons who treat intersex patients are aware of the guidelines regarding clitorises, and physicians tend to refer to the average clitoris size in food terminology, such as the size of a pea or a small bean. *Id.* at 43.

⁴⁸ Kate Newman et al., *The Surgical Management of Infants and Children with Ambiguous Genitalia*, 215 ANNALS OF SURGERY 644, 651 (1992).

⁴⁹ *Id.*

and, like transsex persons, they have set out to define and control their own futures. Determined that this surgery not happen to future intersex children, in 1993, Cheryl Chase founded the Intersex Society of North America (ISNA), a group dedicated to asserting intersex identities and halting genital surgery on intersexed infants and children.⁵⁰ ISNA's politics and legal attempts are the first and most visible political mobilization of intersex identities.⁵¹ ISNA's mission is to stop the current practice of early intersex genital surgeries to "end shame, secrecy, and unwanted genital surgeries for people born with an *anatomy* that someone decided is not standard for male or female."⁵²

ISNA's goal is the opposite of that of Medicaid litigants—to stop medical surgeries on intersex subjects. Thus, while the transsex double-edged sword described above produces a strategic legal argument for a medicalized transsex identity, ISNA attempts just the opposite—to *de-medicalize* intersex bodies in order to avoid early normalizing surgeries. Another way to understand these mirror claims of medical necessity (transsex) and non-necessity (intersex) of surgery and of attempts for medicalization (transsex) versus non medicalization (intersex) is that, while GID is presented as a *psychological disorder*, intersex is presented in medical literature as a *physical condition*.⁵³ ISNA and other intersex alliances are focused on the de-medicalization of a *physical* condition in order to stop surgeries and sex reassignment, while transsex advocacy for Medicaid coverage medicalizes a *psychological* condition in order to pursue surgeries and sex change.

In contrast to Medicaid advocacy that centers on a federal statute to provide for the medical needs of lower-income Americans, intersex anti-surgery litigation is premised on legal doctrines that regulate notions of bodily autonomy and the right to self-determination: international human rights law and the tort of battery.

The Convention on the Rights of the Child (CRC) is currently one of the main sources of international human rights used by opponents of early genital surgeries.⁵⁴ The CRC, entered into force on September 2, 1990, is

⁵⁰ Cheryl Chase, "Cultural Practice" or "Reconstructive Surgery"? *U.S. Genital Cutting, the Intersex Movement and Medical Double Standards*, in *GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD: DISPUTING U.S. POLEMICS* 126, 139 (Stanlie M. James & Claire C. Robertson eds., 2002).

⁵¹ Other organizations, such as *Bodies Like Ours*, have also emerged with goals such as peer support, elimination of early normalizing surgeries, and awareness about intersex issues. See *Bodies Like Ourselves*, Mission Statement, <http://www.bodieslikeours.org/content/view/16/73/> (last visited Oct. 27, 2005).

⁵² Intersex Society of North America, Our Mission, <http://www.isna.org/> (last visited Mar. 19, 2005); see also, e.g., Chase, *supra* note 50, at 128 ("[We] advocate that surgery need not be performed on children born with ambiguous genitals unless there is a medical reason (to prevent physical pain or illness) and that parents be given the conceptual tools and emotional support to accept their children's physical differences.").

⁵³ The definition of GID explicitly excludes intersex conditions which are conceived as physical. See *supra* note 19.

⁵⁴ Convention on the Rights of the Child, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/Res/44/25 (Nov. 20, 1989) [hereinafter CRC]. For general reli-

the first binding international instrument to recognize the human rights of children. To date, almost all countries have ratified the CRC, except two: the United States and Somalia.⁵⁵ It is considered “the most universally accepted human rights instrument in history.”⁵⁶

Article 12 of the CRC protects children’s rights to have their opinion taken into account in any matter affecting them, stressing that “[s]tates Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.”⁵⁷ Opponents of early surgeries rely on this article for the proposition that children have a universal right to participate in decision-making regarding all matters affecting them.⁵⁸

In addition, the “best interests” standard is set forth in Article 3 of CRC.⁵⁹ This is an “umbrella provision” invoked as a guiding principle in the interpretation of other provisions, which reads: “In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.”⁶⁰ Relying on this standard, opponents of early surgery have claimed that the “best interests” of a child are in no way synonymous with the fears of the child’s parents.⁶¹

Normalizing genital surgeries are also problematized through tort law, specifically by the doctrine of “informed consent.”⁶² The doctrine is an adjunct of the legal tort of battery. According to Restatement (Second) of Torts,

ance on the CRC as a source of the international human rights of children, see ISNA’s Amicus Brief on Intersex Genital Surgery, <http://www.isna.org/node/97> (last visited Nov. 20, 2005) [hereinafter ISNA Amicus Brief] (submitted to the Colombian Constitutional Court).

⁵⁵ United Nations Children’s Fund, Convention on the Rights of the Child: Introduction, <http://www.unicef.org/crc/crc.htm> (last visited Nov. 20, 2005).

⁵⁶ *Id.*

⁵⁷ CRC, *supra* note 54, art. 12, ¶ 1.

⁵⁸ See, e.g., the recent American Bar Association (ABA) proposal currently pending committee approval. Organisation Internationales des Intersexués, ABA Proposed Resolution, http://www.kindredspirittlakeside.homestead.com/P_ABA.html (last visited Nov. 20, 2005) [hereinafter ABA Proposed Resolution].

⁵⁹ CRC, *supra* note 54, art. 3, ¶ 1.

⁶⁰ *Id.*

⁶¹ See, e.g., ISNA Amicus Brief, *supra* note 54 (“[P]arents have considerable legal control over their children, but they do not have the right to disregard the child’s intrinsic human rights to privacy, dignity, autonomy, and physical integrity by altering a child’s genitals through irreversible surgeries based on an unproven and controversial psychosocial rationale.”).

⁶² The legitimacy of parental consent to intersex surgeries has not been litigated yet in the United States. One explanation for this is that usually no conflict exists between the treating physician’s recommendation and the decision of the parents, leaving no party with a stake in bringing the lawsuit to enjoin the surgery.

[A]n actor is subject to liability to another for battery if (a) he acts intending to cause a harmful or offensive contact with the person of the other or a third person, or an imminent apprehension of such a contact, and (b) an offensive contact with the person of the other directly or indirectly results.⁶³

The doctrine of informed consent applies battery to medical practitioners. If a medical practitioner obtains a person's consent to medical treatment without informing the patient of the nature of the treatment or the extent of the harm involved, the patient's consent is held not to be informed.⁶⁴ Thus, legal informed consent involves three criteria: the decision must be informed, voluntary, and competent.⁶⁵ A patient should be able to appreciate the nature, extent, and possible consequences of the medical procedure.⁶⁶ Because infants are generally considered incapable of providing informed consent for their own treatment at common law,⁶⁷ the doctrine of "parental consent" recognizes parents as the natural guardians of their child, best situated and able to make such decisions on a child's behalf.⁶⁸ This privilege is not absolute, though, and when parents make choices that are considered controversial or that may endanger a child under the "best interests" standard, courts may overrule such choices.⁶⁹

⁶³ RESTATEMENT (SECOND) OF TORTS § 18 (1965).

⁶⁴ RESTATEMENT (SECOND) OF TORTS § 892B (1979) ("If, to the knowledge of the surgeon, the patient was not aware of what he was consenting to and he was not consciously ignorant and ready to give consent to the surgeon to operate in any way he sees fit, then the patient's consent was induced by a substantial mistake and . . . is not effective.").

⁶⁵ *Id.*

⁶⁶ RESTATEMENT (SECOND) OF TORTS § 892A (1979).

⁶⁷ *Id.*; RESTATEMENT (SECOND) OF TORTS § 59 (1965).

⁶⁸ *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."). It is a common legal presumption that parents should be trusted to act upon their knowledge regarding what is best for a child. *See, e.g., Stanley v. Illinois*, 405 U.S. 645, 654-55 (1972) (requiring a hearing of fitness as a parent before the loss of custody of one's child); *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972) (allowing Amish parents to remove their children from the public education system); *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925) (upholding the discretion of the parents in the choice of schooling on the theory that "those who nurture [the child] and direct [the child's] destiny have the right, coupled with the high duty, to recognize and prepare [the child] for additional obligations"); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (upholding the rights of parents to direct the upbringing and education of their children).

⁶⁹ *See, e.g., Wisconsin v. Yoder*, 406 U.S. at 234 (holding that parental discretion may be challenged "if it appears that parental decisions will jeopardize the health and safety of the child, or have a potential for significant social burdens"); *In re Phillip B.*, 92 Cal. App. 3d 796, 801 (Cal. Ct. App. 1979) (upholding a parent's discretion to deny medical treatment for a child only after finding inconclusive evidence that the alternative would be in the best interests of the child).

Parental choices also are subject to limitations in the context of the sterilization of minor children. *See, e.g., In re C.D.M.*, 627 P.2d 607, 612 (Alaska 1981) (requiring that the sterilization is in the best interests of the child before it may be ordered); *In re Romero*, 790 P.2d 819, 822 (Colo. 1990) (allowing sterilization only after a showing that it is medically essential or in the patient's best interests); *In re Debra B.*, 495 A.2d 781, 783 (Me. 1985)

Intersex activists and supporters argue that, in the case of intersex infants, parents are placed in a hard position where their beliefs or fears may result in action that is not necessarily in their child's best interest.⁷⁰ Parents' fears are often exacerbated when they are given partial or no information about intersex conditions, and are counseled to act quickly in order to establish a sex for rearing that is unequivocal.⁷¹ Focusing on this parental lack of information, some solutions to the current situation emphasize the need for greater autonomy of parents in making the choice to consent to surgery, and the need for parents to be as knowledgeable as possible about intersex conditions,⁷² while others propose an absolute ban on any form of parental consent. These supporters of an absolute ban on parental consent warn that a heightened standard of parental consent may obscure the real issue at stake, which is that normalizing surgeries are not "medically necessary." They must therefore be approved by the individual patient, when mature enough to do so, and not by his or her parents, even when the parents are fully knowledgeable about the topic.⁷³

Whatever the conclusion, however, all current medical-social-legal resistance to early normalizing surgeries rises and falls on the proposition that early normalizing surgeries are not medically necessary—as opposed

(employing a best interests test to determine whether sterilization should be ordered).

⁷⁰ See, e.g., ISNA Amicus Brief, *supra* note 54 ("It is repugnant and contrary to a child's basic human rights to allow a parent to consent to medically unnecessary genital surgery for the purpose of dictating the child's future gender identity or of altering the child's body to conform to an idealized cultural notion of 'normal' genital appearance."); Hazel G. 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, 46 (2000) ("recommending prompt surgery based on the fear of parental rejection and failure to bond is premised more on medical opinion than fact").

⁷¹ See, e.g., ABA Proposed Resolution, *supra* note 58. For an extended discussion of five grounds for criticizing the consent obtained by some practitioners in these cases, see Beh & Diamond, *supra* note 70, at 42–58 ("(1) the false aura of urgency; (2) the failure to impart complete and accurate information; (3) the oppressive secrecy in which parents were advised to not discuss the situation with others and to particularly withhold all information from the child; (4) the failure of physicians to reveal the uncertainty of the outcome; and (5) the failure to account for the child's 'right to an open future' in the decisional calculation").

⁷² See, e.g., ABA Proposed Resolution, *supra* note 58 (suggesting a "midway" resolution that consists of a heightened standard of informed parental consent to genital-normalizing surgery performed on intersex infants).

