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THE ISSUE IS BEING INTERSEX:  
THE CURRENT STANDARD OF CARE IS A RESULT  
OF IGNORANCE, AND IT IS AMAZING WHAT A  
LITTLE ANALYSIS CAN CONCLUDE

*Marla Joi Ferguson*<sup>1</sup>

**I. Introduction**

*“The most horrible part about it was, within three minutes of the time that our doctor said to us ‘your daughter is infected, and she is diagnosed as having AIDS, your son is infected, and you are infected,’ he also said ‘Don’t Tell Anyone, because the world is not ready for your family.’”<sup>2</sup>*

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\* Marla Joi Ferguson is a J.D. candidate, 2014, St. Thomas University School of Law. She graduated from the University of Florida ten years ago with her B.A. in History/Minor in Education, and has since held successful positions in Human Resources and Operations Management. More significantly, though, Marla has gotten married and has two daughters: Daisy, who is three years old, and River, who is two years old. Writing this article was a group effort, many people sacrificed in order to make it possible. First and foremost, she has to thank her husband Chris. He is more amazing than words can say. All of the hours that she has dedicated to research and writing for this article, he has been at home taking care of their two children. He is one-in-a-million. Marla also has to thank her daughters and promise them that all of the sacrifice now will pay off for them in the future. Additionally, she has to thank her parents and sisters who help her everyday and always support her in everything she does. Finally, she has to thank her uncle Robert who gave her the courage and pushed her to study for her LSAT and apply to law school . . . and so much more! The reason the author is thanking her support system so profusely is because none of this would have been achievable without them, they deserve as much credit as she does.

Lastly, Marla wants to thank her professor Amy Ronner for her encouragement and enthusiasm about the author’s ideas and abilities. Marla recalls something Professor Ronner told her on one of the first weeks of class, “If you want something done, ask a busy person.” Thanks professor for showing her that nothing is too out of reach and her plate can never be too full. Also for instilling the principle that being a good person with compassion for others is just as important in the practice of law as anything else. Oh yeah, and always fight for what you believe in and stand up for those who need a voice.

2. In 1991, Elizabeth Glaser appeared on the Oprah show and came out to the world that she had AIDS, and that her daughter and son both contracted it from her in utero. Her daughter died of the disease and Elizabeth was told by her doctors to keep her diagnosis a secret because of the stigma and ridicule that she would receive if the world found out that she and her children have AIDS. Elizabeth went against her doctor’s advice, and ultimately shifted the world’s perception of AIDS from a shameful and dirty secret, to a disease that anyone can contract. The knowledge and education that resulted broke open the gates for AIDS activists’

This quote is an example of how the medical community's standard of secrecy has created an entire culture of fear, embarrassment and shame within the AIDS infected population and their families. The woman who made the statement disobeyed her doctors and ultimately became a change agent<sup>3</sup> for the legal, medical and moral standards of care and education for AIDS in the United States and throughout the world.

My research began focused strictly on intersex individuals in America and the audacities of Gender Reassignment Surgery. My mind was set; I had every intention of concentrating on '*doctors and parents mutilating these poor children who are born intersex.*' Of course, I initially read about the shocking statistics. For example; one in every 2,000 babies born in the United States has some form of Disorder of Sex Development ("DSD") and every day approximately five gender reassignment surgeries are performed on these infants.<sup>4</sup> I hurriedly and intensely made notes of the numbers and percentages as I read the articles. As my research progressed, my attention began to shift away from the "normalizing" surgeries<sup>5</sup> and began to gravitate

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access to the mainstream. The doctor who informed Elizabeth to keep her disease a secret was essentially telling her to be ashamed and embarrassed, because in the 1980s and early 90s the belief was, it was a gay man's or a poor person's disease. However, in the 1990s, as a result of the courage of people like Elizabeth Glaser, who have come out to the world to educate them about the dangers and reality of AIDS, the world knows it exists and everyone is susceptible. OPRAH: Elizabeth Glaser On Her Family's Struggle With AIDS (ABC Television Broadcast 1991).

3. See *infra* note 199, Ronner. The term change agent is used to explain the positive influence that Elizabeth Glaser was on the world and her impact on the medical and social cultures.

4. See Peter A. Lee, et al., *Consensus Statement on Management of Intersex Disorders*, 118 PEDIATRICS OFFICIAL J. AM. ACAD. PEDATRICS 488, 490-91 (2006). "Criteria that suggest DSD are usually recognized in the neonatal period, they include (1) overt genital ambiguity, (2) apparent female genitalia with an enlarged clitoris, (3) apparent male genitalia with bilateral undescended testes or a micropenis, (4) a family history of DSD, and (5) discordance between genital appearance and a prenatal karyotype. There are symptoms or signals of DSD that do not surface until puberty, such as (1) previously unrecognized genital ambiguity, (2) inguinal hernia in a female, (3) delayed or incomplete puberty, (4) virilization in a female, (5) primary amenorrhea, (meaning that girls do not get their period) (6) breast development in a male, and (7) gross and occasionally cyclic hematuria in a male, (meaning there are blood cells in his urine).

5. See *generally* Emi Koyama, Director, Intersex Initiative, Apple Keynote slide presented at the LGBTI Health Summit in Cambridge, Mass: Intersex and Public Policy: Legislative Strategies and Public Health Responsibilities (Aug. 228, 2004). "Normalizing" Surgeries are defined . . . as any surgery that a) does not

toward the victims and their parents. I got to know them intimately. I felt their struggles and realized that the subject of this article was much bigger than the surgery itself.

As I dug deeper, I began to connect the victim's stories together and found a common thread running within each of them. ***There is absolutely no communication going on!*** The lack of communication exists among the intersex individual, their families, and the medical doctors facilitating their care. The doctors are scared, the parents are scared, and the intersex individuals are scared, leading to a lack of communication.

One would think that the idea of "open communication" is nothing new in the medical field, and most of the time they would be correct. When the focus is on the subject of DSD, however, the complete lack of open communication is the root of the many evils that manifest themselves within the intersex community. The current concealment centered model "allows doctors to decide based on medical tests what gender identity the child will find most comfortable."<sup>6</sup>

In this article I focus on the psychological damage that results from the shame that attaches to intersex individuals and their parents. I will not go into detail about the "normalizing" surgery itself, but I will explain that as a result of the lack of education and communication the surgery is still in practice today. Additionally, I will define a few terms that are commonly used in this area of study. This will help build the foundation of the article by exposing the harsh reality; the majority of the population's knowledge does not extend beyond the two sexes, "male" and "female." We need to educate ourselves in order to begin to facilitate communication.

Part II will focus on the history and treatment of intersex individuals, with specific emphasis on Dr. John Money's controversial theory that he proved with the results of his experiment on David/Brenda Reimer.<sup>7</sup> Part III will dig into the current standard of care

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improve the health or function of the body in which it is performed on, and b) is designed to transform the appearance of the body part deemed "abnormal" to more closely approximate "normal." "Normalizing" surgeries are distinguished from "cosmetic" surgeries, which are designed to "improve" the appearance of a body part that is already considered "normal."

6. Nicki Burrill&Valita Fredland, *The Forgotten Patient: A HealthProvider's Guide to Providing Comprehensive Care for Transgender Patients*, 9 Ind. Health L. Rev. 69, 72 (2012).

7. See *infra* text accompanying note 14.

and concealment from a medical, legal, and moral perspective that resulted from Dr. Money's erroneous medical reporting. In order to enhance the reader's understanding of the current standard of care, in Part IV, I will introduce a few intersex individuals and share their stories of struggle, confusion, anger, addiction, disbelief and eventually acknowledgment and healing that can grow out of the willingness and opportunity to communicate.

After combining all of the data from the personal stories and medical experiments, Part V will introduce Dr. Milton Diamond. Dr. Diamond is one of the most important figures in the intersex community because he is the person who is responsible for exposing Dr. Money's fabricated reports about David/Brenda Reimer's gender reassignment surgery. Dr. Diamond proves that 'nurture can always defeat nature' is factually incorrect and has caused endless damage to its victims. This is the reason that it is our duty as human beings to facilitate change.

Finally, and most importantly, Part VI will lay out a plan that will lead the medical professionals, parents and the intersex individuals themselves onto a path of education, discovery, and recovery. The ultimate goal of this plan is shedding the disgrace that accompanies DSD through a heightened standard of care that requires patient-centered informed consent tied together with therapeutic jurisprudence.<sup>8</sup>

## II. The History of Treatment of Intersex Individuals

### a. Dr. Money's Theory

*"It simply does not make sense to talk of a third sex, or a fourth, or a fifth, when the phylogenetic scheme of things is two sexes. . . . To advocate medical nonintervention is irresponsible. It runs counter to everything [my] book stands for, which is to enhance health and well-being to the greatest extent possible."*<sup>9</sup>

In 1967, Dr. Money established that gender-"normalizing" surgery was in the best interest of the intersex child and their family based on an experiment he conducted and the positive results therefrom that he reported to the medical community.<sup>10</sup> Before the "ex-

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8. See discussion *infra* Part VI-b.

9. SUZANNE J. KESSLER, LESSONS FROM THE INTERSEXED 121 (1998) (quoting JOHN MONEY, SEX ERRORS OF THE BODY AND RELATED SYNDROMES: A GUIDE TO COUNSELING CHILDREN ADOLESCENTS AND THEIR FAMILIES 6 (1968)).

10. See Money *infra* note 13.

periment” began, a set of twin boys was circumcised at 7 months of age.<sup>11</sup> During the circumcision, the knife used on one of the boys (“David”) severely burned his penis, destroying it. Shortly afterward, a psychiatrist told David’s parents, “He will be unable to consummate a marriage or have normal heterosexual relations; he will have to recognize that he is incomplete, physically defective, and that he must live apart. . . .”<sup>12</sup>

The parents of the boys got in touch with Dr. John Money, a psychologist at the Gender Identity Clinic at Johns Hopkins University who had published a book and written articles on successful reassignment surgery. Dr. Money assured the parents of the accuracy of his theory that “nurture, rather than nature, had the greatest influence on one’s sexual identity”<sup>13</sup> and that if they castrated the boy with the damaged penis before he turned two years old, they could raise him as a normal girl who would fit in seamlessly with society.<sup>14</sup> He went a step further and told the parents that this was a social emergency and in order to save the boy from the trauma of growing up ‘different’ they must decide immediately.<sup>15</sup> The parents trusted Dr. Money’s medical opinion and completed the surgery when David was 17 months old, and thereafter raised the child as Brenda.<sup>16</sup>

Dr. Money’s theory was grounded on the importance of keeping everything a secret from Brenda. The parents were told “in order to foster secrecy. . .to settle in a distant city.”<sup>17</sup> The belief was that as long as Brenda did not know that she was born a male, she would accept the gender they assigned her without resistance because “nur-

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11. They were brought in at 7 months due to a narrow opening of the foreskin.

