

## ARTICLE

## Surgical Intervention on Intersex Infants: Legal Issues and Recommendations for New Zealand

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The standard medical practice of surgical intervention on intersex infants continues despite overwhelming anecdotal evidence from intersex adults about the long-term trauma it causes. Performing genital-normalising surgery on intersex infants raises multiple legal issues stemming from the ability, or lack thereof, to consent to such a procedure. Consent is complicated by the imbalanced power dynamics between doctors, parents and the child. These issues have been judicially considered in several jurisdictions. The resulting jurisprudence overseas has not prohibited the medical practice but has endorsed a more conservative approach. The issue has not been tested in the New Zealand courts. It is recommended that clear guidelines be drafted to assist medical practitioners, that courts be empowered to authorise surgical intervention, that express legislation on the matter be drafted and that awareness of intersex and the ramifications of surgery be increased.

### I Introduction

Intersex infants comprise approximately 1.7 per cent of live births.<sup>1</sup> These infants have ambiguous genitalia that do not conform to the male/female sex binary. Their binary-challenging “conditions” are regarded as a medical “emergency” requiring urgent

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1 Organisation Intersex International Australia “On the number of intersex people” (28 September 2013) <[www.oii.org.au](http://www.oii.org.au)>; and Anne Fausto-Sterling *Sexing the Body: Gender Politics and the Construction of Sexuality* (Basic Books, New York, 2000) at 53.

intervention.<sup>2</sup> Intervention typically takes the form of genital-normalising surgery.<sup>3</sup> Although surgery is the standard treatment model, there is no research to support the idea that surgery is medically necessary or beneficial.<sup>4</sup> On the contrary, evidence suggests surgery is not beneficial and many intersex people are angry about their treatment.<sup>5</sup> Every intersex person who has spoken publicly about their treatment has been against surgical intervention.<sup>6</sup> In performing genital-normalising surgery, medical professionals arguably violate the first principle of medicine, “do no harm”.<sup>7</sup> Intersex children suffer physical and psychological trauma “at the hands of authority figures”, leading to potentially “devastating results”.<sup>8</sup> Some intersex adults have likened the trauma to childhood sexual abuse.<sup>9</sup>

Despite increasing intersex visibility, legal activism and legislation lags.<sup>10</sup> This article explores legal strategies that could improve treatment of intersex infants. The article begins by introducing a working definition of intersex, and then goes on to discuss the background and rationale for surgical intervention, including New Zealand’s approach. Following this is a summarisation of legal issues raised and recent legal responses, and, finally, consideration of recommendations for New Zealand reform. Potential ramifications of using gene-editing technology instead of surgery and the legal barriers intersex people face in obtaining official documents reflective of their non-binary identity, including related issues to do with marriage, are beyond the scope of this article.

## II Defining “Intersex”

There are many variances of intersexuality, making it impossible to settle upon a single definition. An intersex infant may be born with a large clitoris, micropenis or sex chromosome anomalies. Intersex conditions are categorised as a Disorder of Sexual Development (DSD). Many in the intersex community reject the “disorder” categorisation and some do not identify as “intersex.”<sup>11</sup> In this article, the term “intersex” is used in a wide sense to include anyone with sexual anatomy that does not fit the male/female sex binary. This is consistent with the “intersex status” definition in the Sex Discrimination Act 1984 (Cth) in Australia:<sup>12</sup>

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2 Francesca Romana Ammaturo “Intersexuality and the ‘Right to Bodily Integrity’: Critical Reflections on Female Genital Cutting, Circumcision, and Intersex ‘Normalizing Surgeries’ in Europe” (2016) 25 S & LS 591 at 602.

3 See SM Creighton and L-M Liao “Changing attitudes to sex assignment in intersex” (2004) 93 BJU Int 659.

4 Kate Haas “Who Will Make Room for the Intersexed?” (2004) 30 Am JL & Med 41 at 42.

5 Kishka-Kamari Ford “‘First, Do No Harm’—The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants” (2001) 19 Yale L & Pol’y Rev 469 at 483.

6 Anne Tamar-Mattis “Exceptions to the Rule: Curing the Law’s Failure to Protect Intersex Infants” (2006) 21 Berkeley J Gender L & Just 59 at 68.

7 Ford, above n 5, at 469.

8 Tamar-Mattis, above n 6, at 70.

9 At 70.

10 Julie A Greenberg *Intersexuality and the Law: Why Sex Matters* (New York University Press, New York, 2012) at 128.

11 Elisabeth McDonald “Intersex People in Aotearoa New Zealand: The Challenges for Law and Social Policy—Part I: Critiquing Gender Normalising Surgery” (2015) 46 VUWLR 705 at 709.

12 Sex Discrimination Act 1984 (Cth), s 4(1), definition of “intersex status”.

... the status of having physical, hormonal or genetic features that are:

- (a) neither wholly female nor wholly male; or
- (b) a combination of female and male; or
- (c) neither female nor male.