⁷³ See, e.g., Alice D. Dreger, *A History of Intersexuality: From the Age of Gonads to the Age of Consent*, 9 J. CLINICAL ETHICS 345, 352 (1998) ("Intersexed people have their autonomy violated because their doctors and parents are allowed to make decisions about how their genitals should look."); Bruce E. Wilson & William G. Reiner, *Management of Intersex: A Shifting Paradigm*, 9 J. CLINICAL ETHICS 360, 364 (1998) ("The right of the individual to determine what happens to his or her body has been increasingly asserted," and surgery should be delayed "until we can take into account the affected individual's determination of his or her own gender."); Alyssa C. Lareau, *Who Decides? Genital-Normalizing Surgery on Intersexed Infants*, 92 GEO. L.J. 129, 151 (2003) (concluding that "[t]he current inability of the medical community to differentiate between truly medically-necessary surgery and surgery performed for social and psychological reasons renders even fully-informed parents unable to consent to irreversible and unnecessary cosmetic genital surgery").

to transsex legal claims for Medicaid coverage that rise and fall on the proposition that sex change surgery is absolutely medically necessary. The narratives of ISNA and other opponents to surgeries will be closely examined here to study this claim for the non-necessity of intersex sex change surgeries.

ISNA offers a definition of intersex as an anatomical condition and a biological variation. For ISNA and its medical allies, intersex is an *anatomical condition*, which is “neither a medical nor a social pathology”: “Intersex is a relatively common anatomical variation from the ‘standard’ male and female types; just as skin and hair color vary along a wide spectrum, so does sexual and reproductive anatomy.”⁷⁴

Along these lines, sex researchers Milton Diamond and Keith Sigmundson, who oppose early normalizing surgeries, offer a similar medical perspective: “Persons with these genitalia are not freaks *but biological varieties commonly referred to as intersexes*. Indeed, it is our understanding of natural diversity that a wide offering of sex types and associated origins should be anticipated. Our overall theme is to destigmatize the conditions.”⁷⁵

Is intersex, as a “variety,” somehow a third sex or gender? The Constitutional Court of Colombia reached out to ISNA to address this issue.⁷⁶

⁷⁴ Alice Dreger, *Shifting the Paradigm of Intersex Treatment*, <http://www.isna.org/compare/> (last visited Nov. 20, 2005).

⁷⁵ Milton Diamond & Keith Sigmundson, *Management of Intersexuality: Guidelines for Dealing with Persons with Ambiguous Genitalia*, 151 ARCHIVES PEDIATRIC & ADOLESCENT MED. 1046, 1046 (1997) (emphasis added).

⁷⁶ The context of ISNA's involvement with the Colombian Constitutional Court involves a series of decisions in the second half of the 1990s in which the Colombian Constitutional Court articulated a critical position toward the current management of intersexuality. ISNA activists used the forum to draft and submit a position to articulate their opposition to intersex surgeries. In 1995, a young, male-identified petitioner, whose penis was accidentally harmed at infancy, petitioned the Colombian Constitutional Court, contesting his past childhood feminine gender assignment, which was followed by surgical sex reassignment. The petitioner alleged that despite the gender assignment through surgical means, he had never developed a female “gender identity.” The court ruled in favor of the petitioner and held that there are certain circumstances where parents cannot consent to genital surgeries on a child. This ruling placed Colombian surgeons specializing in intersexuality in a complicated position where they continued to recommend surgeries to parents of intersexed children, but as a consequence of the court's holding on parental consent, they refused to perform the actual surgeries in fear of legal disobedience. Several years later, this situation led to the filing of two lawsuits by the parents of two children, requesting that the Constitutional Court of Colombia approve genital normalizing surgeries. The court once again invalidated parental consent, recognizing that: (1) intersexed people constitute a minority entitled to protection by the state against discrimination; (2) “corrective” surgery may be a violation of autonomy and bodily integrity motivated by the intolerance of parents toward their children's anatomy; (3) parents are likely to make decisions based upon their own fears and concerns rather than what is best for the child, especially if they are pressed to decide quickly; (4) a new standard of consent, “qualified, persistent informed consent,” must be adopted in order to force parental decisions to take into account only the child's interest; and (5) for children over five years old, parents cannot consent, because the child has achieved an autonomy that must be respected, and because the child has already developed a gender identity. Thus, the consent of the parents of an eight-year

Specifically, a judge asked ISNA for a landmark article by Anne Fausto-Sterling entitled, *The Five Sexes*, in which Fausto-Sterling argued that there are not two, but five or more biological sexes:

If the state and the legal system have an interest in maintaining a two-party sexual system, they are in defiance of nature. For biologically speaking, there are many gradations running from female to male; and depending on how one calls the shots, one can argue that along that spectrum lie at least five sexes—and perhaps even more.⁷⁷

Interestingly, Cheryl Chase, the founder and, at the time, the executive director of ISNA, replied to the judge, in an amicus brief filed by ISNA, that intersex is not a third sex or gender but only *biological* variety:

I have enclosed that article, but I would like to emphasize that . . . neither *Dr. Fausto-Sterling* nor *I* nor *ISNA* is suggesting that there are actually five sexes. Dr. Fausto-Sterling and ISNA support the recommendations of (Diamond and Sigmundson 1997b). In the current case [genetic female with an atypically large clitoris], those recommendations indicate that the child should continue to be raised as a girl, but that no genital surgery be done unless at her own initiative and with her informed consent.⁷⁸

Intersex identities, according to this narrative, do not exist beyond the male-female binary. While at first glance it does not seem that there is much of a difference between “variation” and “third sex/gender,” the presentation of intersex as a “variation” and not as a third sex or gender is situated at the core of ISNA’s articulated position regarding why early intersex surgery is not medically necessary, and is therefore cosmetic,⁷⁹ elective,⁸⁰ and experimental.⁸¹

old was invalidated by the court because the child was too old for a surrogate to consent on her behalf. The Columbian Constitutional Court decisions are summarized on the ISNA’s website. Julie A. Greenberg & Cheryl Chase, Intersex Society of North America, Background of Columbia Decisions, <http://www.isna.org/node/21> (last visited Nov. 27, 2005).

⁷⁷ Anne Fausto-Sterling, *The Five Sexes, Revisited*, 40 THE SCIENCES 18, 21 (2000). In revisiting her article in 2000, Fausto-Sterling accepted critique of her five sex classification as giving priority to genitals, and agreed that it would be better for intersex people and their supporters to “turn everyone’s focus away from genitals” and to acknowledge that people come in a wide assortment of sexual identities and characteristics than mere genitals can distinguish. *Id.* at 22.

⁷⁸ ISNA Amicus Brief, *supra* note 54 (emphasis added).

⁷⁹ *Id.* (“We argue . . . that only the child has the right to make decisions regarding her sexual identity and cosmetic genital surgery.”).

⁸⁰ See, e.g., ABA Proposed Resolution, *supra* note 58 (“Allowing doctors to perform elective surgery that may result in involuntary sterilization violates the child’s fundamental right to privacy.”).

⁸¹ See, e.g., ISNA Amicus Brief, *supra* note 54 (“Although these surgeries have been

The argument for the experimental nature of the procedure relies heavily on the argument that there is currently a lack of data regarding medical outcomes and therefore a possibility of “mistakes” in assignment. ISNA and allies have asserted that no significant data has been collected on long-term “outcomes” of these assignments, and that this makes normalizing surgery *experimental* by nature.⁸² In the context addressed in the amicus brief filed to the Constitutional Court of Colombia—a six-year-old genetic female whose parents and doctors requested clitoral reduction and vaginoplasty—ISNA stated:

There is no guarantee that the child will have a female gender identity as an adult. As discussed above, a significant fraction of children with her specific medical condition and history have a male gender identity as adults. If the child grows up to have a male gender identity, then the surgeries that the doctors seek to perform will have been a *terrible mistake*.⁸³

The term “terrible mistake” here anticipates possible “bad outcomes.” The main assumption here appears to be that a “good outcome” is a match between body and “identity” and a “bad outcome” is a mismatch between the two.

By far the most well-known example of such a “mistake” is the case of David Reimer, also known as the John/Joan case. In that case, a genetic male was raised as a girl in the late 1960s after a traumatic surgical loss of penis at infancy. While the feminine reassignment of John/Joan was initially reported in the literature as a success,⁸⁴ sex researchers Diamond and Sigmundson later claimed that John/Joan’s reassignment in fact failed when in adolescence John/Joan transitioned from female to male.⁸⁵ At the time of the critical “exposure,” David Reimer (John/Joan) was living as a young man in his thirties, had married a woman, and had adopted her chil-

performed for many years with numerous refinements of technique and are considered by many surgeons to be standard practice, in pragmatic terms they should be considered experimental techniques which must not be imposed without the patient’s fully informed consent.”).

⁸² See, e.g., *id.* (“The belief that these surgeries provide any benefit at all is speculative and unexamined. Given the clear risk of harm, the Court is obligated to protect the child’s human rights by declining to approve the surgery.”); Beh & Diamond, *supra* note 70, at 57 (“The assurances that counselors were urged to convey concerning the effectiveness and foundation of the treatment were not accurate because the only experience which clinicians could report was actually drawn from anecdotal and incomplete case reports that were appearing in the medical literature.”).

⁸³ ISNA Amicus Brief, *supra* note 54 (emphasis added).

⁸⁴ JOHN MONEY & ANKE EHRHARDT, MAN & WOMAN, BOY & GIRL: THE DIFFERENTIATION AND DIMORPHISM OF GENDER IDENTITY FROM CONCEPTION TO MATURITY 118–23 (1972).

⁸⁵ See Milton Diamond & Keith Sigmundson, *Sex Reassignment at Birth: A Long Term Review and Clinical Implications*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 298 (1997).

dren. David Reimer's story became known nationally and worldwide when his biography, *As Nature Made Him*,⁸⁶ was published. In 2004, David Reimer took his own life.⁸⁷ ISNA and others frequently cite this case as an example of potential "mistakes" in sex assignment.⁸⁸

Others, however, have critiqued the trend of presenting John/Joan as medical proof of inherent biological differences between the sexes.⁸⁹ This representation of the John/Joan case as a "mistake" signifies a conceptual marriage of sex and gender: if sex and gender do not match, the assignment is conceived as a "mistake." But even more disturbingly, this rhetoric presents current surgical practices as wrong not because they violate human liberty and the right to self-determination, but because surgery is perceived as wrong because doctors may simply *get it wrong*, and eventually may create a transsexual situation where sex and gender do not match. But does this mean that, if theoretically doctors could always get it "right," intersex subjects' claims for liberty and choice would no longer be relevant? If so, are these liberal rights simply masks for a different scientific theory (the "biological centered" theory offered by Diamond, Sigmundson, Reimer, and others) that will allegedly produce "good outcomes"?

This links back to the presentation of intersex as a variation and not as a third sex or gender, which is the lynchpin to ISNA's explanation of early normalizing surgery as an experiment that is cosmetic and not necessary. The classification of intersex as a "variation" on the two sexes enables a dichotomy of good and bad outcomes. For instance, when the John/Joan case is used by ISNA and Diamond to demonstrate a "bad outcome" (because of a mismatch between genitals and gender) a "good outcome," therefore, must be a correspondence of male genitals to male genders and female genitals to female genders. An idea of a third, fourth, or fifth sex/gender

⁸⁶ JOHN COLAPINTO, *AS NATURE MADE HIM: THE BOY WHO WAS RAISED AS A GIRL* (2000).

⁸⁷ Obituary, *David Reimer*, 38, *Subject of the John/Joan Case*, N.Y. TIMES, May 12, 2004, at A21.

⁸⁸ See, e.g., ISNA Amicus Brief, *supra* note 54 ("Worldwide medical thinking about surgical management of intersexuality has been strongly influenced by a case in which a boy whose penis was accidentally destroyed during circumcision, and who after being surgically assigned and raised female. . . . The patient now lives once again as a man, and reconsideration of this case is causing experts to assert that early genital surgery requires the informed consent of the patient.").

⁸⁹ See, e.g., Judith Butler, *Doing Justice to Someone: Sex Reassignment and Allegories of Transsexuality*, 7.4 GLQ: J. LESBIAN & GAY STUD. 621, 628 (2001) (analyzing John/Joan's personal post-transition narrative, and suggesting that, paradoxically, "to return to who he is, he requires—and wants, and gets—a subjection to hormones and surgery. He allegorizes transsexuality to achieve a sense of naturalness. And this transformation is applauded by the endocrinologists on the case, since they understand his appearance now to be in accord with an inner truth. Whereas Money's institute enlists transsexuals to instruct Joan in the ways of women, and *in the name of normalization*, the endocrinologists prescribe the sex change protocol of transsexuality to John for him to reassume his genetic destiny, *in the name of nature*.").

cannot fit with this notion of a “good outcome” that depends on male-female, man-woman binaries.