12. John Colapinto, *The True Story of John/Joan*, ROLLING STONE MAGAZINE, December 11, 1997.

13. John Money et al., *Hermaphroditism: Recommendations Concerning Assignment of Sex, Change of Sex, and Psychologic Management*, BULLETIN JOHNS HOPKINS HOSPITAL 97, 284 (1955).

14. See JOHN COLAPINTO, *AS NATURE MADE HIM, THE BOY WHO WAS RAISED AS A GIRL* (2006). Dr. Money’s idea of the Gender Identity Gate, is the term he used for that moment after which a child has locked into an identity as a male or female. Approximately two years of age or a little after is when the gate closes forever.

15. *Id.*

16. *Id.*

17. Hazel Glenn Beh& Milton Diamond, *An Emerging Ethical and Medial Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants With Ambiguous Genitalia?* 7 MICH. J. GENDER & L. 1, 3 (2000).

ture (social factors), rather than nature, had the greatest influence on one's sexual identity."<sup>18</sup>

Dr. Money published reports and follow up documentation about Brenda, explaining that she was a well-adjusted female who accepted the assigned gender.<sup>19</sup> This was a landmark case for the medical community; it set the precedent for the widely adopted surgical standard of care in treatment of intersex individuals.<sup>20</sup> Additionally, Dr. Money made very clear that secrecy was imperative in order to maintain the successful adoption of the gender that is assigned.<sup>21</sup>

In essence, Dr. Money set a standard for the medical community to follow that infringes on the intersex individual's fundamental right to life, liberty, and property without even meeting a rational basis standard of review.<sup>22</sup> The courts have a fundamental interest in regulating the medical community's ability to deprive intersex patients of their right to accept or reject medical treatment and surgical invasion of their body. The performing of surgery on intersex individuals, therefore, should only be allowed if the reason for the surgery is necessary to save the child's life.<sup>23</sup> In other words, the legislation regulating the medical community's ability to perform surgery should be required to meet at the very least, a heightened level of scrutiny.<sup>24</sup>

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18. Dean Kotula, Pacific Center for Sex and Society, *The Phallus Palace: Female to Male Transsexuals* <http://www.hawaii.edu/PCSS/biblio/articles/2000to2004/2002-conversation.html> (last updated December 8, 2011).

19. See COLAPINTO *supra* note 14.

20. *Id.*

21. *Id.*

22. See, ERWIN CHERMERINSKY, CONSTITUTIONAL LAW 718 (Vicki Been et al. eds. 3rd ed. 2009). "The rational basis test holds that legislation is presumed to be valid and will be upheld if the statutory classification is rationally related to a legitimate state interest." While the medical community may or may not be considered a state actor as required by the Fourteenth Amendment to require Due Process, this shows that the actions by private actors would not meet this lowest level of scrutiny.

23. See *id.* at 718. (Intermediate scrutiny is used for discrimination based on gender, clearly intersex can be lumped in this category and receive a heightened level of scrutiny.)

24. See *id.* at 719. (Heightened scrutiny consists of Strict and Intermediate. Discrimination based on race or national origin is subject to strict scrutiny. This means, the government may use racial or national origin classifications only if it proves that they are necessary to achieve a compelling government interest. Discrimination based on gender and against non-marital children is subject to intermediate scrutiny and the law will only be upheld if it is substantially related to an important government purpose. The means need not be necessary, but must have a substantial relationship to the end being sought.)

Dr. Money's experiment on the twin boys is an example of the damage that can be caused when new standards that have not been sufficiently tested are accepted as proven facts. The medical and legal communities have a responsibility to require adequate qualification and justification for the standards that they put into practice.

The standard of care that has been set by this experiment is a direct effect of the unawareness exhibited by the specialists in this field. The willingness of doctors around the world to accept and apply a standard of care that has not been supported by adequate tests and trials is unacceptable and offensive.

Believe it or not, there are arguments in support of Dr. Money's medical perspective. For Example; Sara A. Aliabadi stated in her article, *You Make Me Feel Like A Natural Woman*,

Absent any demonstrable conflict between the interests of the family and the interests of the patient, and assuming that the medical decision made by the family for the infant is within the range of reasonableness, society should exhibit deference to the parents in the context of gender assignment surgery. Legislators and courts should refrain from instituting a legal moratorium on gender assignment surgery and recognize the legal capacity of parents to consent to surgery on behalf of heir intersexed infants.<sup>25</sup>

Aliabadi mentions a quote from Chief Justice Stone's concurrence in *Skinner v. Oklahoma*, explaining that blanket regulations of a class may be appropriate for certain members, while inappropriate for others.<sup>26</sup>

"[I]f we must presume that the legislature knows-what science has been unable to ascertain. . . the real question we have to consider is . . . whether the wholesale condemnation of a class to such an invasion of personal liberty, without opportunity to any individual to show that his is not the type of case which would justify resort to it, satisfies the demands of due process."<sup>27</sup>

I agree with Justice Stone's opinion, however, my interpretation of it is something wholly different. In reading the opinion by Chief Justice Stone, I understood his words to mean that all individuals are different. Moreover, those differences demand due process on a case-by-case basis. Every individual with a DSD has a unique case and the legislature is in no better a position than the doctors to allow such

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25. Sara A. Aliabadi, *You Make Me Feel Like a Natural Woman: Allowing Parents to Consent to Early Gender Assignment Surgeries For Their Intersexed Infants*, 11 WM & MARY J. WOMEN & L. 427, 459 (2005).

26. *Skinner v. Okla.*, 316 U.S. 535 (1942) (Stone, J., concurring).

27. *Id.* at 544.

invasions of intersex individuals' fundamental right to Due Process and Equal Protection of the law.<sup>28</sup> Within the quote mentioned above, Stone says, "the real question to consider is . . . whether the wholesale condemnation of a class to such an invasion of personal liberty, without opportunity to any individual to show that his is not the type of case which would justify resort to it, satisfies the demands of due process."<sup>29</sup> It is clear that Stone's opinion supports my argument that there needs to be a legal standard of patient-centered informed consent placed on medical doctors in the United States to protect the liberty interests that are guaranteed by the Constitution.<sup>30</sup>

### III. The Current Standard of Care

#### a. Medical Standard of Care

*"The Birth of a Child with Ambiguous Genitalia is a Medical and Psychosocial Emergency!"*<sup>31</sup>

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28. A highly publicized case of an intersex individual with a unique situation is that of Maria Patino. Maria was an adult woman who lived, functioned, and identified as a woman. She had no signs or concerns about her sex or gender. In 1985 Maria tried out for the World University Games in Kobe, Japan. Each participant was required to take a sex verification blood test. That blood test showed male chromosomes. This was a complete shock. Maria, therefore, was intersex based on her chromosomal makeup and not her genitalia. This type of DSD is referred to as Androgen insensitivity syndrome ("AIS"). ROBERT PEEL, *Maria's Story*, in *EVE'S RIB - SEARCHING FOR THE BIOLOGICAL ROOTS OF SEX DIFFERENCES* (Crown Publishers, 1994) available at <http://www.aissg.org/articles/MARIA.htm>. "AIS occurs when a person who is genetically male (who has one X and one Y chromosome) is resistant to male hormones (called androgens). As a result, the person has some or all of the physical traits of a woman, but the genetic makeup of a man." American Psychological Association, *Answers to Your Questions About Individuals with Intersex Conditions*, available at <http://www.apa.org/topics/sexuality/intersex.pdf> (last visited March 26, 2013).

29. See Skinner *supra* note 26 at 544.

30. See, U.S. CONST. amend. V. ("No person shall be deprived of life, liberty, or property without due process of law.") See also, U.S. CONST. amend. XIV, § 1. ("No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any state deprive any person of life, liberty, or property without due process of law, nor to deny to any person within its jurisdiction the equal protection of the laws.")

31. Arlene Istar Lev, *Intersexuality in the Family: An Unacknowledged Trauma*, 10(2) J. OF GAY & LESBIAN PSYCHOTHERAPY 27, 29 (2006). See also Elizabeth Reilly, *Radical Tweak-Relocating the Power to Assign Sex from Enforced of Differentiation to Facilitator of Inclusiveness Revising the Response to Intersexuality*, 12 CARDOZO J.L. & GENDER 297 (2005). (This belief was championed in the 1950s by the group at Johns Hopkins University led by Dr. John Money within the "optimum of sex rearing approach." This approach included a

The current medical model focuses on choosing a sex for the infant and immediate surgical treatment.<sup>32</sup> This model also requires doctors to prescribe hormonal treatment designed to promote “gender-appropriate” secondary characteristics as they age, while practicing deception to keep the fact of intersexuality from the individual.<sup>33</sup> This includes explaining the importance of a strong gender-reinforcing upbringing to the parents of intersex children.<sup>34</sup> A majority of physicians believe in the Concealment-Centered Model, in which the standard practice is for the doctor to determine whether the child has such physical attributes that he can construct a “normal” looking penis of 1 inch or larger.<sup>35</sup> If he believes he can do so, then the child will be assigned to the male gender.<sup>36</sup> The doctor performs surgery

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rush to choose the optimum sex of rearing for the child (‘male’ or ‘female’). There was an emphasis that time is of the essence to avoid unnecessary trauma to the family. The optimum sex was determined by the physical make up of the genitals. If there was a micropenis, the ideal situation would be to castrate and construct a vagina. If there was enough ‘material’ to construct a penis, they would construct one for the child and assign it to the male gender. For the rest of the child’s life, hormone replacement therapy would be required to maintain the child’s appearance and control the physical characteristics through puberty and adulthood so that it matches the assigned sex.)