### III The Background of Surgical Intervention

Surgical intervention only became the norm since medical advances enabled it in the 1950s.<sup>13</sup> This article now turns to discuss the rationale for surgery, the surgery itself and the New Zealand approach.

#### A *The John/Joan case*

The genesis of the current surgical intervention approach is Dr John Money's "John/Joan" case study of 1972.<sup>14</sup> Money tested his psychosocial theory of gender identity on infant David Reimer, who lost his penis in a botched circumcision.<sup>15</sup> Following Money's advice to raise David as female, David's parents consented to surgical alteration of his genitalia and hormone treatment.<sup>16</sup> Touted as a sex transformation success story for many years, the case formed the justification for the dominant surgical "concealment model".<sup>17</sup> This model is characterised by "early and conclusive assignment of gender, early genital-normalizing surgery (before two years of age), and secrecy and denial about the child's condition".<sup>18</sup> However, when two doctors decided to verify the case with David 25 years later, it became apparent that Money had lied: David had rejected the assigned female gender very quickly after the surgery.<sup>19</sup> Despite having been discredited, Money's work continues to rationalise intersex intervention.

#### B *Cultural rationale*

It is apparent that the medical basis for intervention is weak and that the true reason behind it is a strong cultural urge to make bodies conform to sexual binarism.<sup>20</sup> Julie A Greenberg calls the period between the 1950s and the 1990s the "Age of the Genitalia",

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13 See Johanna Schmidt "Gender diversity—Intersex people" (5 May 2011) Te Ara <[www.teara.govt.nz](http://www.teara.govt.nz)>.

14 Hazel Glenn Beh and Milton Diamond "An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?" (2000) 7 *Mich J Gender & L* 1 at 5–7.

15 Mayur Suresh "Pendulous Penises and Couture Clitorises: What Medical Men do to Intersex Infants" in Arvind Narrain and Vinay Chandran (eds) *Nothing to Fix: Medicalisation of Sexual Orientation and Gender Identity* (SAGE Publications, New Delhi, 2016) 160 at 174.

16 Greenberg, above n 10, at 88.

17 Tamar-Mattis, above n 6, at 64.

18 At 64.

19 Ford, above n 5, at 473.

20 See Elizabeth Reis "Intersex Surgeries, Circumcision, and the Making of 'Normal'" in George C Denniston, Frederick M Hodges and Marilyn Fayre Milos (eds) *Genital Cutting: Protecting Children from Medical, Cultural, and Religious Infringements—Proceedings of the 11th International Symposium on Circumcision, Genital Integrity, and Human Rights, 29–31 July 2010, University of California, Berkeley* (Springer, Dordrecht (Netherlands), 2013) 137.

because genitalia, rather than gonads (sex glands), became the basis for determining sex.<sup>21</sup> Genitals are key to determining the all-important question: is it a boy or a girl? Non-conforming genitalia are “culturally unintelligible”, which can make parents and doctors uneasy about the baby’s body.<sup>22</sup> Many commentators argue that cultural bias severely impacts on parents’ and doctors’ ability to weigh the risks and benefits of surgery to arrive at a fully informed decision.<sup>23</sup> Homophobia and transphobia are also factors, with doctors telling parents that surgical intervention will result in a heterosexual child with “a normative gender identity”.<sup>24</sup> Additionally, adults can be averse to discussing children’s sexuality, further inhibiting objective consideration of the risks and benefits.<sup>25</sup> The decision to intervene surgically may be made by the parents’ needs being placed above those of the child. As Anne Tamar-Mattis points out, infant genital-normalising surgery is an inappropriate way of treating parental discomfort or anxiety.<sup>26</sup> Cultural discomfort should be addressed through counselling and proper information; this would enable the making of a more objective decision with minimal cultural bias.<sup>27</sup>

### C *Genital-normalising surgery and gender assignment*

Recent medical textbooks still recommend surgical intervention; one states that “[t]he diagnosis of ambiguous genitalia is extremely disconcerting to the family and should be addressed as a medical emergency.”<sup>28</sup> Before surgery, doctors must choose which gender to assign the infant. Factors in this decision include chromosomal patterns, internal reproductive organs and exterior genitalia.<sup>29</sup> However, the overriding concern for surgeons is to ensure “the best surgical outcome”.<sup>30</sup> For a male-assigned infant, this means a penis capable of penetration and the ability to urinate from a standing position. For a female-assigned baby, it means a vagina capable of being penetrated. It is “easier to surgically repair the genitals with female-like anatomy”;<sup>31</sup> thus, most intersex infants are assigned female. The emphasis is on functionality, not fertility or the retention of sensation for future sexual pleasure.<sup>32</sup> The “guessing game”<sup>33</sup> doctors play with gender assignment is clearly influenced by heteronormative gender and sex conceptions.

### D *The New Zealand approach to intersex infants*

In 2007, the Human Rights Commission released a report on discrimination experienced by transgender people.<sup>34</sup> Initially limited to transgender experiences, the Commission’s

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21 Greenberg, above n 10, at 15.