Despite making the argument that sex assignment is cosmetic, elective, medically unnecessary, and experimental, ISNA does *not* make a similar argument regarding early *gender* assignment. Everyone, according to ISNA, should be raised with masculine or feminine gender. Thus ISNA’s published narratives adhere to a distinction between sex and gender, explaining that despite ISNA’s objection to surgeries (the alteration of “sex”), intersex children, for their sense of comfort, should be raised as either girls or boys, and not as a third sex.⁹⁰ A third sex or gender would not allow for a “good outcome,” thereby reinforcing the male-female binary. ISNA relies on the following guidelines published by sex researchers Diamond and Sigmundson:

In rearing, parents must be consistent in seeing their child as either a boy or girl; not neuter. In our society intersex is a designation of medical fact but not yet a commonly accepted social designation. With age and experience, however, an increasing number of hermaphroditic and pseudohermaphroditic persons are adopting this identification. In any case, advise parents to allow their child free expression as to choices in toy selection, game preference, friend association, future aspirations, and so forth.⁹¹

This approach provides a “scientific” justification for the sex/gender distinction in the assignment of intersex subjects (i.e., that sex assignment should be legally banned because it is not medically necessary, but gender assignment is nonetheless socially necessary). Intersex in this text is a medical condition but not a kind of sex or gender because it is not yet accepted as such.

Adopting this approach, Alice Dreger, ISNA’s current Executive Director, recently described ISNA’s suggested “patient centered model” as follows:

This approach does *not* advocate selecting a third or ambiguous gender. The child is assigned a female or male gender but only *after* tests (hormonal, genetic, diagnostic) have been done We advocate assigning a male or female gender because intersex is not, and will never be, a discrete biological category any more

⁹⁰ See, e.g., Chase, *supra* note 50, at 137. (“We also advocate that children be raised either as boys or girls, according to which designation seems likely to offer the child the greatest future sense of comfort.”); Dreger, *supra* note 74 (“This approach does *not* advocate selecting a third or ambiguous gender.”).

⁹¹ Diamond & Sigmundson, *supra* note 75, at 1047–48.

than male or female is, and because assigning an “intersexed” gender would unnecessarily traumatize the child.⁹²

ISNA’s stance here follows that of sex researchers Diamond and Sigmundson. Sex assignment will be based on the highest probability of the child’s future gender, which is allegedly based on the child’s *hormonal and genetic diagnosis*.⁹³ This will lead to the much desired outcome—female girls and male boys.

ISNA’s “patient-centered model” supports the assignment of the intersex infant to one of the only two existing genders. At the same time, ISNA courageously challenges the necessity of a “normal” body, claiming that there is no need for a child to have “normal” genitals. But following the same logic, what gives society justification to assign a gender to the intersex child (or to any child)? Why would it be more traumatic to grow up as a third gender—or with no gender—than it would be to grow up as a boy or a girl? Under what justification is gender presented as a necessary category at the same time that sex is presented as an unnecessary category?

In summary, ISNA focuses on the body as the site of regulation, while also presenting a disturbing neutrality regarding “gender.” Gender is theorized by ISNA as a natural thing that one must have as a condition for intelligibility. Judith Butler has recently implied this same critique of intersex politics, but chose to dismiss it:

It does not follow, therefore, that queer theory would oppose all gender assignment or cast doubt on the desires of those who wish to secure such assignments for intersex children. . . . [T]he perfectly reasonable assumption here is that children do not need to take on the burden of being heroes for a movement without first assenting to such a role. In this sense, categorization has its place and cannot be reduced to forms of anatomical essentialism.⁹⁴

What Butler suggests here is that, because almost all children in society today are assigned a gender at birth according to the traditional reading of their genitals, the choice not to have a gender or to have a third gender cannot be made for a child. Instead, the child should get a gender like everybody else. Butler’s reason for this is that “being heroes for a movement” is a burden, a role to which one must assent.⁹⁵

Although Butler’s position makes intuitive sense, it relies on difficult reasoning. The Supreme Court faced a comparable dilemma in the 1980s

⁹² Dreger, *supra* note 74 (emphasis in original).

⁹³ *Id.*

⁹⁴ BUTLER, *supra* note 3, at 7–8.

⁹⁵ *Id.*

in *Palmore v. Sidoti*.⁹⁶ When a Caucasian mother cohabited with a “black” partner, the child’s Caucasian biological father sued to have the child removed from the home claiming that the child would probably be ostracized for being raised in an interracial household. A Florida trial court had awarded custody to the father, concluding that child’s best interests would be served thereby, and the Florida District Court of Appeal affirmed.⁹⁷ The Supreme Court reversed.⁹⁸ The Court acknowledged that the child probably would be raised under circumstances *different* from that of other children,⁹⁹ but nonetheless, cultural biases could not justify the use of official state force:

The question, however, is whether the reality of private biases and the possible injury they might inflict are permissible considerations for removal of an infant child from the custody of its natural mother. We have little difficulty concluding that they are not Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect.¹⁰⁰

It seems that Butler views the possibility of not assigning a gender to a child (or assigning a third or an intersex gender) as a possible source of social ostracism.¹⁰¹ But this same reasoning is used by John Money and others to justify intersex surgery: the child will adjust better to the environment with “normal” looking genitals than with genitals that are unintelligible.¹⁰² Therefore, challenging sex assignment while using the same logic to justify gender assignment deserves rethinking. If children need not be “heroes for a movement,” one may argue, like Money, that there is still a claim for “corrective” surgery, so that children will not be traumatically different from their peers. In summary, ISNA and others preserve the masculine-feminine binary in the realm of gender, while challenging “sex” with the concept of “variety.”

C. A Critique of the Analogy of Intersex Surgery to African Female Genital Circumcision

An additional binary inherent in contemporary intersex politics involves “first world/third world” perspectives on genital surgeries. The attempt to compare intersex surgeries to a practice of some African traditions known as female genital mutilation (FGM) has become a common

⁹⁶ *Palmore v. Sidoti*, 466 U.S. 429 (1984).

⁹⁷ *Id.* at 429.

⁹⁸ *Id.*

⁹⁹ *Id.* at 433.

¹⁰⁰ *Id.*

¹⁰¹ BUTLER, *supra* note 3, at 7–8.

¹⁰² See, e.g., American Academy of Pediatrics, *supra* note 39, at 141–42.

way of portraying the harms of intersex. However, the disparate contexts of these two practices and their regulation in western societies make this comparison problematic.

In 1997, members of ISNA lobbied in Congress for inclusion of intersex as a protected category under a new federal statutory ban of FGM, claiming that the legislation should not only ban practices imported from other cultures but also American medicalized “mutilation” of intersex infants.¹⁰³ To emphasize the likeness of intersex surgeries and female genital mutilation, ISNA’s press releases in 1997 started referring to intersex surgeries as Intersex Genital Mutilation.¹⁰⁴ But while anti-excision African immigrant women within the United States were receptive to such claims, most western feminists excluded intersex surgeries from global campaigns, drawing a distinction between the “social problem” of female circumcision and the “medical problem” of intersex surgeries.¹⁰⁵

This legislative attempt to analogize intersex surgery to female genital circumcisions failed. As of today, intersex surgeries are arguably still allowed under the anti-FGM statute as cases of “medical necessity.” The statute reads in relevant parts:

(a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or clitoris of another person, who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both.

(b) A surgical operation is not a violation of this section if the operation is—

(1) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner

(c) *In applying sub-section (b)(1) no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual.*¹⁰⁶

Throughout the 1990s, eurocentric discourses of western feminists launched a universal attack on female circumcision, which in the United States and in large parts of the western world ended in a sweeping crimi-

¹⁰³ Natalie Angier, *New Debate over Surgery on Genitals*, N.Y. TIMES, May 13, 1997, at B7; Anne Scheck, *Intersexuality Takes a Conservative Turn*, UROLOGY TIMES, Feb. 1, 1998, at 32–33.

¹⁰⁴ See, e.g., David Tuller, “Intersexuals” Begin to Speak Out on Infant Genital Operations: Surgery Amounts to Mutilation, Some Contend, S.F. CHRON., June 21, 1997, at A15.

¹⁰⁵ Chase, *supra* note 50, at 141 (citing a private correspondence from 1994 with Fran P. Hosken, the author of *The Hosken Report: Genital and Sexual Mutilations of Females*, explaining that “we are not concerned with biological exceptions”).

¹⁰⁶ 18 U.S.C. § 116 (Supp. III 1997) (emphasis added).

nalization of all kinds of female circumcision. Contemporary post-colonial critique of such anti-FGM campaigns has underscored the stereotypical representations of female circumcision by white, liberal, feminist, western discourses that have ignored or belittled the actual experiences of African women and men who support the surgery or have more complex views on the topic.¹⁰⁷

There is an additional marginalization produced by this anti-FGM activism: the isolation and marginalization of intersex subjects through a distinction between "science" and "culture." The statute focuses on banning "cultural" genital surgeries while carefully leaving other surgeries out of the scope of the "cultural." Because "cultural" ignorance is, according to Congress, offensive both to human rights *and* to health,¹⁰⁸ "the practice of female genital mutilation can be prohibited *without abridging the exercise of any rights guaranteed under the first amendment* to the Constitution or under any other law."¹⁰⁹ Unlike "medical" practices such as intersex diagnoses which allegedly make surgery necessary, according to Congress, "cultural" practices *cannot* justify genital surgeries.¹¹⁰

The science-culture distinction in this case can be problematized from both ends of the dichotomy. First, as some post-colonial feminists have pointed out, any culture deserves more attention and less stereotyping before it is ostracized, outlawed, and banned.¹¹¹ Second, scientific theories about gender also deserve special attention and cannot be taken as objective, uncontested facts. In fact, the next Parts demonstrate that intersex surgeries are highly contested by some scientists, and medical-scientific gender theories are far from settled. Thus, the federal anti-FGM statute and the specific

¹⁰⁷ For post-colonial critique of anti-FGM feminist discourses, see, for example, Isabelle Gunning, *Global Feminism at the Local Level: Criminal and Asylum Laws Regarding Female Genital Surgeries*, 3 J. GENDER RACE & JUST. 45, 61 (1999) (concluding that domestic legal implementations of human rights norms must go beyond mere symbolism and must include conscious efforts to improve the lives of the women who are most in need); Rogaia M. Abusharaf, *Virtuous Cuts: Female Genital Circumcision in an African Ontology*, 12.1 DIFFERENCES: J. FEMINIST CULTURAL STUD. 112, 137 (2001) (concluding that "elucidating women's perspectives within societies rather than criminalizing them is not only a pressing political issue, but also the only strategy for the formulation of a sound anti-circumcision policy in the new millennium"); Claire C. Robertson, *Getting Beyond the Ew! Factor: Rethinking U.S. Approaches to African Genital Cutting*, in GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD: DISPUTING U.S. POLEMICS, *supra* note 50, at 54 (critiquing the criminalization and sensationalized western media campaigns against FGM, and suggesting that local and international NGOs should pay more attention to African women's general wellbeing and empower activists in African societies who have the actual capability of changing the practice of female genital cutting from within).

¹⁰⁸ Female Genital Mutilation Act of 1996, Pub. L. No. 104-208, 110 Stat. 3009-709 (codified at 18 U.S.C. § 116) ("[T]he Congress finds that . . . (2) the practice of female genital mutilation often results in the occurrence of physical and psychological health effects that harm the women involved; (3) such mutilation infringes upon the guarantees of rights secured by Federal and State law, both statutory and constitutional.").

¹⁰⁹ *Id.*

¹¹⁰ See *id.* ("Congress finds that . . . the practice of female genital mutilation is carried out by members of certain cultural and religious groups within the United States.").

¹¹¹ See, e.g., sources cited *supra* note 107.

universal feminist politics that led to it are exposed to both post-colonial and queer critique for their trivialization of “culture” and “science.”