32. Jorge J. Daaboul, *A Newborn Infant With a Disorder of Sexual Differentiation*, 114 PEDIATRICS 1473 (Nov. 2004) available [http://pediatrics.aappublications.org/content/114/Supplement\\_6/1473.full.html](http://pediatrics.aappublications.org/content/114/Supplement_6/1473.full.html).

33. *Id.*

34. Alice Dreger, Intersex Society of North America, *Shifting the Paradigm of Intersex Treatment*, [www.isna.org/compare](http://www.isna.org/compare) (last visited March 28, 2013). (“Intersex is a rare anatomical abnormality which is highly likely to lead to great distress in the family and great distress for the person with an intersex condition. Intersex is pathological and requires immediate medical attention.” This treatment protocol is motivated by “[t]he belief that our society can’t handle genital ambiguity or non-standard sexual variation. If we don’t fix the genitals, the child with an intersex condition will be ostracized, ridiculed, and rejected, even by his or her own parents.”)

35. JOAN ROUGHGARDEN, *EVOLUTION’S RAINBOW: DIVERSITY, GENDER, AND SEXUALITY IN NATURE AND PEOPLE* 300 (2004). (“The Intersex Society of North America (ISNA) devised a ruler termed a phallometer. Penis length at birth in typical males ranges from 2.5 centimeters to 4.5 centimeters and clitoral length ranges from 0.20 to 0.85 centimeters. The phallometer is a ruler with 0.20-0.85 marked off as female and 2.5 to 4.5 marked off as male: hold the phallometer next to the phallus of the newborn and read off the child’s sex. An XY child with a penis length of 1.5 is less than the conventional masculine range and is irreversibly assigned as female then and there.”)

36. See SUZANNE J. KESSLER, *LESSONS FROM THE INTERSEXED* 109 (1998), (quoting one group of surgeons who listed the following phallic requirements for males: “The presence of a sufficiently large phallus to function as a male urinary

immediately after birth to “normalize” the genitals to match society’s standard male appearance.<sup>37</sup> Some small penises can be enlarged with exogenous application of hormones, and, although not perfectly, some can construct a penis out of other tissue.<sup>38</sup> On the other hand, if the child has an “inadequate” penis, according to doctors, she or he, will be assigned to the female gender and surgically reconstructed so that she has female cultural genitals.”<sup>39</sup> Today’s standard of care for doctors treating intersex infants is to “normalize” the external genitalia to conform to societal expectations of gender.<sup>40</sup>

The most important focus for the doctor has always been to show no doubt as to the sex of the child when they are born. Doctors have historically believed that parents are not able to cope with an ambiguous gender assignment. For example, Dr. Luce, in Jeffrey Eugenides’ *Middlesex*, believed that, “you do not tell the parents of a newborn, your baby is a hermaphrodite.<sup>41</sup> Instead you say, your daughter was born with a clitoris that is a little larger than a normal girl’s. We’ll need to do surgery to make it the right size.”<sup>42</sup> The United States has allowed medical professionals to make life altering decisions that they are not qualified to make. Research conducted in the United States over the past ten years has revealed that the current

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conduit, to offer a satisfactory appearance when compared with peers, and to function satisfactorily for sexual activity.”)

37. *Id.*

38. *Id.* at 14.

39. *See id.* at 166 (1998). (The definition for ‘cultural genitals’ is the genitals one is assumed to have under one’s clothing.) *See also id.* at 165 (A girl’s clitoris is surgically reduced if it exceeds one centimeter. Anything larger than one centimeter is considered a clitorimegaly, or the condition of having what physicians consider an enlarged clitoris and is treated with a clitoral recession, which is a surgical technique that reduces the apparent size of the clitoris by burying the erectile shaft under a fold of labia minora so that only the glans is visible.)

40. *See* Milton Diamond & Keith Sigmundson, *Sex Reassignment at Birth: A Long Term Review and Clinical Implications*, 151 ARCHIVES OF PEDIATRIC & ADOLESCENT MEDICINE (1997), available at <http://www2.hu-berlin.de/sexology/BIB/DIAM/reassignment.htm>. (Explaining that the majority of intersex children are turned into girls because it is easier to surgically construct a vagina than it is to construct a penis, “It is easier to make a good vagina than a good penis and since the identity of the child will reflect upbringing, and the absence of an adequate penis would be psychosexually devastating, fashion the perineum into a normal looking vulva and vagina and raise the individual as a girl.”)

41. JEFFREY EUGENIDES, *MIDDLESEX* 413 (2002).

42. *Id.*

medical model of treating intersex as a disease that requires immediate treatment does more harm than good.<sup>43</sup>

It is important to note, the current standard of care that the medical community follows is almost entirely based upon the size of the penis.<sup>44</sup> If the penis size establishes that it is big enough for the doctors to construct a ‘normal’ looking penis out of, they will attempt to do so, and thus, will rear the child as a male.<sup>45</sup> Or, if the penis is extremely small the child will be castrated and reared as a female.<sup>46</sup> Public opinion is shifting away from concentrating solely on penis size to determine one’s sex.<sup>47</sup> Medical studies have proven that sex is tied to the brain and nervous system rather than to the penis.<sup>48</sup>

The Medical Standard of Care in the United States is light years behind a number of other countries around the world, especially when it comes to the treatment of individuals with disorders of sex development. For example, in the Netherlands, there is *The Ten Tasks of the Mental Health Professional, (Ten Tasks)*.<sup>49</sup> Every Mental Health Professional who works with an individual with a gender identity disorder is required to follow the guidelines set out in the *Ten Tasks*.<sup>50</sup> Australia and Germany have both passed laws regarding the

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43. See *supra* notes 13, 16, and 17.

44. See *supra* note 34.

45. *Id.*

46. See KESSLER *supra* note 36 at 167 (1990). (A Micro-penis is a penis that has a stretched length of less than two and a half standard deviations below the mean for age or stage of development; a penis smaller than two centimeters at birth.)

47. See *infra* “Dr. Money’s Theory is Debunked.”

48. *Id.*

49. Franklin H. Romeo, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713, 725 (Issue 3 2004-05). (The Ten Tasks of the Mental Health Professional Include-1) To accurately diagnose the individual’s gender disorder; 2) To accurately diagnose any co-morbid psychiatric conditions and to see their appropriate treatment; 3) To counsel the individual about the range of treatment options and their implications; 4) To engage in psychotherapy; 5) To ascertain eligibility and readiness for hormone and surgical therapy; 6) To make formal recommendations to medical and surgical colleagues; 7) To document their patient’s relevant history in a letter of recommendation; 8) To be a colleague on a team of professionals with an interest in the gender identity disorders; 9) To educate family members, employers, and institutions about gender identity disorders; and 10) To be available for follow up of previously seen gender patients.)

50. *Id.*

legal recognition of a third sex.<sup>51</sup> Education, knowledge, and patient involvement are the most significant aspects of the *Ten Tasks* that the Netherlands commands of their Doctors.<sup>52</sup>

More recently and much more significantly, a third gender, eunuchs, was legally recognized in India.<sup>53</sup> This approach is quite different from the approach taken in the United States.<sup>54</sup> In the U.S., the primary approach has been to hide any sexual ambiguity from the parents for fear that they cannot handle the truth.<sup>55</sup> Parents are basing their decision, whether to operate or not, on the belief that the doctor knows what is best for their child, at that time.<sup>56</sup> Sweden has also made strides toward a more accepting national attitude toward gender neutrality by adding a neutral pronoun to refer to both males and females.<sup>57</sup> The wanton secrecy and urgency that is reinforced by the medical standard of care takes away the opportunity for these individuals and their parents to consent or reject medial treatment.<sup>58</sup>

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51. Kharunya Paramaguru, *Boy, Girl, or Intersex?*, TIME WORLD, available at <http://world.time.com/2013/11/12/boy-girl-intersex/>. Australia now allows their citizens to put 'indeterminate' as a third option for gender on their passports. Additionally, just this year, Germany passed a law that no longer requires parents to check either male or female on their infant's birth certificates. A third option of "indeterminate" is legally recognized in Germany as the third gender.

52. See Romeo, *supra* note 49.

53. Dean Nelson, *India's Supreme Court creates official third sex for eunuchs and transgenders*, available at <http://www.telegraph.co.uk/news/worldnews/asia/india/10767555/Indias-Supreme-Court-creates-official-third-sex-for-eunuchs-and-transgenders.html>. Eunuchs are also known as Hijras or Hizras. They are the third sex, neither male nor female. There are an estimated two million eunuchs in India.

54. *Id.* Eunuchs in India are now eligible for benefits from the government, they can legally inherit property, they can obtain employment with the government, this will allow them to travel abroad, and they will be allowed to vote in all elections.

55. See Dreger, *supra* note 34 and accompanying text.

56. *Id.*

57. Nina Banadur, *Swedish Gender-Neutral Pronoun 'Hen' Added to Country's National Encyclopedia*, THE HUFFINGTON POST (April 11, 2013) available at [http://www.huffingtonpost.com/2013/04/11/swedish-gender-neutral-pronoun-hen-national-encyclopedia\\_n\\_3063293.html](http://www.huffingtonpost.com/2013/04/11/swedish-gender-neutral-pronoun-hen-national-encyclopedia_n_3063293.html). (The Swedish National Dictionary added the term "hen" and has explained it as a proposed gender-neutral personal pronoun instead of their traditional 'han' and 'hon' for he and she.)

58. The word wanton, for purposes of this article, refers to the self-serving origination of the idea of imposing a sense of urgency. The urgency is not medically necessary, it is implemented and reiterated in order to pressure parents into making rash unqualified decisions based on the physician's opinion of what is best.

## b. Legal Standard of Care

*Under our precedents it is clear that the State has a significant role to play in regulating the medical profession.*<sup>59</sup>

“For questions of inheritance, legitimacy, paternity, succession to title, and eligibility for certain professions to be determined, modern . . . legal systems require that newborns be registered as either male or female.”<sup>60</sup> As a result, case law is primarily focused on issues affecting transgendered individuals amending their birth certificates, their ability to marry and divorce, and surrogate healthcare decision making for incapacitated partners.<sup>61</sup> The legal system has fundamentally ignored the existence of intersex individuals based in part on the subconscious acceptance of the binary system of biological sex.<sup>62</sup> The history of case law, therefore, has no set precedence or guidelines that regulate decisions about the medical treatment of intersexual individuals.