This critique leads to a concern at the level of intersex politics and strategy. Given the problematization of anti-FGM agendas, is it strategically wise to attempt inclusion in these politics? Do advocates want to enter these specific politics of complete marginalization of African traditions in an attempt to de-subjugate intersex subjects? Some legal scholars and intersex activists have followed the tempting analogy of female circumcision and intersex surgeries, arguing that if the former has been successfully outlawed, the latter should be as well.¹¹² But this analogy may be wrong, both strategically and ethically. Strategically, it may shift the focus from the social-legal, historical shaping of intersex identities by western medical institutions to the demonized African practice of female circumcision. These two types of genital surgeries are exceptionally different in time, place, and ideology, and their merger in legal strategy erases these crucial differences. Furthermore, there is an ethical concern when group projects of de-subjugation undercut each other. Thus, intersex politics that is insensitive to the western normalization of non-western African traditions exchanges one social harm for another harm.

While the use of anti-FGM rhetoric in intersex politics is problematic, *male* genital surgeries theoretically may be a more useful analogy to intersex surgeries. The history of male circumcision, like that of intersex surgeries, is intimately tied with the changing social role of the medical profession in the nineteenth century:

During the last decades of the nineteenth and the first decades of the twentieth centuries, a remarkable shift occurred in the English-speaking world [cite omitted]. Physicians acting as norm entrepreneurs reconceived the phallus [cite omitted]. They portrayed the uncircumcised penis as polluted, unnatural, harmful, alien, effeminized and disfigured, and depicted circumcision as true, orderly, and good. In a remarkably brief period of time, circumcision became ubiquitous: first as a remedy for disease, and later as a prophylactic procedure administered within a few days of birth [cite omitted]. American society reached a “tipping point,” at which the movement towards circumcision gained momentum and became nearly universal [cite omitted]. In 1977, circumcision was the most common operation performed on males in the United States [cite omitted]. It is still performed on approximately six out

¹¹² See, e.g., Beh & Diamond, *supra* note 70, at 21–22; Chase, *supra* note 50, at 140–46; Alice D. Dreger, “*Ambiguous Sex*”—or *Ambivalent Medicine?*: *Ethical Issues in the Treatment of Intersexuality*, 28 HASTINGS CENTER REP. 24, 24–36 (1998) (“Just as we find it necessary to protect the rights and well-being of African girls, we must now consider the hard questions of the rights and well-being of children born intersexed in the United States.”).

of every ten infant boys in this country [cite omitted]. The triumph of circumcision continued even after its original rationales—detering masturbation and spermatorrhoea (wet dreams) and treating miscellaneous other disorders—were discredited [cite omitted]. Other purposes were supplied to make up for the deficit: circumcision was said to protect against penile cancer and urinary tract infections, and, lately, to reduce the risk of HIV infection [cite omitted].¹¹³

Today's opponents of intersex and male early genital surgeries are up against western medical-cultural practices that developed in the nineteenth and twentieth centuries. Like intersex advocates, male circumcision opponents offer medical data to support the proposition that male circumcision is *not* medically necessary, arguing that it is merely cultural and should not be forced upon the infant.¹¹⁴ The anti-surgery movements make parallel moves: in order to challenge a medical-cultural practice that is harmful to the group members, both movements try to demonstrate that the genital surgery is in fact *more cultural than medical*, while the opponents claim the opposite.

Like ISNA's attempt to join anti-FGM politics, male circumcision opponents have also attempted inclusion in this statutory ban via equal protection litigation to challenge the FGM statute. The claim alleged that the statute unfairly denies the equal protection of male infants under the law. But so far courts have been unwilling to address this disparity, and the challenges have been dismissed for lack of standing. For example, in *Fishbeck v. State of North Dakota*, plaintiffs brought action against the state of North Dakota, alleging that the statute criminalizing female, but not male, circumcision violated the Equal Protection Clause.¹¹⁵ The Court of Appeals for the Eighth Circuit dismissed the case for lack of standing of all plaintiffs, including a mother whose baby son was circumcised despite her refusal (based on the consent of the child's father).¹¹⁶ The court explained:

Still, we do not see that the plaintiff Fishbeck has standing to invoke the federal judicial process. The injury that her son has received, if it is an injury, is in the past. Nothing that happens in this lawsuit can change it. Similarly, there is no measurable likelihood that the situation will recur in the future. It is always pos-

¹¹³ Geoffrey P. Miller, *Circumcision: Cultural-Legal Analysis*, 9 VA. J. SOC. POL'Y & L. 497, 501 (2002).

¹¹⁴ Male circumcision opponents contend that the original diseases and conditions for which circumcision was recommended at the end of the nineteenth century are in fact either not harmful, or if harmful, have nothing to do with circumcision. See *id.* at 558–59.

¹¹⁵ *Fishbeck v. North Dakota*, 115 F.3d 580 (8th Cir. 1997).

¹¹⁶ *Id.* at 580–81.

sible that Fishbeck will have another child, that the child will be male, that the father will again wish the child to be circumcised, and that the mother will, for some reason, be unable to prevent the procedure. The likelihood of these events' occurring, however, is completely speculative. There is no way to predict that they will occur, and no way to assess the likelihood of such an occurrence. Accordingly, this case must be dismissed for lack of standing.¹¹⁷

Similarly, a recent equal protection challenge of male circumcision was dismissed by the Supreme Court of North Dakota for lack of standing, with slightly different reasoning:

Although the statute may prohibit minor females from having their genital tissue surgically altered, the statute has not burdened or injured [circumcised minor] Flatt in the sense that would confer standing on him. Flatt was circumcised because, through Anita Flatt, he consented to the procedure, and he has not demonstrated his circumcision resulted from the statute. We conclude Flatt lacks standing to challenge the constitutionality of N.D.C.C. § 12.1-36-01.¹¹⁸

In the dismissal of a substantive discussion of these equal protection claims, two distinctions emerged to justify lack of standing for plaintiffs. First, circumcision that happened in the past cannot be undone, and therefore no remedy exists for the plaintiff. Second, the law banning female circumcision does not *directly* harm or burden males. Accordingly, if the anti-female circumcision statute does not order an assault on the male body, it cannot be deemed to wrongfully discriminate against a male plaintiff. In other words, if a statute harms one by *not* protecting them from surgery, the standing requirement is not satisfied, and the law offers no assistance.

Both male and intersex anti-genital cutting movements confront western practices of intersex and male surgeries by actively negotiating the medical-health narratives, by claiming and showing actual ("objective") physical harm, and by claiming that, in fact, science and medicine are on their side. Taking a critical approach to this strong reliance on medical theories, the final Part of this Article will suggest that, at least in cases of gender regulation—where scientific expertise is in a state of uncertainty— notions of individual choice and liberty that are not absolutely dependant on scientific proof can and should be attempted.

In summary, the litigation strategies of intersex and transsex movements offer distinct interpretations of the terms "medical necessity," "cos-

¹¹⁷ *Id.* at 581.

¹¹⁸ Flatt v. Kantak, 687 N.W.2d 208, 225 (N.D. 2004).

metic surgery,” and “medical experiments.” In intersex activism, these terms, together with notions of choice and autonomy, justify a call for a moratorium or heightened consent on the practice of early genital surgeries, while in transsex Medicaid litigation these same terms are utilized in the argument for a federal right to state-subsidized sex reassignment surgeries. The following Part discusses the historical background from which these mirroring arguments regarding the necessity of transsex surgeries and the non-necessity of intersex surgeries emerged.

II. THE DEVELOPMENT OF TRANSSEX AND INTERSEX IDENTITIES IN TWENTIETH-CENTURY UNITED STATES

The histories of transsex and intersex identities in the twentieth century are intertwined. In the United States, they are both connected to the concept of a gendered inner-self that appeared in the second half of the twentieth century to explain sex behavior through a theory of immutable gender identity. Through the study of intersexuality, scientists adopted a concept of “psychological sex.” The new theory about sex supposed that an adult’s “psychological sex” could not be changed, unlike the bodies of transsexuals, which could be changed surgically. Psychological sex was later labeled “gender role and orientation” and “gender identity.”¹¹⁹

A. *The Shaping of Transsex Identities in the Twentieth Century*

In 1952, the American press discovered the sex change surgery of Christine Jorgensen. Jorgensen, born and raised in the Bronx as a boy, struggled for years with what she described as a yearning to live as a woman. In 1950, she sailed to Europe in search of a doctor who would alter her physical sex.¹²⁰ According to historian Joanne Meyerowitz, “in the history of sex change in the United States, the reporting on Jorgensen served as both a culminating episode and a starting point.”¹²¹ In the post-war era, when science, gender, and sexuality were gaining increased attention, Jorgensen embodied the question of what makes us man or woman.

Only after World War II did American doctors and scientists address the issue of sex change. Psychiatrist David O. Cauldwell used the term “transsexual” for the first time in 1949 to refer to individuals who desire to change sex.¹²² After the case of Jorgensen became known and publicized, Harry Benjamin, an endocrinologist, publicized the term and the

¹¹⁹ For a comprehensive historical background on the development of the term gender, see JOANNE MEYEROWITZ, *HOW SEX CHANGED: A HISTORY OF TRANSEXUALITY IN THE UNITED STATES* 98–130 (2002).

¹²⁰ *Id.* at 1 (citing *Ex-Girl Becomes Blonde Beauty*, N.Y. DAILY NEWS, Dec. 1, 1952, at 1).

¹²¹ *Id.* at 49.

¹²² *Id.* at 5.

condition. Hundreds of individuals then tried to convince doctors to recommend or perform surgery, but they encountered doctors who insisted on their own authority to define sex and gender.¹²³ From that point on, doctors and scientists debated the explanatory powers of biology and psychology. These debates underlie the current legal alliances of transsex and intersex strategies.

In the 1960s, the years of the “sexual revolution,” American culture was influenced by more liberal attitudes and by a strong human rights movement that insisted on social change. Doctors who worked with transsexuals organized into networks, clinics, and associations, and at the same time, transsex identified individuals started organizing as a minority group for the support and articulation of legal rights.¹²⁴ Doctors differentiated transexuality from other sex categories, and transsexuals distinguished themselves from other sexual and gender minorities.¹²⁵ While doctors were busy elaborating on different diagnoses of scientific classifications of sexuality, their patients insisted on the right to determine their own sex and gender. By the end of the 1960s, transsexuals persuaded a few doctors to make their bodies accord with their minds.¹²⁶

By the mid 1970s doctors increased their authority over transsex subjects. In 1974, at the Fourth International Symposium on Gender Identity, committees were appointed to draft guidelines to serve as medical standards for diagnosis and treatment of transsexuals.¹²⁷ In 1979, physicians, therapists, and researchers who worked with transsexuals formed a professional organization called the Harry Benjamin International Gender Dysphoria Association (HBIGDA). The members gave official standardized criteria for diagnosis and treatment.¹²⁸ In addition, in 1980, transexualism for the first time appeared as a disorder in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.¹²⁹

While in the 1980s liberal doctors had less influence on courts,¹³⁰ the 1990s saw the rise of strong transgender activism and alliances, which allowed a range of transdiscourses to emerge and challenge medical control of these discourses. Jason Cromwell writes:

¹²³ *Id.* at 6.

¹²⁴ *Id.* at 207.

¹²⁵ *Id.*

¹²⁶ *Id.* at 167.

¹²⁷ *Id.* at 254.

¹²⁸ For a current version of the HBIGDA standards of care, see Walter Meyer III et al., *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version*, 13 J. PSYCHOL. & HUM. SEXUALITY 1 (2001), available at <http://www.hbigda.org/soc.htm>.

¹²⁹ TASK FORCE ON DSM-III, AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 261–64 (3d ed. 1980).

¹³⁰ See Richard Green, *Spelling “Relief” for Transsexuals: Employment Discrimination and the Criteria of Sex*, 4 YALE L. & POL’Y REV. 125, 139 (1985).

Transsexual discourses are those created by medico-psychological practitioners who “diagnose, classify, regulate, and produce transsexed bodies” and the supposed truths about their lives and experiences (citation omitted). These discourses are a “moral discourse” (citation omitted) that assumes that transbehaviors of any kind are abnormal. Consequently those who engage in these behaviors need to be cured. That assumption is reflected in the language used to speak about transpeople. . . . [S]uch language, touted as being “scientific and neutral” or merely descriptive, is stigmatizing and seldom descriptive (e.g. gender dysphoria, “wrong body” and “afflicted” or “suffering” transsexuals).¹³¹

Today, many transdiscourses reject the medicalization and the pathologization of transsex identities by offering a language that empowers rather than entraps its subjects:

Transdiscourses are non-medical, nonpathological, and noncolonizing. They are affirming, empowering, positive, and reflective of trans experiences and the lives people choose to live. The development of an alternate discourse is necessary because the transcommunity is, as Stryker has astutely observed, “something more, and something other than the creatures our makers [i.e., therapists, endocrinologists, and surgeons] intended us to be.” (citation omitted).¹³²

Nonetheless, negotiating the Medicaid standard forces transsex persons to put aside their own transdiscourses, adopting instead the medical diagnostic criteria of GID.

B. The Shaping of Intersex Identities in the Twentieth Century

In the same years that transsex individuals were negotiating with medical experts for support of surgeries, these same experts often conducted studies on individuals that they called “intersex,” in an exploration of the development of human sex and gender.

The commonality of intersex “conditions” depends on how “intersex” is defined. It depends on what counts as “male” and what counts as “female” in a given society at a given time.¹³³ Specifically, one must first define how small a penis or how large a clitoris has to be before one counts as intersex. In addition, one must determine whether sex chromosome anomalies also count as intersex if there is no apparent external sexual ambigui-

¹³¹ CROMWELL, *supra* note 1, at 19–20 (1999).

¹³² *Id.*

¹³³ ALICE D. DREGER, HERMAPHRODITES AND THE MEDICAL INVENTION OF SEX 40–43 (1998).

ity.¹³⁴ If experts at medical centers are asked how often a child is born noticeably atypical in genitalia to the extent that a specialist in “sex differentiation” is called in, the numbers today come out between 1 in 1500 and 1 in 2000 births.¹³⁵ But these figures do not include many more individuals born with subtler forms of atypical sex anatomy that show up later in life.¹³⁶ The intersex category today includes chromosomal variations (chromosomes other than the common XX and XY patterns),¹³⁷ gonadal variations (atypical ovaries or testes), variations in external morphologic sex (genitalia that is classified as neither clearly male nor female), and hormonal variations such as Androgen Insensitivity Syndrome (AIS) and Congenital Adrenal Hyperplasia (CAH).¹³⁸

Like transsex identities, intersex identities were shaped by medico-psychological practitioners in the twentieth century. In fact, the term “intersex” only emerged in the twentieth century. According to historian Alice Dreger, in the last quarter of the nineteenth century, most physicians agreed on one definition of the “true sex” of the hermaphrodite: the structure of his or her gonadal tissue; Dreger therefore labels this period “the age of gonads.”¹³⁹ The gonadal definition, according to Dreger, was based on Theodor Kleb’s 1876 text that divided hermaphroditism into two kinds based on the gonads: true hermaphroditism (“presence of ovaries *and* testes in one individual”) and pseudohermaphroditism (“spurious hermaphroditism”; “doubling of the external genital apparatus with a single kind of sexual gland”).¹⁴⁰ Dreger emphasizes:

One of the significant results of Kleb’s system was that a being could appear almost entirely feminine internally and externally and still be considered a true male by virtue of the possession of testicles and a lack of ovaries. Similarly, a being could look and act very masculine but would have to be classified as female if he had ovaries . . . [i]n short, under Kleb’s system, significantly fewer people counted as “truly” both male and female. This is the trend that we see throughout the rest of the period, that is,

¹³⁴ In cases of chromosomal “anomalies,” an individual has chromosomes other than the “normal” XX and XY patterns. In Klinefelter Syndrome, a mostly phenotypic male typically has two or more X chromosomes, and the testes and often the penis are smaller than in other XY individuals. See JOHN MONEY, *SEX ERRORS OF THE BODY AND RELATED SYNDROMES: A GUIDE TO COUNSELING CHILDREN, ADOLESCENTS AND THEIR FAMILIES* 13 (2d ed. 1994). In Turner Syndrome, individuals have an XO chromosomal pattern and gonads that are not clearly defined as testes or ovaries. See *id.* at 14.

¹³⁵ Dreger, *supra* note 112, at 24. See also Fausto-Sterling, *supra* note 77, at 20.

¹³⁶ For a discussion of intersex conditions at birth, see Blackless et al., *supra* note 2.

¹³⁷ See *id.* at 152.

¹³⁸ For more on AIS, see Griffin, *supra* note 2. For more on CAH, see White & Speiser, *supra* note 2.

¹³⁹ DREGER, *supra* note 133, at 139–66.

¹⁴⁰ *Id.* at 145 (discussing the classification system proposed in EDWIN KLEBS, *HANDBUCH DER PATHOLOGISCHEN ANATOMIE* (1876)).

the trend toward the elimination of true hermaphroditism in humans.¹⁴¹

The end of the “age of gonads” began in 1915, according to Dreger, when physician Blair Bell was the first to question this classification and ask, “whether we are justified . . . in branding [patients] with a sex which is often foreign not only to their appearance but also to their instincts and social happiness.”¹⁴² Recently, historian Geertje Mak has suggested that even before 1915 “medical opinions and concepts of sex in practice were troubled.”¹⁴³

Bernice Hausman locates increased scientific attention around the same period to what was later labeled “gender identity.”¹⁴⁴ She argues that the interest in “psychological” sex emerged when medical science could no longer defend the structure of gonads as the one and only definition of hermaphrodite “true sex”; the scientific discovery of other types of biological sex, such as hormonal and chromosomal sex, made medical science acknowledge that there is no single criterion for “true sex.”¹⁴⁵ Hausman discusses the shift in conceptualization from pseudohermaphroditism to intersexuality, suggesting that because one “true sex” could no longer be claimed, the term “intersex” emerged to describe a “concomitant notion of a continuum of physiological and anatomical sex differences.”¹⁴⁶ Accordingly, “gender” (gender role, gender identity) was coined in the 1950s by John Money and Joan Hampson in the context of protocols for intersex management.¹⁴⁷ The term “gender” emerged, according to Hausman, *only when technologies of sex change* became available in the 1950s.¹⁴⁸ Therefore, the development of material technologies to alter sex produced the modern conceptualization of gender.¹⁴⁹

Since the early 1990s, the current management of the intersex has come under harsh scrutiny.¹⁵⁰ As many critics of current treatment proto-

¹⁴¹ *Id.* at 145–46. Despite this rigid gonadal classification, Dreger gives a much more nuanced description of this period where not everyone was categorized according to their gonads. In cases where patients did not want to change a sex that they had been living as, both English and French doctors sometimes let cases of “mistaken” sex go, or even told their patients that they could try to alter their genitals to match their social status. *Id.* at 157–58.

¹⁴² *Id.* at 163 (citing Blair Bell, *Hermaphroditism*, 35 LIVERPOOL MED.-CHIRURGICAL J. 272, 291–92 (1915)).

¹⁴³ Geertje Mak, “So We Must Go Behind Even What the Microscope Can Reveal”: The Hermaphrodites “Self” in Medical Discourse at the Start of the Twentieth Century, 11.1 GLQ: J. GAY & LESBIAN STUD. 65, 69 (2005).

¹⁴⁴ BERNICE HAUSMAN, CHANGING SEX: TRANSSEXUALISM, TECHNOLOGY, AND THE IDEA OF GENDER 6–8 (1995).

¹⁴⁵ *Id.* at 78–79.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 94–109.

¹⁴⁸ *Id.* at 79.

¹⁴⁹ *Id.* at 7.

¹⁵⁰ For examples of discussion and critique of the current management of intersexual-

cols have documented, intersex surgeons make their decisions and incisions within a heterosexist framework.¹⁵¹ While the decision to produce females is considered relatively foolproof, male assignment is considered difficult, and should only be undertaken by an experienced medical team that can determine whether the penis will be adequate for malehood.¹⁵²

Mak suggests that the issue of classifying hermaphroditic sex must also be examined from the point of view of authority and competence: “to what extent were nineteenth-century physicians authorized to assign someone’s sex? Could they force a person with an “erroneous” sex to change it? Why were mid-twentieth-century physicians suddenly competent to define someone’s ‘best sex’?”¹⁵³ To examine these issues, Mak discusses a heated international debate that took place in the first decade of the twentieth century regarding the prerogative of individual hermaphrodites to choose to undergo surgery to make their body correspond to their social sex. The debate turned on the right of the patient to live and construct his or her body according to a perceived sex that was not their gonadal sex.¹⁵⁴ Mak concludes that an important shift took place in the beginning of the twentieth century as a hermaphrodite’s sex-gender consciousness became a field that was claimed as a domain for medical competence:

In other words, instead of offering the hermaphrodite the right to choose his or her own sex, *they* [medical scientists] *started to turn sex-gender consciousness into an object of medical investigation*, into a measurable identity whose importance in relation to the final decision only they could define. The diagnostic techniques developed in psychiatry and sexology had not yet been fully put to use, but already they provided doctors with new explanations and categorizations. By discussing the subject professionally, doctors started to claim exclusive professional competence to balance their judgment of someone’s sex-gender consciousness against their judgment of the patient’s gonadal sex.¹⁵⁵

ity, see KESSLER, *supra* note 43; DREGER, *supra* note 133; Fausto-Sterling, *supra* note 77, at 20–25; Anne Fausto-Sterling, *How to Build a Man*, in SCIENCES AND HOMOSEXUALITIES 219, 219–25 (Vernon Rosario ed., 1997); Chase, *supra* note 50, at 126.

¹⁵¹ See, e.g., DREGER, *supra* note 133, at 184. The heterosexist assumption that drives this assignment system is that an adequate male is one who can penetrate a vagina and that an adequate female should be penetrable and fertile. Males and females are assumed to have sex with each other, for the purpose of fertility. Sexual pleasure of females and same-sex desires are generally not considered as significant factors in this current system of intersex gender assignment.

¹⁵² *Id.*

¹⁵³ Mak, *supra* note 143, at 71.

¹⁵⁴ *Id.* at 67.

¹⁵⁵ *Id.* at 87–88 (emphasis added).

Thus, the shift, emphasized by Mak, is from the subject's right to speak *from* the self to a doctor's right to speak *about* the self.¹⁵⁶ At the beginning of the century, doctors were gradually enhancing their power to name the "inner-self," just as they had been classifying the body since the nineteenth century, in order to make the self an object of classification. Self-perception—later to become gender identity and gender role—became one more field of modern expertise.

This historical shift in the twentieth century from the right to speak from the self to a right to speak about the self is manifested in interwoven histories of transsex and intersex identities. In the legal debates regarding transsex entitlement to Medicaid and intersex struggles against unwanted surgeries, gender identity and all aspects of biological sex are discussed as fields of scientific knowledge, exclusively in the domain of medical and scientific experts.

This Article problematizes the fact that arguments for liberty to speak *for* the self are entangled in scientific arguments *about* the self. Medical-scientists on both sides of the debates offer rival theories of medical-scientific subject classification, supported by "outcome studies" and competing knowledge about transsex and intersex individuals. The next Part demonstrates how competing scientific narratives about the self produced paradoxical medical alliances with these two advocacies.

III. PARADOXICAL EFFECTS OF MEDICAL DEBATES ON CURRENT INTERSEX AND TRANSSEX MEDICAL ALLIANCES

Since the second half of the twentieth century and the coining of the terms "gender" and "gender identity" medical experts have labored to substantiate theories about how the "inner-self" develops and what determines our "psychological sex." Two medical approaches have offered rival explanations to this question. One approach emphasizes the impact of social imprinting of gender and the development of gender identity, or the socialization approach. The other underscores biology and/or nature as the more significant factors in the production of gender identity and "psychological sex," or the biological approach. What follows is an introduction and discussion of the main components of the two theories, followed by the argument that the historical cross-alliances of these rival approaches with intersex and transsex politics and advocacy produce a conflict for intersex and transsex politics.