Jurisprudence in the United States has largely avoided creating a legal standard of care for doctors to follow when they are presented with an intersex child. In fact, there is a tradition to give strong deference to the medical community’s self-imposed standard of care. This is troubling because the medical community’s data is misleading and their studies are insufficient to support any findings of fact that secrecy, surgery, and urgency are nontoxic to these individuals.<sup>63</sup> In light of recent studies and data collected from intersex individuals, the scientific, educational, and medical communities have been

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59. See generally *Washington v. Glucksberg*, 521 U.S. 702 (1997).

60. Anne Fausto-Sterling, *The Five Sexes: Why Male and Female Are Not Enough*, THE SCIENCES, Mar. 1993, at 20.

61. Nikki Burrill and Valita Fredland, *The Forgotten Patient: A Health Provider’s Guide to Providing Comprehensive Care for Transgender Patients*, 9 IND. HEALTH L. REV. 69, 92 (2002).

62. Julie Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265, 273-279 (Summer, 1999). (Intersex is a medical condition that can be caused by either (1) failure to meet the typical criteria within any one factor, such as; Gonadal Ambiguity, External Morphologic Sex, Hormonal Sex, Phenotypic Sex, Assigned Sex/Gender of Rearing, and Sexual Identity. Additionally, (2) one or more factors may be incongruent with the other factors, such as; Chromosomal Sex Disorders, Gonadal Sex Disorders, Internal Organ Anomalies, External Organ Anomalies, Hormonal Disorders, Gender Identity Disorders, and Surgical Creation of an Intersex Condition. Each one of the disorders listed above have subsections or different mutations they can appear in. For an exhaustive list and discussion of the additional subsections of the above disorders, see *id.*)

63. See *supra* Part II. See also *infra* Part V.

forced to question their long-standing definition of sex as binary.<sup>64</sup> This supports my overarching theme, “the legal community must question its long-held assumptions about the legal definitions of sex, gender, male, and female.”<sup>65</sup>

*“Such recognition will promote the individual’s quest for inner peace and personal happiness, while in no way disserving any societal interest, principle of public order or precept of morality.”*<sup>66</sup>

There are landmark Supreme Court cases emphasizing the importance of informed consent and how competent human beings have the choice to accept or refuse medical treatment.<sup>67</sup> Why does our legal system furnish such rights to “men” and “women”<sup>68</sup> while refusing to extend them to “intersex” individuals? For example, *Casey v. Planned Parenthood*<sup>69</sup> created the condition that doctors are required to give informed consent and the patient must wait at least 24 hours prior to receiving an abortion.<sup>70</sup> The required information and waiting period is put into place as a tool or mechanism to get women to *choose* to change their mind. Thus, medicine is using the law as a tool to overcome an individual’s will to get an abortion, but it will not use laws to promote *choice* for infants born with ambiguous genital.

Informed consent and a waiting period should be required guidelines for doctors to meet prior to performing any “normalizing” surgery on an intersex infant. This would give parents more time to gather information, get a second opinion, and make a well-informed

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64. *See supra* note 62 at 292.

65. *Id.*

66. *M. T. v. J. T.*, 355 A.2d 204, 211 (App. Div. N.J. 1976).

67. *Id.*

68. For purposes of this article, the terms *men* and *women* include boys, girls, males, and females.

69. *Casey v. Planned Parenthood of Se. Pennsylvania*, 14 F.3d, 848 (3d Cir. 1994).

70. *Id.* at 853. (The informed consent requirement for abortions requires the referring physician or the physician who will perform the abortion to speak with the patient at least 24 hours prior to the abortion, informing her of the nature and risks of abortion, the probable gestational age of the fetus, and the risks of carrying the child to term. One of those physicians, or a qualified medical practitioner, must also inform her of printed materials available from the Commonwealth concerning alternatives to abortion, medical assistance benefits for childbirth, and the liability of the father for support.)

decision; without the pressure of time constraints that are blamed on a false implication of a “medical emergency”.<sup>71</sup>

Further, in *Cruzan v. Director* the Missouri court recognized that competent human beings have the right to refuse unwanted medical care.<sup>72</sup> Justice O’Connor, in her concurring opinion stated, “the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual’s deeply personal decision to reject medical treatment.”<sup>73</sup> The court emphasizes that there is a general fundamental right to refuse medical treatment.<sup>74</sup> The court goes a step further and extends that right to individuals who are not able to communicate what is in their best interest and requires that “evidence of an incompetent’s wishes as to the withdrawal of. . .treatment [must] be proved by clear and convincing evidence.”<sup>75</sup> Clearly the court is carving out and protecting an individual’s right to be considered and consulted before medical decisions are made on his or her behalf.

Applying intermediate scrutiny and requiring clear and convincing evidence of the patient’s best interest would be a solid base for creating a legal standard of care that requires patient-centered informed consent governing doctors treating intersex patients.<sup>76</sup> The state has a substantial interest in rearing happy, well-adjusted human beings without the threat of permanent physical damage at the hands of a doctor.<sup>77</sup> There are no notable differences between the fundamental rights enumerated in *Cruzan* and the fundamental rights that a patient-centered standard of care would protect.<sup>78</sup> Adding legally enumerated standards, such as a waiting period, requirement of informed consent, and a prerequisite of clear and convincing evidence of patient’s best interest poses no additional or undue burden on the doctor, community, patient, or their family. Currently, there is no

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71. Elizabeth Reilly, *Radical Tweak-Relocating the Power to Assign Sex from Enforced of Differentiation to Facilitator of Inclusiveness Revising the Response to Intersexuality*, 12 *CARDOZO J.L. & GENDER* 297, 303-04 (2005); *See also*, Diamond *supra* note 40 at 14 (Explaining that clinicians have imported a sense of medical urgency to parents upon the birth of an intersex child. Although the intersex state is typically not life-threatening, parents are counseled to act quickly in order to establish a sex of rearing that is unequivocal).

72. *Cruzan v. Director*, Missouri Dept. of Health 497 U.S. 261, 289 (1990).

73. *Id.*

74. *Id.*

75. *Id.* at 261.

76. *See* CHEMERINSKY, *supra* note 22 at 718.

77. *See* CHEMERINSKY, *supra*, note 22.

78. *See* *Cruzan supra* note 72.

standard requirement for informed consent from the parents or from the patient prior to medical decisions and care of infants with DSD.<sup>79</sup>

The intersex community has tried numerous approaches to get the courts to recognize that intersex individuals' fundamental right to life, liberty and the pursuit of happiness are being trampled on without the due process<sup>80</sup> that is enumerated in the Constitution. One avenue that has been attempted, is legally assimilating "normalizing" surgery to female genital mutilation so that it will be covered under §645(a) of Div. C. of Pub. L 104-208.<sup>81</sup>

Internationally, the medical standard of care varies from country to country. For example, in Colombia, intersex is a protected minority class;<sup>82</sup> it is illegal for a doctor or parent to perform surgery to "normalize" an intersex infant before they reach the age of eighteen, without their informed consent.<sup>83</sup> There is no case law in the United

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79. It is important to keep in mind an idea pointed out by the court in *In re Gault*, 387 U.S. 1, 13 (1967), "whatever may be their precise impact, neither the Fourteenth Amendment nor the Bill of Rights is for adults alone." This points out the importance of the rights of minors that are protected in our Constitution, rights that are completely ignored and trampled on everyday by the medical community when performing surgery on these infants.

80. See *Skinner supra* note 26 at 544.

81. Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, § 645(a), 110 Stat. 3009 (1996).

(1) the practice of female genital mutilation is carried out by members of certain cultural and religious groups within the United States;

(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;

(4) the unique circumstances surrounding the practice of female genital mutilation place it beyond the ability of any single State or local jurisdiction to control;

(5) 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; and

(6) Congress has the affirmative power under section 8 of article I, the necessary and proper clause, section 5 of the fourteenth Amendment, as well as under the treaty clause, to the Constitution to enact such legislation.

82. Aliabadi, *supra* note 25 at 427. (In 1999, Constitutional Court of Colombia ruled that intersex is a protected class.)

83. *Id.* (Of course, there are exceptions for medical emergencies. There are situations where ambiguous genitalia can present a danger to the life and well-being of the infant. These medical emergencies should be evaluated and treated accordingly.)

States declaring a medical legal standard that doctors must follow when treating individuals with disorders of sex development.

Until today, the closest that an intersex individual has come to legal recognition in the United States is in *Wood v. C.G. Studios*,<sup>84</sup> where the term “hermaphrodite” was included in the opinion.<sup>85</sup> Notwithstanding the fact that the outcome was not favorable, the inclusion of the word “hermaphrodite” was proof of the court’s acknowledgment of Intersex.<sup>86</sup> Currently, a case of first impression has made its way to the courts! The current lawsuit was brought by the parents of an intersex child, on behalf of that child (“M.C.”).<sup>87</sup> The parents claim that medically unnecessary sex assignment surgery was performed on M.C. when he was sixteen months old, in violation of his 14th Amendment Substantive and Procedural Due Process rights.<sup>88</sup> The parents further alleged gross negligence and medical malpractice on behalf of the hospital, its staff, and many others that were instrumental in the decision to perform surgery on M.C.<sup>89</sup> This case has the potential to change the course of jurisprudence when it comes to giving recognition and a voice to the intersex individuals of the United States.

Whether this case is successful or not, either way, it is a monumental step in the right direction for children born with DSD. Not

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84. *Wood v. C.G. Studios, Inc.*, 660 F. Supp. 176, 176 (1987).

85. *Id.* “[A] worker brought action claiming employer discriminated against her based on sex in violation of the Pennsylvania Human Relations Act by failing to promote worker and terminating her employment solely because employer learned worker had undergone surgery to correct her *hermaphroditic* condition prior to working for employer. Employer moved for summary judgment. The District Court . . . would find that discrimination on basis of gender-corrective surgery did not constitute discrimination on the basis of sex. . .” years prior to *Wood*. See also, *Ulane v. E. Airlines, Inc.*, 742 F.2d 1081, 1083 (7th Cir. 1984) (Where the court defined the term hermaphrodite as a person whose sex is not clearly defined due to a congenital condition.)