The process of gender socialization is described by the socialization approach as the following:

Children growing up in a culture differentiate a gender identity free from ambiguity if the adults of that culture, especially those clos-

¹⁵⁶ *Id.*

est to them, transmit clear and unambiguous signals with respect to the procreative nucleus of gender dimorphic behavior, no matter what the signals with respect to peripheral options may be.¹⁵⁷

The key assumption of this approach is that the process of forming an inner-self, a gender identity, a “psychological sex,” is for the most part a process of socialization and is not purely biological. There are three inter-linked components to this approach: (1) infants are born “gender neutral”; (2) the appearance of genitals is more important than the “sexual brain,” (the embryonic brain exposure to hormones); and (3) early genital surgery on intersex subjects is necessary to ensure “normal” gender identity.

The assumption of gender neutrality at birth means that psychological differentiation must determine development of masculine or feminine identifications which a child acquires in the course of socialization.¹⁵⁸ This idea is crucial for the medical claim that, regardless of genes or hormone composition, an intersex child can be raised successfully either as boy or girl. For a child to feel socially accepted, according to this approach, his or her genitals must appear “normal.”¹⁵⁹ Because the behavioral development of binary gender identity can be socially controlled and altered, under this approach, the appearance of genitals should be reconstructed so that the social reproduction of the male-female model can continue. Thus, boys should have “real” looking penises, and girls should have “normal” appearing clitorises and penetrable vaginas.

Despite this focus on gender socialization, John Money and others have not altogether ignored findings on the effects of hormones on “gender-identity” development. For example, in 1959 a study on guinea pigs claimed to prove that sex hormones had a major effect on the sexual differentiation of the brain.¹⁶⁰ While such studies were acknowledged by Money and other supporters of this “gender socialization approach,” they maintained that the crucial part of “gender-identity differentiation” remains to be accomplished *after* birth.¹⁶¹ To this day, supporters of the so-

¹⁵⁷ MONEY & EHRHARDT, *supra* note 84, at 145.

¹⁵⁸ John Money et al., *An Examination of Some Basic Sexual Concepts: The Evidence of Human Hermaphroditism*, 97 BULL. JOHNS HOPKINS HOSP. 301–19 (1955) (“[P]sychologically, sexuality is undifferentiated at birth and it becomes differentiated as masculine or feminine in the course of various experiences of growing up.”).

¹⁵⁹ See, e.g., American Academy of Pediatrics, *supra* note 39, at 141 (“The size of the phallus and its potential to develop at puberty into a sexually functional penis are of paramount importance when one is considering the male sex of rearing.”).

¹⁶⁰ Charles H. Phoenix et al., *Organizing Action of Prenatally Administered Testosterone Propionate on the Tissues Mediating Mating Behavior in the Female Guinea Pig*, 65 ENDOCRINOLOGY 369 (1959).

¹⁶¹ MONEY & EHRHARDT, *supra* note 84, at 114 (“Nonetheless, as compared with the lower species, much that pertains to human gender-identity differentiation remains to be accomplished after birth, not in a developmental vacuum, so to speak, but, like language, in interaction with the social environment. The prenatal determinants of gender identity can be perhaps not entirely overridden, but they can be and are incorporated into the postnatal program of differentiation . . .”).

cialization-centered approach generally acknowledge the “sexualization” of the brain, but grant more weight to the gender of rearing.¹⁶²

In contrast with the gender socialization approach, the biology-centered approach treats biological conditions as the main trigger and indicator for the future development of gender identity. Thus, because for this approach nature is the most significant foundation of gender identity, the reverse position on each one of the above propositions is assumed: (1) infants are not born “gender neutral”; (2) the natural “sexualized brain” is more significant than the outer shape of genitals; and (3) the practice of early genital surgery is harmful and should be abandoned.

This theory, as articulated by Milton Diamond and Glenn Beh, underscores “biological” drives that exist before social forces come into play: “The last decade has produced genetic, neurological and biological studies that support a premise that humans are, in keeping with their mammalian heritage, predisposed and biased to interact with environmental, familial and social forces in either male or female mode.”¹⁶³

Just as proponents of the socialization theory recognize some sexualization of the brain, here, too, we see that societal impact is acknowledged; the process of socialization is perceived as something that does not happen in a biological vacuum. Instead, this approach reminds us that humans are only a type of mammal, and, as such, have a heritage of sex predisposition and bias to interact either as male or female.

This human “bias” was supposedly confirmed by Diamond and Sigmundson in 1997 when the case of John/Joan provoked a discursive explosion over infant gender disposition, or lack thereof. The sensationalized knowledge, exposed by Diamond and Sigmundson, of the “failure” of John Money’s extraordinary John/Joan “gender experiment” when John/Joan adopted a male identity was immediately declared a victory for this biological approach. For example, Diamond and Sigmundson back up their theory about disposition at birth by citing Reimer’s recorded reaction at the age of fourteen upon discovery of his forced gender transition: “All of a sudden everything clicked. For the first time things made sense and I understood who and what I was.”¹⁶⁴ David Reimer, according to this narrative, had always been a boy, and was never really a girl.¹⁶⁵ Regardless

¹⁶² 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 e9 (1998), <http://www.pediatrics.org/cgi/content/full/102/1/e9> (“[O]ur case suggests that it is possible for a female gender identity to differentiate in a biologically normal genetic male, which supports the original conclusion of Money et al (sic) that sex of rearing may be the most important determinant of a person’s gender identity.” (footnote omitted)).

¹⁶³ Beh & Diamond, *supra* note 70, at 23–24 (footnote omitted).

¹⁶⁴ Diamond & Sigmundson, *supra* note 85, at 300.

¹⁶⁵ Diamond describes being contacted in 1999 by two men who had been raised as girls: “[t]hey recalled always harboring inner thoughts that they were male. . . . One young man recalled asking his mother, ‘Does God make mistakes?’” Beh & Diamond, *supra* note 70, at 2.

of how they were reared, these children were always allegedly, in accordance with their “mammalian heritage,” boys.¹⁶⁶ Gender is not neutral at birth, according to this theory, because our mammalian heritage is determined by something called the “sexual brain”: “[T]he organ that appears to be critical to psychosexual development and adaptation is not the external genitalia, but the brain. If the brain knows its gender independent of social-environment influences, then we need to be able to predict what that gender is.”¹⁶⁷

The sexual brain “influences postnatal psychosexual development.”¹⁶⁸ Therefore, “[w]hen assignment is based on the most likely outcome [as signaled by the sexual brain], most children will adapt and accept their sex assignment and it will coincide with their sexual identity.”¹⁶⁹ Predictable sex identity will allegedly follow the embryo’s prenatal exposure to hormones.¹⁷⁰

Therefore, genital appearance, according to the biological approach, should not be prioritized as the central feature in the development of gender identity. As Diamond and Sigmundson explain:

The sex of assignment, when based on the nature of the diagnosis rather than only considering the size or functionality of the phallus, respects the idea that the nervous system involved in adult

¹⁶⁶ For an additional report of “failure” in female gender assignment of an XY male, see Chanika Phornphutkul et al., *Gender Self-Reassignment in an XY Adolescent Female Born With Ambiguous Genitalia*, 106 PEDIATRICS 135, 136 (2000) (“Our current practices coincide with Diamond and Sigmundson’s recommendations. Most notably . . . that the sex of assignment should be based on the underlying diagnosis, even if sex of rearing may not coincide with size and functionality of the phallus.” (footnote omitted)).

¹⁶⁷ William Reiner, *To be Male or Female—That Is the Question*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 224, 225 (1997).

¹⁶⁸ *Id.* at 224.

¹⁶⁹ Diamond & Sigmundson, *supra* note 75, at 1047.

¹⁷⁰ Thus the following recommendations were published by Diamond and Sigmundson as guidelines for management of intersexed patients:

Rear as male: XY persons with AIS (grades 1-3); XX persons with CAH with extensively fused labia and a penile clitoris; XY persons with hypospadias; Persons with Klinefelter syndrome; XY persons with micropenis; and XY persons with 5-alpha or 17-beta reductase deficiency. Rear as female: XY persons with AIS (grades 4-7); XX persons with CAH with hypertrophied clitoris; XX persons with gonadal dysgenesis; XY persons with gonadal dysgenesis; and persons with Turner’s syndrome. For those patients with mixed gonadal dysgenesis, assign male or female depending on the size of the phallus and the extent of the labia-scrotum fusion. The genital appearance of persons with mixed gonadal dysgenesis can range from that of a typical Turner’s syndrome to that of a typical male. Evaluation of high malelike testosterone levels in these cases is also rationale for male assignment. True hermaphrodites should be assigned male or female depending on the size of the phallus and extent of the labia-scrotum fusion. If there is a micropenis, assign as male.

Diamond & Sigmundson, *supra* note 75, at 1047.

sexuality has been influenced by genetic and endocrine events that will most likely become manifest with or after puberty.¹⁷¹

Following this thesis, it is generally recommended that, although genetic males with a "micropenis" or "absent penis" may "function sexually more easily as a female," they should be raised as males because "the brain is masculinized."¹⁷² In other words, sex assignment is a question of correct or incorrect outcomes and predictions.¹⁷³

To understand the alliances of each of these two opposing approaches with intersex and transsex politics, it is also significant to examine the often unspoken assumptions *shared* by both of these approaches. Despite opposing views on questions of gender neutrality/disposition, the sexual brain, the importance of genitals, and the need for early surgery, there are also significant points of agreement that may be as illuminating as the points of disparity.

First, for both the biological and socialization approaches, same sex desire and/or lack of longing for heterosexual marriage is considered an undesired outcome of gender development. Thus, regardless of the process of gender-identity, the "good" result is, for both approaches, the married heterosexual subject: "Concerning the one woman who reported heterosexual attraction and fantasies in adolescence followed by homosexual thoughts and actions in adulthood, perhaps a short vagina coupled with fear of vaginoplasty contributed to this change. Several women were married and/or mothers."¹⁷⁴

This unusual explanation for lesbian desire appears in a report on successful female assignment of a group of genetic males with complete androgen insensitivity. The subject in this paragraph is a genetic male raised as a woman who reportedly had "homosexual thoughts and actions."¹⁷⁵ This study, co-authored by John Money, conveys the success of his general socialization approach but also explains its local failure (lesbianism). The woman experienced lesbian desire, according to this study, because there was a problem with the shape of her genitals. The subject's "short vagina

¹⁷¹ *Id.*

¹⁷² William Reiner, *Sex Assignment in the Neonate with Intersex or Inadequate Genitalia*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1044, 1044 (1997).

¹⁷³ In 2004, an additional study was published in further support of this theory, which similarly concluded that genetic males may develop masculine identifications despite being raised as females and undergoing feminizing genitoplasty at birth. See William Reiner & John P. Gearhart, *Discordant Sexual Identity in Some Genetic Males with Cloacal Exstrophy Assigned to Female Sex at Birth*, 350 NEW ENG. J. MED. 333, 340 (2004) ("Reassignment of genetic males to female sex because of phallic inadequacy may complicate already complex neonatal conditions.").

¹⁷⁴ Amy B. Wisniewski et al., *Complete Androgen Insensitivity Syndrome: Long-Term Medical, Surgical, and Psychosexual Outcome*, 85 J. CLINICAL ENDOCRINOLOGY & METABOLISM 2664, 2668 (2000).

¹⁷⁵ *Id.*

and a fear of vaginoplasty” allegedly caused this “malfunction” in desire.¹⁷⁶ As Eve Sedgwick observed, with the liberalization of attitudes to same sex desires since the 1970s and the removal of homosexuality from the *DSM-IV*, there appeared an institutional anxiety about development of “normal” gender identities in children.¹⁷⁷ This attitude is manifested here in outcome studies such as the one cited above, which include heterosexual desire and marriage as measures for success or failure in human “gender development.”