86. Three years later, Justice O’Connor’s concurring opinion in *Cruzan v. Director, Missouri Dept. of Health* 497 U.S. 261, 286 (1990), points out that “[b]ecause our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed State incursions into the body repugnant to the interests protected by the Due Process Clause.”

87. *Crawford v. Aaronson et al.*, No. 2:13-CV-01303, *complaint filed* (D.S.C. May 14, 2013).

88. *Id.*

89. *Crawford v. Medical University of South Carolina et al.*, No. 2013-CP-400-2877, *complaint filed* (S.C. Ct. Com. Pl., Richland County May 14, 2013).

only is it challenging the current medical standards and attempting to hold the decision makers accountable, it is opening the doors of knowledge to the world. There may be children, or adults, who are currently living with this secret and believe they are all alone. Hearing about this case may set them free emotionally and change their lives for the better.

Legal recognition of intersex and a standard of care requirement added to the statutes would serve the important government objective of rearing happy and healthy children into well-balanced adults that function comfortably in society. Therefore, leaving intersex individuals free to make their own decision about whether to castrate, mutilate, or none of the above, is vital to the achievement of that objective.

### c. Moral Standard of Care

*“We now understand that cutting genitals doesn’t change or reinforce gender or sexual preference. We know that repeated childhood trauma, secrecy and shame shape us as adults.”<sup>90</sup>*

Immediately after birth, doctors discreetly fix the defect before the parents have the opportunity to worry, which is done with good intentions by the doctors in order to save the parents the trauma of having a child with ambiguous genitalia. Morally, these doctors think that they are doing what is in the best interest of the child,<sup>91</sup> and their family. The current belief is that an intersex child can live a normal life as whichever gender the doctor has chosen to assign to them. Although the standard of care and informed consent has not overruled the concealment-centered standard, public opinion is moving toward adopting a legal minimum requirement of patient-centered informed consent, and away from the belief that surgery is the only option.

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90. Riki Wilchins, *A Girl’s Right to Choose: Intersex Children and Parents Challenge Narrow Standards of Gender*, National Organization for Women (2002), <http://www.now.org/nnt/summer-2002/intersex.html>.

91. The *best interest of the child* standard is too objective, there is too much wiggle room for the doctors to work within their guidelines of what they think is the best, and far too often bias and prejudice can be included in their decision. The best interest of the child can only be decided by the child themselves, when they reach an age of which they can comprehend their differences and make their own choice about surgery, or not.

The intersex community has slowly gained a voice through support groups,<sup>92</sup> websites,<sup>93</sup> and medical education. However, the moral standard of care is still in the hands of the doctor, and statistics have proven that most doctors will choose to “normalize” their patients immediately.<sup>94</sup> Today, education and communication are beginning to make a difference.<sup>95</sup> Doctors are beginning to incorporate the opinion and informed consent of the parents when making the decision to perform surgery or, preferably, not to perform surgery.<sup>96</sup> This is paramount to the child’s overall ability to cope with their differences as they mature.

In a 2010 response to a request for an evaluation of a child who had a botched circumcision, Dr. William Reimer,<sup>97</sup> explained that the first response to be considered when dealing with a child who has a genital abnormality is the parents.<sup>98</sup> He went on to say that parents are the ones who must carry on the day-to-day physical and emotional care of their child.<sup>99</sup>

Unquestionably, there are many competing theories about the most effective way for parents to fulfill their central role in assisting their children on the way to responsible adulthood. . . [W]e cannot ignore that central to many of these theories, and

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92. See e.g. Noodles Group, Mayer-Rokatinsky-Kustur-Hauser\_Syndrome Support Group, Humanitas, LandelijkeKnotactGroep Tent, AIS Support Group of the US-AISSG, H.E.L.P.-Hermaphrodites Education and Listening Post, Trans Masculine Community Network, Bodies Like Ours, and many more. For more, visit [www.bodieslikeours.org](http://www.bodieslikeours.org).

93. See e.g. [transgenderlawcenter.org](http://transgenderlawcenter.org), [www.transgenderlaw.org](http://www.transgenderlaw.org), [srlp.org](http://srlp.org), [accordalliance.org](http://accordalliance.org), [AICLegal.org](http://AICLegal.org), <http://isna.org/faq.html#anchor643405>, [BornBetween.com](http://BornBetween.com), and [DallasDenny.com/Chrysalis](http://DallasDenny.com/Chrysalis).

94. Hazel Gelell Beh & Milton Diamond, *David Reimer’s Legacy: Limiting Parental Discretion*, 12 *CARDOZO J.L. & GENETICS* 5, 25 (2005) (Dr. Money’s theory is proven wrong by Milton Diamond’s follow up interview of the Reimer family and the medical and mental health professionals that treated the twins.)

95. *Id.*

96. *Id.*

97. *Id.* at 18-19. (Dr. William Reimer has been in clinical practice in the area of genital anomalies for thirty-eight years. He spent eighteen years in urology and the following twenty years in psychiatry. At the beginning of his career, Reimer agreed with Dr. Money’s theory and routinely performed reassignment surgery on intersex infants. However, he began to view the surgeries as unsatisfactory and stopped performing them. Dr. Reimer trained as a child psychiatrist and became a vocal opponent of surgical sex assignment in infants.) See also, Expert Report and Affidavit at 1-2, *Robinson v. Hillcrest Baptist Medical Center* (No. A-09-CA-640-SS ) US 2009 WL 4639901.

98. *Id.*

99. *Id.*

deeply rooted in our Nation's history and tradition, is the belief that the parental role implies a substantial measure of authority over one's children.<sup>100</sup>

As Sherri Groveman<sup>101</sup> notes, when we look at the big picture, and study first hand accounts of adults and families affected by a DSD,

[T]he most critical variable . . . is not surgical management followed up by platitudes and half truths, but instead is the provision of resources for parents to be thoroughly educated about what intersex is, and to work through any anxiety or guilt they feel about having an intersex child. . . . When parents are able to communicate their comfort and acceptance, the child's self-esteem can develop from a solid foundation.<sup>102</sup>

A strong point for the intersex argument that the activist group Fighting for Change has not put an emphasis on is the fundamental right to procreate. Many of these normalizing surgeries result in the individual's reproductive organs being removed or altered in some way, thus leaving the patients infertile.<sup>103</sup> I don't understand why it is not argued that these surgeries are impinging on the individual's fundamental right to procreate and thus are unconstitutional unless they are necessary to achieve a compelling government interest. Further, there are other less intrusive ways the government can achieve their goal of rearing happy, well-adjusted children. One example is to can stop these surgeries and let the affected children decide on their own whether or not to have the surgery; this is less harmful and just as effective. Every single child in this world will be teased, ridiculed, or bullied at some time in his or her life for one reason or another. The surgery is not necessary to rear healthy well-adjusted children; in fact, it is counter productive. Facts show that over time, infants who had normalizing surgery, and therefore can't reproduce, end up feeling isolated and suicidal at much higher rates than those who are left alone.<sup>104</sup>

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100. *Bellotti v. Baird* 443 U.S. 622, 629 (1979).

101. SHERRI A. GROVEMAN, *The Hanukkah Bush: Ethical Implications in the clinical management of Intersex*, INTERSEX IN THE AGE OF ETHICS 23, 25. (Sherri Groveman is a woman who was born intersex and had her testicles removed from her because they didn't descend. Doctors lied to her and told her that she was having a twisted ovary removed.)

102. *Id.* at 25.

103. See Hammond *infra* note 119.

104. See Groveman *supra* note 101 and Hammond *infra* note 119.

#### IV. First Hand Accounts of Intersexed Individuals

*“No one ever told me there was anything wrong with my body (until a gynecologist appointment when I was twenty) and I grew up loving it just the way it was. I still do. While many doctors would refer to my clitoris as “grossly-enlarged,” I have to tell you, having an overabundance of the only organ in the human body whose sole purpose is pleasure is far from a negative thing!”*<sup>105</sup>

Anne Fausto-Sterling showed the flaws in the way today’s medical system approaches treatment of intersex individuals when she pointed out, “[i]n the past thirty years . . . the scientific community has . . . avoided contemplating the alternative route of unimpeded sexuality.”<sup>106</sup> She continued by explaining how today’s doctors tend to overlook a substantial body of case histories, most of them compiled between 1930 and 1960, before Dr. Money’s theory promoted surgical intervention.<sup>107</sup> “Almost without exception, those reports describe children who grew up knowing they were intersexual . . . and adjusted to their unusual status . . . there is not a psychotic or suicide in the lot.”<sup>108</sup>

When Hida Vioria was a child, she managed to avoid surgery to reduce the size of her enlarged clitoris because her father was a doctor and knew that it was not medically necessary to operate.<sup>109</sup> When Hida was born, doctors told her parents that she needed surgery to normalize her genitals. Her father, however, was not persuaded by their false claims.<sup>110</sup> Later, as Hida approached puberty her doctors and father wanted her to take estrogen pills to ensure that her body would feminize but her mother put a stop to that idea and, thus, she managed to avoid the hormone therapy treatment as well.<sup>111</sup> Hida was a true intersex, she had an enlarged clitoris that would become erect in the same way a penis would because she was born with extra testosterone.

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105. Hida Vioria, *Commentary: MyLife as a ‘Mighty Hermaphrodite’*, CNN.com, <http://www.cnn.com/2009/HEALTH/09/18/hida.vioria.intersex.athlete/index.html?iref=allsearch>,. (September 18, 2009).

106. Anne Fausto Sterling, *The Five Sexes: Why Male and Female Aren’t Enough*, THE SCIENCES 20, 24 (1993).

107. *Id.*

108. *Id.*

109. *See* Vioria, *supra* note 105.

110. *Id.*

111. *Id.* The doctors and her father wanted to assure that Hilda would grow breasts and avoid any unwanted facial and body hair.