The two positions also overlap regarding the significance of female fertility in the medical process of gender assignment. While there is a serious controversy regarding genetic males, there is a general agreement between the two approaches regarding genetic females. When it comes to genetic females, the American Academy of Pediatrics (AAP) strangely disregards the importance that it grants to genital appearance, recommending that “[a]ll female infants virilized because of CAH or maternal androgens are potentially fertile and should therefore be raised as girls.”¹⁷⁸ A genetic female with a clitoris that appears as a penis will not be assigned male, and the child’s potential fertility will overrule the child’s apparent genitals: “Infants raised as girls will usually require clitoral reduction which, with current techniques, will result not only in a normal-looking vulva but preservation of a functional clitoris.”¹⁷⁹

Interestingly, those opposing the AAP approach do not contest the AAP on this point and are also in favor of female fertility. Thus, for example, William Reiner, an advocate for the biological sexual brain, recommends “it is prudent to raise [genetic females with CAH] as female. Her potential fertility and sexual function may be vital elements of her later psychosexual development.”¹⁸⁰ Although Reiner supports following the sexual brain, genetic female infants are recommended to be raised as females due to “potential fertility and sexual function.” As we see in this inconsistency, female masculinity seems to be a soft spot for advocates of the “sexual brain” approach.¹⁸¹

¹⁷⁶ *Id.* For another discussion of lesbianism as failure in a similar context, see Bradley et al., *supra* note 162 (“Unfortunately, after the most recent surgery, the patient developed a recto-vaginal fistula. . . . The patient’s post-surgery complications have been monitored by ABC and she reported to him that she was currently living with a new partner, a woman, in a lesbian relationship.”).

¹⁷⁷ Eve K. Sedgwick, *How to Bring Your Kids Up Gay: The War on Effeminate Boys*, in *TENDENCIES* 154–55 (1993) (arguing that following the American Psychiatric Association’s publicized 1973 decision to de-pathologize homosexuality from its next *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, parent and teacher anxiety became focused on preventing the *becoming* of adult homosexuals).

¹⁷⁸ American Academy of Pediatrics, *supra* note 39, at 141.

¹⁷⁹ *Id.*

¹⁸⁰ Reiner, *supra* note 172, at 1045.

¹⁸¹ Not all supporters of this approach are in agreement regarding gender assignment of genetic females with CAH. Diamond and Sigmundson apply an additional distinction in this case. In general, they suggest that genetic females with CAH who have “extensively fused labia and a penile clitoris” should be raised as males. However, genetic females with

A. Paradoxical Medical-Legal Alliances

Intersex and transsex politics are now at odds with each other. As advocates for the two movements strategically use medical people and alliances to advance group goals, medical experts also exercise control on intersex and transsex subjects by way of classifications and medical name-giving. Biology-centered narratives and allies such as Milton Diamond provide direct support to intersex advocacy and politics in the struggle to end surgeries, while socialization-centered narratives that emphasize gender identity and GID as psychological conditions that are distinct from the body are used in transsex Medicaid advocacy.¹⁸² But since the two medical approaches are structured by scientific-medical experts as two ends of the nature/nurture binary, the two social movements are supported by opposing medical structures and refute each other's medically based narratives. The biology-centered experts generally, though not always, oppose transsex Medicaid advocacy at the same time that they support intersex advocacy, and the socialization-centered experts oppose intersex advocacy while they support transsex advocacy. In other words, the two movements are "at odds with each other," as Butler suggests, not only because one movement seeks to *stop* surgeries, while the other seeks to *promote* surgeries.¹⁸³ In addition, they are at odds because they constitute legal representations of opposing medical positions and (perhaps more importantly) experts who have been challenging each other for years regarding meanings of sex and gender.

1. Biology-Centered Medical Narratives: Support of Intersex Advocacy and Opposition to Transsex Advocacy

Intersex activism is generally backed by medical researchers and data that support the biology-centered approach. This approach counters societal claims about gender by pointing to biological "facts," to a "mammalian heritage," and to cases such as John/Joan, to prove that only the "sexualized brain" can predict future masculinity and/or femininity. Researchers who take this approach assert that for both males and females, early surgeries are harmful and unnecessary because boys can be boys with

CAH who have a "hypertrophied clitoris" should be reared as females. In the rearing of genetic females with an allegedly masculinized brain, Diamond and Sigmundson apply a distinction based on genital appearance. Interestingly, as we have seen, the appearance of genitals is the lynchpin of the opposing "adequate phallus" approach. Genital appearance is what Diamond generally views as the less relevant factor in gender prediction, but it seems that in cases of female fertility, "sexual brain" advocates are willing to compromise scientific principles for the more important social value of procreation. Diamond & Sigmundson, *supra* note 75, at 1047.

¹⁸² It should be noted, however, that the divide is not clear here and some biology-centered researchers actually support sex surgery for transsexuals as they view the transsexual brain as imprinted with a sex different from the body.

¹⁸³ BUTLER, *supra* note 3.

a micropenis or even without a penis, and girls can be girls with an enlarged clitoris.¹⁸⁴ As summarized by William Reiner, “remembering that the brain is the most important sex organ, the treatment team must endeavor to come to a consensus, with the parents realizing that *there is no surgical emergency or even urgency that need hinder decision. . .*.”¹⁸⁵

In objecting to intersex normalizing surgeries, supporters of this “biological” position borrow the legal terminology of the common law doctrine of informed consent. Diamond and Sigmundson, for example, make the following recommendations:

Perform no major surgery for cosmetic reasons alone; only for conditions related to physical or medical health. . . . Surgery can potentially impair sexual or erotic function. Therefore, such surgery, which includes all clitoral surgery and any sex reassignment, should typically wait until puberty or after puberty, when the patient is able to give *truly informed consent*.¹⁸⁶

The legal doctrine of informed consent is used here as an additional argument for the medical-scientific opinion that there is a pre-determination of gender in embryos. This move demonstrates the two-way influence of medical-legal discourses. While medical discourses are generally perceived as providing objective factual bases for the legal decision-making process, Diamond and Sigmundson use legal doctrine to support a medical argument. The idea of informed consent, when used in this context, means that only the intersex individual can make a decision about intersex surgery because this “decision” is mostly (though not exclusively) pre-determined by the hormonalized brain:

Prenatal androgens appear to be a major biologic factor in the development of male sexual identity in the absence of postnatal or pubertal androgen surges, but we cannot assert that they are the only factor. . . . [O]ur findings suggest that children who are born genetically and hormonally male may identify themselves as male despite being raised as females and undergoing feminizing genitoplasty at birth. Reassignment of genetic males to fe-

¹⁸⁴ See, e.g., Diamond & Sigmundson, *supra* note 75, at 1049 (“Most intersex conditions can remain without any surgery at all. A woman with a phallus can enjoy her hypertrophied clitoris and so can her partner. Women with AIS or virilizing CAH who have smaller-than-usual vaginas can be advised to use pressure dilation to fashion one to facilitate coitus; a woman with partial AIS likewise can enjoy a large clitoris. A male with hypospadias might have to sit to urinate without mishap but can function sexually without surgery. A person with a micropenis can satisfy a partner and father children.”).

¹⁸⁵ Reiner, *supra* note 172, at 1045 (emphasis added).

¹⁸⁶ Diamond & Sigmundson, *supra* note 75, at 1047 (emphasis added).

male sex because of phallic inadequacy may complicate already complex neonatal conditions.¹⁸⁷

Choice and nature are therefore synonyms in this context and “informed consent” means giving more time for nature to show its signs.

Given its premises, it is not surprising that the biology-centered approach favors current intersex advocacy. Yet it is perhaps not as anticipated that at the same time many (but not all) supporters of this approach reject transsex surgery as medically unnecessary.

While the biological approach alludes to the doctrine of informed consent in the intersex context, ideas of choice and consent are not found in parallel narratives by some supporters of this approach regarding transsex surgeries. “Choice” and “informed consent” are legal terms applied by these medical experts to young children, but not to adults who wish to make determination about their own sex and gender. Jon Meyer, a psychoanalyst at Johns Hopkins, concluded in a 1974 article that surgery does not really “cure” the problem of transsexuals, but seems to “temporarily palliate an unfortunate emotional state.”¹⁸⁸ In 1979, Meyer, who had founded the clinic with John Money, announced in a press conference that Johns Hopkins would “no longer perform sex-reassignment surgery on transsexuals.”¹⁸⁹ Meyer stressed his objection to transsex surgeries, suggesting that ““these patients have severe psychological problems that don’t go away following surgery.””¹⁹⁰

This anti-transsex (but also anti-intersex) surgery approach was recently voiced by Professor Paul McHugh, the current director of the Johns Hopkins Psychiatry Department. Regarding intersex surgeries, McHugh writes:

Having looked at the Reiner and Meyer studies [on intersex subjects], we in the Johns Hopkins Psychiatry Department eventually concluded that human sexual identity is mostly built into our constitution by the genes that we inherit and the embryogenesis we undergo. Male hormones sexualize the brain and the mind. Sexual dysphoria—a sense of disquiet in one’s sexual role—naturally occurs among those rare males who are raised as females in an effort to correct an infantile genital structural problem.¹⁹¹

What this text tells us is that if we raise genetic males as girls, they will develop sexual dysphoria and feel trapped in the wrong body. But then how

¹⁸⁷ Reiner & Gearhart, *supra* note 173, at 340.

¹⁸⁸ Jon K. Meyer & John E. Hoopes, *The Gender Dysphoria Syndromes: A Position Statement on So-Called “Transsexualism,”* 54 PLASTIC & RECONSTRUCTIVE SURGERY 444, 450–51 (1974).

¹⁸⁹ Jane E. Brody, *Benefits of Transsexual Surgery Disputed as Leading Hospital Halts the Procedure*, N.Y. TIMES, Oct. 2, 1979, at C1.

¹⁹⁰ *Id.*

¹⁹¹ Paul McHugh, *Surgical Sex*, 147 FIRST THINGS 34, 37 (2004).

can one explain transgender/transsexual subjects with perfectly “normal” bodies who nonetheless develop other identities? McHugh attempts to answer this by classifying transsex identities as yet another form of “socially induced” sexual dysphoria: “A seemingly similar disquiet can be socially induced in apparently constitutionally normal males, in association with (and presumable prompted by) serious behavioral aberrations, amongst which are conflicted homosexual orientations and the remarkable male deviation now called autogynephilia.”¹⁹²

The classification of transsex identifications as “socially induced” is surprising, since “normal” identifications are allegedly *not* “socially induced.” This turn to “socially induced” identifications can nonetheless be explained by examining the structure of the claim. A theory dedicated to nature and biology must explain the development of “natural bodies” in unexpected “unnatural” directions. Such explanation, if made within the biology-society binary, must be non-biological, i.e., societal. Thus the theory ends up advocating, with a slight modification, the very thing that it opposes—the influence of society on gender identity. But it does so with one minor change. Society can have a “bad” influence and lead to gender dysphoria, but not a “good” influence that leads to “normal” gender identities.¹⁹³ Medical scientists such as McHugh and Meyer oppose surgeries for both intersex and transsex subjects for similar reasons that stress the natural and biological basis of sex. As an alternative to surgery for transsex subjects, these experts suggest psychotherapy for “troubled” individuals and their families.¹⁹⁴

Not all supporters of biological theories reject transsex surgeries, however. Milton Diamond, for example, has suggested that transsex conditions are induced by a “sexualized brain” and are therefore a kind of intersex condition.¹⁹⁵ While many sexual brain theory proponents conceive of transsexuality as a psychological disorder, Diamond in fact views it as a

¹⁹² *Id.*

¹⁹³ On the “socially induced,” serious behavioral aberrations of “autogynephilia,” McHugh also writes:

Further study of similar subjects in the psychiatric services of the Clark Institute in Toronto identified these men by the auto-arousal they experienced in imitating sexually seductive females. Many of them imagined that their displays might be sexually arousing to onlookers, especially to females Because most of them found women to be the objects of their interest they identified themselves as lesbians. The name eventually coined in Toronto to describe this form of sexual misdirection was “autogynephilia.” Once again, I concluded that to provide a surgical alteration to the body of these unfortunate people was to collaborate with the mental disorder rather than to treat it.

Id. at 35.

¹⁹⁴ *Id.* at 37.

¹⁹⁵ See Milton Diamond, *Sex and Gender: Same or Different?*, 10 FEMINISM & PSYCHOLOGY 46, 50 (2000) (claiming that the transsexual brain is already imprinted with sex that does not necessarily correspond to the body, and that transsex people are, in fact, intersex, and surgery should be available to them).

biological condition that may require surgical procedures. In other words, transsex and transgender individuals according to this approach do not live in a chosen or socially induced sex or gender. Instead, they live according to their transsexual brain.

Overall, the biological approach and its supporters are good allies for intersex advocacy, providing the much needed medical justification to end genital surgeries. This is a negative development for transsex advocacy, however, because this approach may also lead courts to deny state subsidy of transsex surgeries, as it declares other forms of “treatment” more appropriate.¹⁹⁶ Given the tremendous costs of the sex change process,¹⁹⁷ such denial makes surgery practically impossible for lower- and mid-income individuals.¹⁹⁸

2. Socialization-Centered Medical Narratives Support of Transsexual Advocacy and Opposition to Intersex Advocacy

For supporters of the socialization-centered theory, the postnatal process of socialization is the main factor in “normal” psychosexual development.¹⁹⁹ At a certain point, gender identity becomes fixed and practically immutable.²⁰⁰ Thus, these medical experts and sex researchers stand in opposition to the biology-centered experts and the legal positions that they represent. Just as biology focused experts often reject surgery for *both* intersex and transsex individuals, the gender socialization-focused narratives generally support surgeries for both intersex and transsex. The notion here is that if gender identity is a process of socialization that becomes fixed at an early point in life, then intersex genitals must be constructed early in life for the development of a solid hetero-normative appearance. Similarly, transsex adults must be operated upon, because their cross-gender identifications are immutable. According to Money, a long-time supporter of transsex surgeries:

The majority of human beings have a gender identity . . . that is so firmly set by the time of puberty that it cannot be changed. . . . [O]ne cannot expect every individual of normal anatomy but with discordant gender identity to be susceptible to psychotherapeutic change of gender identity. Such individuals whose gender identity is not ambivalent but clearly incongruously monosexual are

¹⁹⁶ See McHugh, *supra* note 191, at 37.

¹⁹⁷ For a discussion of the prohibitive costs of sex-reassignment surgery, see Gordon, *supra* note 10.

¹⁹⁸ See Dasti, *supra* note 8, at 1749–55.

¹⁹⁹ See, e.g., MONEY & EHRHARDT, *supra* note 84, at 144–45 (asserting that child-rearing as it relates to gender has an “extraordinary influence on shaping a child’s psychosexual differentiation and the ultimate outcome of a female or male gender identity.”).

²⁰⁰ See *id.*

best helped by being rehabilitated according to the sex of their gender identity.²⁰¹

These experts justify their support of transsex surgery not only by the conceived immutability of the transsexual condition, but by their self-identification as liberals who help their patients live by their chosen sex. For example, in 1975, at a celebration of Harry Benjamin's ninetieth birthday, Money announced that, "[t]he public ha[d] begun to learn to be more open-minded about the ethics and personal rights of self-determination regarding social and legal gender status."²⁰² But these experts were not entirely selfless, since, at the same time that medical experts helped patients change their sex, they also enhanced their authority by promoting the medical classification of transexuality.²⁰³

John Money typifies the similar approach taken to intersex and transsex surgeries. A champion of transsex surgeries, he is also well known as the father of current management protocols of intersexuality. These protocols were recently followed by the guidelines of the AAP, advising that:

Infants raised as girls will usually require clitoral reduction. . . . The testes should be removed soon after birth in infants with partial androgen insensitivity or testicular dygenesis in whom a very small phallus mandates a female sex of rearing. . . . Correction of chordee and urethroplasty in boys with hypospadias is usually performed between 6 and 18 months of age. . . ."²⁰⁴

As developed in Parts I and II above, supporters of this approach typically emphasize the societal influence on gender development, and recommend that early surgery is necessary for the "normal" appearance of genitals, which allegedly leads to the "normal" development of corresponding gender identities.

B. Summary

The paradoxical medical alliances of the intersex and transsex movements are disturbing if the argument for liberty substantially is based upon the contradicting "biology" and "socialization" theories of gender identity. The alliances are disturbing not only from a Foucauldian perspective of medicalized identities,²⁰⁵ but also at the more basic strategic level

²⁰¹ *Id.* at 23.

²⁰² MEYEROWITZ, *supra* note 119, at 253–54.

²⁰³ *Id.*

²⁰⁴ American Academy of Pediatrics, *supra* note 39, at 141.

²⁰⁵ See MICHEL FOUCAULT, HISTORY OF SEXUALITY 13 (Robert Hurley trans., 1978) (discussing the "science of sexuality" that has emerged as part of discursive explosions regarding sex and sexuality).

of attempting to convince judges and legislators that one medical theory is true in one context and that the opposite medical theory is true in another context.

The final Part will develop this consideration further by shifting the focus to two meanings of liberty that appear in the two struggles, and the interaction of these meanings with medical norms defining “health” and “illness.”

IV. CONCLUSIONS

A. *Two Concepts of Liberty and the Medical Norm*

Philosophers and jurists have developed two primary conceptualizations of liberty: negative liberty and positive liberty. Negative liberty generally refers to freedom from government intrusion, whereas positive liberty generally refers to affirmative government action that facilitates an individual’s pursuit of freedom.²⁰⁶ In the context of this Article, the legal claim for freedom from early intersex surgery can be viewed as a claim for individual negative liberty of *non-interference* with one’s body.

In contrast, the claim for transsex surgery is a claim for positive liberty—for federal-state *action* for the welfare of the individual. This is a struggle for positive liberty because individuals seek the financial assistance of the state to achieve a sense of comfort in their bodies. Without Medicaid coverage, many transgender and transsexual individuals may live in a chosen sex or gender that is not their *legal* sex, thus suffering many forms of legal discrimination.²⁰⁷ For such people, lack of positive liberty for Medicaid coverage may make negative liberty meaningless.²⁰⁸

Intersex and transsex advocates use reverse strategies to negotiate these two concepts of liberty with scientific-medical regimes. In claiming negative liberty for intersex infants, advocates assert that intersex should not be the subject of medicine,—that intersex surgeries are a social and not a medical issue. In claiming the positive liberty for state subsidized sex change surgery, advocates make the reverse assertion that transsex is not merely a social condition but also a medical condition. While positive liberty in the form of state/federal assistance involves demonstrating *illness*, negative liberty from unwanted medical intervention involves a demonstration of

²⁰⁶ For an early distinction between negative and positive liberty, see generally Isaiah Berlin, *Two Concepts of Liberty*, in *FOUR ESSAYS ON LIBERTY* 118 (1979). Many different accounts of both positive and negative liberty have been proposed since Berlin’s essay was first published in 1969. See generally Charles Taylor, *What’s Wrong with Negative Liberty*, in *THE IDEA OF FREEDOM: ESSAYS IN HONOUR OF ISAIAH BERLIN* 175 (Alan Ryan ed., 1979) (decisions and actions which result from certain uncontrolled motivations are not really free). In addition, the meaning of “coercion” within the definition of negative liberty is itself open to various interpretations. See, e.g., ROBERT NOZICK, *SOCRATIC PUZZLES* 15–45 (1997); JOSEPH RAZ, *THE MORALITY OF FREEDOM* 148–57 (1986) (discussing the various different ways in which coercion interferes with human autonomy).

²⁰⁷ See Dasti, *supra* note 8, at 1749–55.

²⁰⁸ Berlin makes a similar point. See BERLIN, *supra* note 206, at 125–26.

health. Entitlement to the positive liberty of Medicaid coverage entails claims to *abnormality*, while entitlement to negative liberty demands that subjects make claims to *normality*.

These negotiations of both types of liberty take place in relation to medical diagnoses and an ongoing march of medical experts. Thus, legal norms and liberties become part of the process of medical normalization, and not part of liberation from this process. Assertions for liberties sometimes accompany medical discourses, but only as decorations rather than lead arguments. Consequently, meanings of liberty for intersex and transsex subjects (whether negative or positive) do not exist without the support of medical experts and narratives.

The paradoxical reliance on opposing notions of gender also reflects the positive/negative liberty clash in medical narratives. Current medical narratives that support the negative liberty of intersex subjects also reject the positive liberty of transsex subjects, claiming that they can be cured in other ways and that state support of surgery is unnecessary. At the same time, current medical narratives that support the positive liberty of transsex identified individuals by declaring them pathological also maintain and support the management of intersex infants, thus opposing the idea of negative liberty for intersex subjects.

B. Undiagnosing Gender

Gender identity as an inner-self that is distinct from the body is a lead concept at the core of both movements. Intersex activism emphasizes the coercive practice of assigning sex to match a fictitious biological ideal, and transsex activism focuses on gender identity as an inner truth that calls for wider social recognition and state assistance. The two movements use theories about gender identity to challenge the social treatment of their bodies as unjust, with intersex advocates asserting that surgery is unjust and transsex advocates arguing that not subsidizing surgery is unjust. Both movements distinguish gender identity from bodily manifestations, and call for careful social-legal attention to our legal assumptions about sex and gender.

The call to undiagnose transsex individuals is not novel. It has been made since transexuality appeared in the *DSM* in 1980.²⁰⁹ This Article has attempted to show that it is sometimes not enough to *undiagnose* someone at the expense of another. The attempt to undiagnose intersex subjects so far has involved the same medical theorists who seek to “cure” transsex individuals with psychotherapy and who reject Medicaid coverage of surgeries.

²⁰⁹ See, e.g., BUTLER, *supra* note 3, at 101 (concluding that “[u]ntil those social conditions are radically changed, freedom will require unfreedom, and autonomy is implicated in subjection”); see also Spade, *supra* note 21, at 37 (concluding that “the negotiation of medical knowledge in trans people’s personal and legal struggles makes clear that a multi-strategy approach is always necessary for political action”).

The way we understand sex and gender today is subject, among other things, to scientific-legal construction. This Article has underscored a split in scientific explanations regarding the development of gender identity and forms of “treatment” for those who do not fit the male-female model. The question for us as legal practitioners and academics is how to manage these disagreements.

The legal reliance on medical narratives forms rights that are dependant on medical conceptions of gender. One goal of this Article is to underscore an additional reason for a broader approach to transsex and intersex rights that is detached from medical theories about gender identity. While a certain medical study may help specific human rights advocacy goals, it may at the same time harm other human rights advocates seeking other remedies. This makes the medical ally of one the medical opponent of another. This should be a troubling result for many queer theorists, who seek to enhance the well-being of gender stigmatized individuals—but not at the expense of others.

C. Less Reliance on Scientific Method, More Reliance on Liberties

The above discussion of negative liberty and positive liberty portrayed how claims to liberty can theoretically be detached from medical theories about gender. The two forms of liberty can hopefully be advocated using less reliance on medical theories about gender identity and more reliance on liberal notions of choice and pluralism.

In the case of intersex, the argument for negative liberty is based on the notion of non-interference in the body in cases that are not considered life-threatening emergencies. Thus, intersex advocacy can emphasize the liberal argument for negative liberty from intrusive medical interference, while downplaying the medical claims about the “sexual brain” as the key to the understanding of gender identity.

The positive liberty argument for transsex Medicaid coverage can also downplay the medical diagnosis of GID. The argument can underscore that people must be intelligible subjects in order to experience meaningful life, and that, because the law often demands the completion of sex transition as a prior condition for legal intelligibility, surgery is necessary to reach full legal personhood.²¹⁰

Due to the nature of litigation and courts, intersex and transsex advocacy must reflect the specific and superficially conflicting goals of distinct groups of people in a given time and place. As claimants for negative and positive liberties, intersex and transsex goals are not necessarily at odds with each other. They can be, however, if we fail to liberate liberties from scientific presumptions about sex and gender.

²¹⁰ See Dasti, *supra* note 8, at 1775 (concluding that “the nearly fetishistic focus that the law places on genital structures undergirds a strong argument that access to sex-reassignment surgery is necessary in order to avoid shutting an entire class of citizens outside of the law”).