Hida grew up reared as a girl, she got her menstrual cycle, she is able to get pregnant, and she did not have trouble fitting in with her peers.<sup>112</sup> The only difference that was physically noticeable on her body was that she had somewhat male-looking genitalia.<sup>113</sup> In her interview with CNN, Hida said, “I’m very lucky to have escaped corrective surgeries. . . . [N]o one ever told me there was anything wrong with my body and I grew up loving it just the way it was.”<sup>114</sup> She continued by explaining that she always felt strongly masculine and feminine, but didn’t see a way for the two to co-exist. It wasn’t until the age of twenty-six that Hida discovered the term “intersex”.<sup>115</sup> She was relieved to make sense of her internal connection to both sexes and actually have a name for her difference.<sup>116</sup>

Hida shares her story to point out that she loves her different genitalia and has always embraced her special sexuality.<sup>117</sup> The thing she is most thankful for throughout her journey, is that she has her enlarged clitoris in tact without scars or decreased sexual sensitivity.<sup>118</sup>

*“The pressure soon built to be a good little girl, and that was contrary to my nature.”<sup>119</sup>*

Hida is not the only person who survived childhood intersex while also avoiding surgery and hormone therapy. Next, I will introduce Steve Hammond. When Steve was born his penis was covered by folds of flesh, which gave his genitals the appearance of a vagina.<sup>120</sup> Doctors quickly told his parents they had a girl and they named him Linda Hammond.<sup>121</sup> Linda was raised as a girl and she believed she was a girl because that is what everyone told her.<sup>122</sup> However, Linda always hated to wear dresses, play with dolls, or do

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112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. STEVEN HAMMOND, *LOOKING BEYOND THE MOUNTAIN* 98 (2007).

120. *Id.* (Steve was born with all the normal male organs, but his testicles remained inside his body where they produced male hormones.)

121. *Id.*

122. *Id.*

anything that would be considered girly.<sup>123</sup> She was labeled a Tom-boy and teased for her masculine character and build.<sup>124</sup>

Linda had trouble fitting in with her peers, but she took up cheerleading and played sports and that helped her socially.<sup>125</sup> As time progressed, she noticed that she would get an erection when she was aroused, usually at the sight of a pretty girl.<sup>126</sup> Linda later explained, “I assumed this hard feeling in my secret part must be normal for young girls, even though none of the girls talked about getting hard in their private parts.”<sup>127</sup> Linda started to get nervous that her hardness in her private area might have been a tumor or something.<sup>128</sup> She knew that something was different about her, but she couldn’t put her finger on exactly what it was.<sup>129</sup> Linda was clearly a female, but felt so much like a male.<sup>130</sup>

Finally, when Linda was fifteen years old, she had not gotten her period yet and all of her friends had.<sup>131</sup> She explained, “The pressure to become a young woman was building . . . I kept waiting for breasts to develop and monthly periods to start. . . . I knew that my genital area was not that of a typical female, and I had many unanswered questions.”<sup>132</sup> Something was definitely wrong, so Linda summoned enough nerve to speak to her mother.<sup>133</sup> Linda’s mother claimed to have always noticed that she was very masculine, but figured that nature made her that way and she loved her just the way she was.<sup>134</sup> After speaking with Linda, however, she became concerned and tried to convince Linda to see a doctor, but she refused.<sup>135</sup>

As the years passed, Linda’s desires for women only got stronger and her feeling of entrapment in a woman’s body did not subside.<sup>136</sup> At the age of twenty-four, Linda finally broke down and

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123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* at 69.

128. *Id.* at 70.

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.* at 62.

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.*

went to see a doctor.<sup>137</sup> The doctor immediately told Linda that she had ambiguous genitalia and that her penis was covered with a layer of fleshy tissue.<sup>138</sup> Linda had finally heard what she has been waiting to hear her entire life: “I was born incomplete. I had all the normal male organs, but my testicles remained inside my body where they produced male hormones. My penis was covered with a fold of skin that normally joins together to form a scrotal sack.”<sup>139</sup>

Linda hastily elected surgery to fix her birth defect and currently lives very happily as Steven, with the same sexual faculty as a standard male who was born without genital ambiguity.<sup>140</sup>

Steven is a success story for the intersex community because he was not mutilated. The doctors did not notice his abnormality when he was born, so he was reared free of the knife.<sup>141</sup> If Steven had had surgery as an infant, correcting his birth defect would not be an option because genital surgeries are permanent and they unnecessarily foreclose the child’s right to an open future.<sup>142</sup>

Another lesson from Steven’s story, which I will address later in the article, is that public knowledge and education could have saved him a lot of pain and confusion. Steven felt scared because he thought he was the only person in the world that had ambiguous genitalia. Once he was diagnosed and a name was given to his differences, he felt free from the prison in which he was living.<sup>143</sup>

*“Leave me be and I’ll be fine . . . Its bizarre. My genitals are not bothering me, I don’t know why its bothering you guys so much.”*<sup>144</sup>

Angela was born in 1972 without any complications or signs of ambiguous genitalia. She was determined to be female and raised as a girl.<sup>145</sup> She did not show any signs of differences until she turned twelve and her clitoris began to grow more prominent.<sup>146</sup> From An-

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137. *Id.*

138. *Id.* at 96.

139. *Id.* at 98.

140. *Id.*

141. *Id.*

142. Hazel Glenn Beh & Milton Diamond, *David Reimer’s Legacy: Limiting Parental Discretion*, 12 *CARDOZO J.L. & GENDER* 5, 5 (2005-2006).

143. *See supra* note 119.

144. ANGELA MORENO, *In Amerika They Call Us Hermaphrodites*, *INTERSEX IN THE AGE OF ETHICS*. 138 (1998).

145. *Id.*

146. *Id.*

gela's perspective, this was normal, but when her mother caught a glimpse of her naked she was very alarmed.<sup>147</sup> Angela's mother sent her immediately to a doctor and exactly one month later she was admitted to the hospital.<sup>148</sup> They told her that they were going to remove her ovaries because they suspected that they could be cancerous.<sup>149</sup> "They didn't mention the part where they were going to slice off my clitoris. All of it. I guess the doctors assumed I was as horrified by my outsized clit as they were, and there was no need to discuss it with me."<sup>150</sup>

Angela spent her childhood and early adulthood confused and depressed because she knew that something had been done to her body, but no one would talk about it.<sup>151</sup> The doctors told her parents that she did not need to know the truth.<sup>152</sup> Even further, they told the parents a story about a girl, just like Angela, who saw her file while the doctor was not in the room and ended up killing herself after learning the truth.<sup>153</sup> On top of the lack of emotional support, the doctors put Angela on "display" for "parades of earnest young residents with 'you're-a-freak-but-we're-compassionate' grins on their faces."<sup>154</sup> Further, Angela claims that clitoral recession and vaginoplasty decreased her sexual responsiveness by a factor of five or ten.<sup>155</sup>

At the age of twenty-four, Angela finally got a hold of her medical records from the hospital that performed her surgery and she learned more than she ever imagined.<sup>156</sup> The medical team lied to her about removing her ovaries; they actually removed her testes.<sup>157</sup> To put it in her own words, "I am horrified by what has been done to me and by the conspiracy of silence and lies. I am filled with grief and rage, but also relief finally to believe that maybe I am not the only one."<sup>158</sup>

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147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.* at 139.

158. *Id.*

In the documentary film, *Hermaphrodites Speak*, Angela articulates her point,

[I]t is very painful for me to think of how, to conceptualize that what has been taken is very specific eroticism, a hermaphroditic eroticism, that must really scare people and really cause a great deal of anxiety. It is just a really special part of whatever culture that we have developed individually and that we are bringing together: that a special part, our sexuality, that sacred sexuality, has been ripped from us . . . I am wary of saying that I do not have the kind of genital sensation that I did, because that does not mean that I do not have great sex. It does mean that I have a not-so-reliable sexual response. But most importantly, it means that: that very special form of sexuality, arousal, and all of that that was uniquely hermaphroditic was taken. That is a crime.<sup>159</sup>

## V. Dr. Money's Theory is Debunked

*"What once was a landmark case to prove influence of nurturing is now regarded as significant to the theory of a biological premise in the formation of sexual identity."*<sup>160</sup>

Dr. Milton Diamond is most well known for his role in the follow-up interview of Brenda, the twin who was accidentally castrated as an infant and reared as a girl.<sup>161</sup> Dr. Money proclaimed that his experiment was a success and his theory 'nurture trumps nature' was proven by Brenda's acceptance of life as a female.<sup>162</sup> The medical community accepted this research as fact and used it as the basis for their surgical standard of care and treatment for infants born with ambiguous genitalia.<sup>163</sup> Thousands upon thousands of surgeries have been, and are continuing to be, performed on babies based on the results of Dr. Money's research.<sup>164</sup>

The medical community was shocked when Dr. Milton Diamond and Dr. Keith Sigmundson published their article, *Sex Reassignment at Birth: A Long Term Review and Clinical Implications* in

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159. B.J. Rye, & R. Humpartzoomian, *Teaching about Intersexuality: A review of HERMAPHRODITES SPEAK! and a critique of introductory human sexuality textbooks*. JOURNAL OF SEX RESEARCH, 37, 295-298 (2000).

160. Dean Kotula, Pacific Center for Sex and Society, *The Phallus Palace: Female to Male Transsexuals* <http://www.hawaii.edu/PCSS/biblio/articles/2000to2004/2002-conversation.html> (last updated December 8, 2011).

161. See *supra* Part II.

162. See *supra* Part II.

163. See *supra* note 40.

164. *Id.*

1997.<sup>165</sup> This article revealed to the world that Dr. Money's reports were falsified and that the landmark case<sup>166</sup> was nothing more than a complete disaster. Dr. Diamond got in contact with Brenda Reimer, who now lives as David; along with his parents, the psychiatrists that treated him throughout his adolescence, and his current wife.<sup>167</sup> David Reimer's parents followed the instructions Dr. Money gave them without deviation.<sup>168</sup> They kept the fact that he was born a boy a secret from him, and encouraged him to act and dress like a normal girl.<sup>169</sup> Extensive interviews with each of the parties made it clear that a person's gender is not a blank slate until they are two years old.<sup>170</sup>

Contradicting the reports and books that Dr. Money published, the truth is that David never accepted that he was a female.<sup>171</sup> In fact, he would urinate standing up, play with all of his brother's toy trucks as opposed to the dolls his mother purchased, and he told Dr. Diamond that he suspected he was a boy since the second grade.<sup>172</sup>

"I was told I was a girl. I didn't like dressing like a girl, I didn't like behaving like a girl, I didn't like acting like a girl. I'm not a professor or anything, but you don't wake up one morning deciding that you are a boy or a girl, you just know."<sup>173</sup>

Dr. Money's experiment on the twin boys solidified the idea that gender is an immutable trait that develops in the brain, not the penis.<sup>174</sup> William Reiner said it best when he explained, "the organ that appears to be critical to psychosexual development and adaptation is not the external genitalia, but the brain."<sup>175</sup> The following quote was found within the opinion of a 1968 case involving a transsexual who was seeking to legally change the name on their birth certificate to match the gender that they identify as.

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165. *Id.*

166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

171. *Id.*

172. *Id.*

173. *Horizon: Dr. Money and the boy with no penis* (BBC television broadcast Nov. 4, 2004), [http://www.bbc.co.uk/sn/tvradio/programmes/horizon/dr\\_money\\_prog\\_summary.shtml](http://www.bbc.co.uk/sn/tvradio/programmes/horizon/dr_money_prog_summary.shtml).

174. William Reiner, *To Be Male or Female - That is the Question*, 151 ARCHIVES PEDIATRIC & ADOLESCENT MED. 224 (1997).

175. *Id.*

“Should the question of a person’s identity be limited by the results of mere histological section or biochemical analysis, with a complete disregard for the human brain, the organ responsible for most functions and reactions, many so exquisite in nature, including sex orientation? I think not.”<sup>176</sup>

In addition to exposing the crime that was committed by Dr. Money’s false reporting, Dr. Diamond also exposed the crime the medical community commits everyday when it accepts new standards of care and procedures without adequate studies or insistence of corroborating data to support them.<sup>177</sup>

*“Nature loves Variety. . . . It is the fundamental of evolution. Without differences nature wouldn’t work. Unfortunately, society doesn’t like differences, but nature does.”*<sup>178</sup>

The majority of the population in the United States has never heard the term ‘intersex’ and believes that sex and gender are one and the same. Personal accounts of intersex individuals prove that the majority of these children grow into adulthood feeling like a “freak.” All of the emotional issues that intersex individuals must carry around are direct results of ignorance, which starts first and foremost with the medical professionals. The law must play an active role in the regulation of the deference that is afforded to doctors when making decisions about assigning gender to intersex individuals. A doctor is not more qualified to make that decision than a teacher, or a lawyer, or a plumber.

A number of individuals born with ambiguous genitalia report having had similar experiences with feelings of fear, shame, and embarrassment about their differences. They revealed the following reflections when they were asked about their childhood,

I spent my adolescence filled with shame, though I was never told the true details of my diagnosis. My trauma was needlessly compounded by my doctor’s stony silence while examining me, and his asking me to lie naked on an examining table so that teams of interns and residents could inspect my genitals. Such experiences themselves, far more than the true facts I later learned about the nature of [my DSD], instilled a sense of freakishness that I have only recently shaken.<sup>179</sup>

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176. In the Matter of Anonymous, 57 Misc. 2d 813, 814 (1968).

177. See Alice Dreger, *Sex, Lies, Separating Science From Fiction*, THE ATLANTIC (Feb. 15, 2003), for an example of false precedent set by false reporting of facts.

178. See *supra* note 25.

179. Groveman *supra* at 101.

No one told me the information [about myself], so I thought it must be so horrible, such a hideous and freakish thing, that if I told anyone else they would bolt.<sup>180</sup>

There were little things from early on. I began to see how different I felt and was, from what I was supposed to be. But I didn't know what it meant. I thought I was a freak or something.<sup>181</sup>

I began getting this familiar hardness in my private area just beneath the skin. I was afraid. I thought maybe I had a tumor.<sup>182</sup>

I felt like a freak, an embarrassment, and a burden to my family. But I got the message that I had to pretend everything was OK. The privacy of my hell was something that I had to deal with on my own, and I was very withdrawn and depressed. By the time I was a teenager I was just hopeless, suicidal.<sup>183</sup>

Nobody asked me how I felt, nobody explained to me what was so interesting. And they certainly didn't tell me they were going to amputate my clitoris. Indeed, that isn't even what they told my father. . . . I realized I had been so ugly that they had to change me.<sup>184</sup>

Empowering intersex patients and their parents with knowledge about their differences and letting them know that they are not the only ones going through this will reduce the feelings of isolation and embarrassment that these individuals are plagued with. A number of adults shared the feeling of elation that they felt when they were told, or when they realized on their own, that they were intersex and that there were many others out there just like them,

The thing that is so hard to describe is the relief, I feel it every day, every minute. There's no longer this inner conflict between my inner self and that outer woman.<sup>185</sup>

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180. Simon LeVay, *Male, Female, Other: The Tale of Two Children*, Interviewing Sherri Groveman (2000), [www.gendercentre.org.au/resources/polare-archive/archived-articles/male-female-other.htm](http://www.gendercentre.org.au/resources/polare-archive/archived-articles/male-female-other.htm).

181. Milton Diamond & Keith Sigmundson, *Sex Reassignment at Birth: A Long Term Review and Clinical Implications*, 151 *ARCHIVES OF PEDIATRIC & ADOLESCENT MEDICINE* (1997), available at <http://www2.hu-berlin.de/sexology/BIB/DIAM/reassignment.htm>, Interviewing David Reimer.

182. Hammond *supra* note 119 at 70.

183. Howard Devore, *Growing Up in the Surgical Maelstrom*, in *INTERSEX IN THE AGE OF ETHICS* 29, 35 (Alice Domurat Dreger ed., 1999) (1998).

184. Morgan Holmes, *Is Growing Up In Silence Better Than Growing Up Different?*, 2 *CHRYSALIS, THE JOURNAL OF TRANSGRESSIVE GENDER IDENTITIES* 7, 8 (1997).

185. Simon LeVay, *Male, Female, Other: The Tale of Two Children*, Interviewing James Benson (2000), [www.gendercentre.org.au/resources/polare-archive/archived-articles/male-female-other.htm](http://www.gendercentre.org.au/resources/polare-archive/archived-articles/male-female-other.htm).

All of a sudden everything clicked. For the first time things made sense and I understood who and what I was.<sup>186</sup>

I now realized that things were going to be ok. This was the day my life began. . . . I felt like the burden I had been carrying all my life was finally over. I was overwhelmed with joy—a very happy MAN.<sup>187</sup>

I am horrified by what has been done to me and by the conspiracy of silence and lies. I am filled with grief and rage, but also relief finally to believe that maybe I am not the only one.<sup>188</sup>

Dr. Money's theory that all infants are born sexually neutral and are thus a blank slate that can be reared as whichever sex the doctor chooses until about eighteen to twenty-four months has been disproved by Dr. Milton Diamond's follow up interview with David Reimer.<sup>189</sup> Moreover, the first hand accounts of hundreds of victims of the genital normalizing surgery are overwhelmingly dispositive of the damage it has caused and is continuing to cause intersex individuals today.

## VI. Proposals

There is no single solution to solve the problems that consume intersex individuals, in fact there are many avenues for consideration.<sup>190</sup> I cannot address them all in this article, so I am forced to consolidate the results into a workable plan of action. The two proposals that I find worthy of inclusion and elaboration, are; (A) informed consent; and (B) therapeutic jurisprudence. The combination

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186. Diamond *supra* note 181.

187. Hammond *supra* note 119 at 97.

188. MORENO *supra* note 144 at 35.

189. Kenneth Kipnis and Milton Diamond, *Pediatric Ethics and the Surgical Assignment of Sex*, in INTERSEX IN THE AGE OF ETHICS 173, 178 (Alice Domurat Dreger ed., 1999) (1998).

190. Of course other things will foster informed consent and therapeutic jurisprudence, such as; (1)education and knowledge on the subject of ambiguous genitalia; (2)support group participation; (3)public outreach programs to inform the population about DSD; (4)advocate programs to support the proposed standards and the individuals they are meant to represent; (5)medical health coverage for treatment of DSD conditions as well as to cover therapy and professional support for mental well-being; (6)enactment of laws to protect intersex individuals, preferably to classify them as a protected minority class to enable them to receive a heightened level of scrutiny when laws are proposed to infringe on their rights; and (7)malpractice procedures for doctors who fail to meet the proposed standard of care.

of education, open communication, and the 3 V's<sup>191</sup> are the best way to begin to shed the negative implication that is so affixed to the thought of having a child with ambiguous genitalia.

#### a. Patient Centered Informed Consent

In order to pave the way for intersex people to have a fair shot at a happy life, the United States court system must put a legal standard on the medical profession that requires all doctors to act in their patient's best interest, with specific emphasis on the fact that gender is embedded in the patient's brain, not their penis or lack thereof. Which naturally concludes that the patient is the only person who can determine what gender or genders the patient identifies as.

The court in *Cruzan* explicated that the informed consent doctrine preserves a patient's right to make medical decisions on his or her own behalf. It protects the "right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."<sup>192</sup> It is only after the patient has been given enough information about his or her situation to make an intelligent and informed decision that intersex individual will be able to decide what is in his or her best interest. Logically, this cannot be decided by an infant, so the informed consent requirement would be a huge barrier between the doctor's knife and the patient's genitals until the patient is old enough to make his or her own decision.

The deference that is given to doctors in regard to decisions about mutilating their patient's body is unacceptable and the legal system needs to step in and regulate the current practices. Dr. Money's theory depended on deceit for its success; specifically, the withholding of information from both the affected children and their parents about the true nature of the condition and its treatment.<sup>193</sup> If the legal system limits the doctor's powers to make these decisions and has checks and balances put into place, perhaps the Dr. John Money's of the world will be stopped before they cause more harm.

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191. See *infra* note 136 and accompanying text.

192. *Cruzan* 497 U.S. at 269 (quoting *Union Pacific Railroad Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

193. Karen Gurney, *Sex and The Surgeon's Knife: The Family Court's Dilema . . . Informed Consent and the Specter of Iatrogenic Harm to Children With Intersex Characteristics*, 33 AM. J. OF L. & MED. 625, 632 (2007).

Patient-centered informed consent is the first step toward giving intersex individuals a sense of control over their lives. The Intersex Society of North America<sup>194</sup> pinpointed a great way to frame the recommendations to the medical world that would be both compelling and easy to understand. The Society recommends asserting that patient-centered informed consent requirement is a Healthcare Quality Improvement initiative, which will allow the doctors to initiate change and progress without having to admit that they have been so wrong for so long.<sup>195</sup>

In addition to benefiting the long-term health and wellbeing of the patients, the families will benefit from the abundance of information that doctors will be required to give them. The patient-centered model requires doctors who are faced with an intersex patient to explain to the patients “what a reasonable person objectively needs to hear from his or her physician to allow the patient to make an informed and intelligent decision regarding proposed medical treatment.”<sup>196</sup>

This progression away from the physician-oriented standard will evoke a heightened awareness about the disorder, which will eliminate the traumatizing feeling of loneliness that is so prevalent in these cases. Individuals with DSDs wholeheartedly believe that there is no one else out there that is going through or has ever gone through the same nightmare.

*“I would have cut off my arm, I was that desperate to look into someone else’s eyes and have them know what I was experiencing.”<sup>197</sup>*

Even further, patient centered informed consent will require the doctors to become more educated. In order for a doctor to adequately counsel patients, he or she should be required to participate in a spe-

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194. Intersex Society of North America is a group that was created by Cheryl Chase, an intersex individual who underwent a clitoridectomy as a child. The group advocates putting a stop to performing surgery on infants with ambiguous genitalia. They recommend assigning the child a sex for the birth certificate, but do not perform surgery. That way the child has choices in the future and can make their own decision without being permanently foreclosed from all option.

195. It is important to note that doctors are people too; they have egos that are very sensitive. Look back to Dr. John Money, he was so eager to prove he was right that he lied to the world and created an erroneous standard of care, which resulted in devastating effects on generations of intersex individuals.

196. Carr v. Strode, 904 P.2d 489, 500 (Haw. 1995).

197. Simon LeVay, *Male, Female, Other*, Interviewing Sherri Groveman (2000), <http://www.nerve.com/LeVay/intersex>.

cific amount of training on the particular subject. For doctors who fail to meet the requirement, the patient centered informed consent model will require that the doctors refer the patients to a specialist in that particular field.

According to Michael King, this is the “ethic of care”:

“People see social institutions and people in authority with whom they interact as important in valuing their identity and status in the community; treating them with an ethic of care confirms their status as a valued member of society worthy of respect. As a result, people respect the institution or the court-or other justice system instrumentality or professional-and obey its orders.”<sup>198</sup>

## b. Therapeutic Jurisprudence

Therapeutic Jurisprudence (“TJ”) is an interdisciplinary movement<sup>199</sup> that views legal rules as social forces that often produce therapeutic or anti-therapeutic consequences.<sup>200</sup> If TJ is applied to the medical profession, it can be helpful and healing for the intersex community. Professor Amy Ronner<sup>201</sup> and Professor Bruce Winick<sup>202</sup> explain that the social forces under the theory of therapeutic jurisprudence.<sup>203</sup> Specifically the importance of an outcome centered around the “3 V’s”: (1)voice, (2)validation, and (3)voluntary participation.<sup>204</sup> In furtherance of the fact that TJ is interdisciplinary, I am going to

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198. AMY D. RONNER, LAW, LITERATURE, AND THERAPEUTIC JURISPRUDENCE: A MULTIDISCIPLINARY PARTNERSHIP 22 (2009) (quoting Michael S. King, *Therapeutic Jurisprudence, Criminal Law Practice and the Plea of Guilty in REHABILITATING LAWYERS: PRINCIPLES OF THERAPEUTIC JURISPRUDENCE FOR CRIMINAL LAW* 3, 231 (David B Wexler ed., 2008)).

199. *Id.* at 17.

200. Julie A Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265 (1999).

201. See Amy D. Ronner, *The Crucible, Harvard’s Secret Court, and Homophobic Witch Hunts*, 73 BROOKLYN LAW REVIEW 217, 217 (2007) (Amy D Ronner is a Professor of Law at St. Thomas University School of Law. She received her; J.D. in 1985 from the University of Miami, Ph.D in 1980 at the University of Michigan, M.A. in 1976 at University of Michigan, and B.A. in 1975 at Beloit College. Mrs. Ronner is an advocate of therapeutic jurisprudence and a well-respected professor, author, and mentor.)

202. See Dennis P. Stole et al., *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering*, 34 CAL. W. L. REV. 15, 15 (1997-1998), (Bruce Winick is a Professor of Law at University of Miami School of Law, having received his J.D. at New York University).

203. Amy D. Ronner, *Silencing the Appellant’s Voice : The Antitherapeutic Per Curiam Affirmance*, 24 SEATTLE U. L. REV. at 499(2000).

204. *Id.* at 501.

take the concepts as applied to attorneys and judges and tie them into the medical field.

The similarities between an attorney-client relationship and a physician-patient relationship are obvious and applying TJ to the medical field subsequently complements the impact of its therapeutic reach. Therefore, I will employ Professor Amy Ronner and Bruce Winick's three core components of a fair, therapeutic experience, also known as the 3Vs, to my proposal for change.

The first V is Voice, or the opportunity for a patient to tell his or her doctor about his or her gender and what sex he or she wishes to be assigned.<sup>205</sup> Or, more importantly, the patient can tell the doctor that he or she is happy with his or her body the way it is and do not want surgery. This leads to the second V, Validation. Patients will gain a sense of validation when doctors wait until they genuinely listen to the patient's personal interest before performing any medical procedures on their bodies.

*"David Reimer recalls frustration, which remains, at not having his feelings and desires recognized."*<sup>206</sup>

This feeling of Voice and Validation that the patients will gain from being an active participant in the medical decisions pertaining to their bodies will avoid future individuals and their parents from feeling intimidated into the life altering decision. This results in the 3rd V, Voluntary Participation. People are more likely to accept their bodies when they play a role in protecting them. The doctor must facilitate TJ, because without the doctor's participation, the medical standard of physician-centered informed consent will stay exactly where it is and change will not be possible.

Embarrassment, shame, secrecy, confusion, anger, and ignorance are the result of the lack of legal requirement for education and communication regarding intersex disorders. A child's confidence is molded predominantly by his or her parent(s). Once we remove the anxiety and resentment from the parents, we can stop the parents from passing on the same negative mindsets to their children. In order to end this cycle, first and foremost, the doctors must arm all parents with the knowledge required to prepare their children to live a

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205. *Id.*

206. Milton Diamond, Ph.D. & H. Keith Sigmundson, M.D., *Sex Reassignment at Birth: A Long Term Review and Clinical Implications*, ARCHIVES OF PEDIATRIC & ADOLESCENT MED. (Oct. 20, 2006), available at <http://www.cirp.org/library/psych/diamond1/>.

normal life and, most importantly, to be proud of who they are.<sup>207</sup> Therefore, if parents are educated and comfortable with their child's intersex condition, they will likely pass those feelings onto their children.<sup>208</sup> No more secrets and shame. In *M.T. v. J.T.*, the court stated that it is "practical, realistic, and humane" to allow individuals to self-identify their sex.<sup>209</sup> The court continued by explaining that "such recognition will promote the individual's quest for inner peace and personal happiness, while in no way disserving any societal interest, principle of public order or precept of morality."<sup>210</sup>

"Such [hermaphroditic] creatures seem to have been formed merely to show us that this much-talked-of-difference of sex is, after all, nothing inherent in the constitution of things, and that individuals may be born, live, and thrive, of both sexes or neither." —Geo. H. Napheys, 1870<sup>211</sup>

Arresting doctors with the legal responsibility of upholding a minimum level of informed consent will put an end to many of the stigmas attached to intersex disorder by fostering open communication and acceptance. Informed consent harmonizes with therapeutic jurisprudence, which says that everyone should be afforded the ability to present an opinion to a physician who sincerely listens and gives the patient the opportunity to understand the doctor's opinions and reasons for requiring treatment.<sup>212</sup>

## VII. Conclusion

Like AIDS in the 80s and 90s, intersex has a negative stigma—an implication of freakishness and something you should hide because it implicates that you are not normal. Elizabeth Glaser was a change agent<sup>213</sup> for the perception of AIDS, and with informed consent and therapeutic jurisprudence the millennium will see more and

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207. *Bellotti*, 99 S.Ct. at 3043 (quoting *Moore v. East Cleveland* (1977)(The unique role in our society of the family, [is] the institution by which 'we inculcate and pass down many of our most cherished values, moral and cultural'.")

208. *Id.* "The unique role in our society of the family, [is] the institution by which 'we inculcate and pass down many of our most cherished values, moral and cultural'."

209. *M.T.* 355 A.2d at 209

210. *Id.* at 211.

211. *KESSLER supra* note 9 at 105.

212. Douglas S. Stransky, *Civil Commitment and the Right to Refuse Treatment: Resolving Disputes from a Due Process Perspective*, 50 U. MIAMI L. REV. 413, 442 (1995).

213. *Supra* note 2.

more intersex individuals following her lead. There is a perfect correlation between the AIDS quandary and the plight of individuals born with ambiguous genitalia. Intersex is considered shameful and is thus kept a secret and these secrets foster and manifest within these persons and does not benefit anyone. If doctors are required to get informed consent prior to surgery and they impute therapeutic jurisprudence in their practice of communicating the differences, the layer of shame will evaporate. If history has taught us anything, it is to speak up and make sure to be heard, educate the world, thus breaking the barriers of silence and embarrassment. Just like with AIDS, education and research can bring about change and acceptance for intersex individuals, and, most importantly, open up new avenues of communication and interaction between others in similar situations. The communication will introduce intersex to each other, feelings of isolation will go away and the healing will begin.

*"We are just real people wanting a more hopeful life. But, words and ideas are not going to save my family."*<sup>214</sup>

Elizabeth Glaser's quote above is proof that communication is a start, but is only the beginning. She went on to say,

*"I started out as just a mom fighting for the life of her child, but along the way I learned how unfair America can be today. Not just for people who have HIV, but for many many people. Poor people, gay people, people of color, children."*<sup>215</sup>

It is our duty as human beings to facilitate change by giving a voice to those who do not have one. We have to start with setting legal standards for the medical community to communicate and educate. Once that gate is opened, information and strength will flow all of the way down through the parents and the intersex children themselves. Elizabeth Glaser is an example of how communication and education can influence change.

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214. Elizabeth Glaser Pediatric AIDS Foundation, *Elizabeth Glaser's Speech at the Democratic National Convention*, YOUTUBE (1992), <http://www.youtube.com/watch?v=hK15XLRn3XM>.

215. *Id.*