22 Suresh, above n 15, at 160.

23 Tamar-Mattis, above n 6, at 82–83. See Creighton and Liao, above n 3.

24 Tamar-Mattis, above n 6, at 84.

25 At 83–84.

26 At 90.

27 At 90.

28 John M Gatti “Disorders of Sexual Differentiation” in George W Holcomb III, J Patrick Murphy and Daniel J Ostlie (eds) *Ashcraft’s Pediatric Surgery* (6th ed, Elsevier, London, 2014) 826 at 832.

29 Tamar-Mattis, above n 6, at 66.

30 At 66.

31 Beh and Diamond, above n 14, at 16.

32 Tamar-Mattis, above n 6, at 66.

33 Ford, above n 5, at 484.

34 Human Rights Commission *To Be Who I Am/Kia noho au ki tōku anō ao: Report of the Inquiry into Discrimination Experienced by Transgender People/He Pūrongo mā te Uiuuitanga mā Aukatitanga e Pāngia ana e ngā Tāngata Whakawhitiira* (January 2008).

mandate was widened to include intersex experiences after it received many submissions from the intersex community.<sup>35</sup> The report confirms that intersex people in New Zealand have been subject to surgical intervention and are overwhelmingly “unhappy with decisions that had been made on their behalf”.<sup>36</sup> Submitters reported that parents were sometimes not given full information regarding the condition and the potential ramifications of surgical intervention.<sup>37</sup> Intersex people reported experiencing discrimination, secrecy and shame,<sup>38</sup> and having difficulty accessing medical records and being recognised on legal documents.<sup>39</sup> The report also included views from New Zealand health professionals, who confirmed that intersex infants are surgically assigned a sex.<sup>40</sup>

#### IV Legal Issues

There are clear “imbalanced power dynamics” between doctors, parents and the child.<sup>41</sup> SM Creighton and L-M Liao argue that the medical profession should not be “decid[ing] behind closed doors on behalf of society how to seal the fate of persons with nonstandard genitals”.<sup>42</sup> Deference to the authoritative medical profession is abating, and legal scholars are becoming increasingly interested in the role the law could play in protecting intersex infants.<sup>43</sup> By analogy to female genital mutilation (FGM), it has been suggested that genital-normalising surgery may already be prohibited under FGM legislation. This argument will now be considered, followed by a discussion of parental consent validity and children’s rights.

##### *A Comparison to female genital mutilation*

Many commentators compare intersex intervention to the practice of FGM. While FGM practices have garnered wide condemnation, the medical profession hypocritically continues to endorse intersex intervention.<sup>44</sup> This comparison is pertinent because FGM is illegal in New Zealand under s 204A of the Crimes Act 1961. Elisabeth McDonald points out that genital-normalising surgery on intersex infants might also be illegal under this section, but notes that in practice this is not the approach taken in New Zealand.<sup>45</sup> Aileen Kennedy argues that the New South Wales equivalent of the provision criminalising FGM<sup>46</sup> was clearly not intended to cover genital-normalising surgery.<sup>47</sup> Noa Ben-Asher notes that, problematically, rhetoric against FGM is often Western condemnation of so-called

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35 At [7.3]–[7.4].

36 At [7.12].

37 At [7.13].

38 At [7.6].

39 At [7.18] and [7.25]–[7.31].

40 At [7.42].

41 Ammaturo, above n 2, at 602.

42 Creighton and Liao, above n 3, at 663.

43 Greenberg, above n 10, at 88.

44 See Ammaturo, above n 2, at 598.

45 McDonald, above n 11, at 707.

46 Crimes Act 1900 (NSW), s 45.

47 Aileen Kennedy “Fixed at Birth: Medical and Legal Erasures of Intersex Variations” (2016) 39 UNSWLJ 813 at 838.

“primitive” practices.<sup>48</sup> Another, potentially more useful, comparison is male circumcision.<sup>49</sup> Like intersex intervention, circumcision is a cultural practice rather than medical necessity. Contentiously, circumcision remains legal in New Zealand.<sup>50</sup>

### B Parental consent

In New Zealand, anyone below the age of 20 is deemed a minor,<sup>51</sup> and the ability to consent to medical treatment crystallises at age 16.<sup>52</sup> This means that for children under the age of 16, parents can make health-related decisions and give consent to medical treatment on their behalf. However, this power is not absolute.<sup>53</sup> Many commentators have analogised intersex intervention to sterilisation, organ donation and other experimental treatments where parental consent is restricted and special authorisation is required.<sup>54</sup> New Zealand courts have jurisdiction under the *parens patriae* doctrine and the Care of Children Act 2004—though the latter is preferred.<sup>55</sup> Courts typically intervene when parents refuse recommended treatment or doctors disagree with experimental treatment desired by parents.<sup>56</sup> But litigation in this area is uncommon; in general, parents accept doctors’ advice and doctors do not view genital-normalising surgery as unorthodox.

Tamar-Mattis argues that the idea of parents giving “informed consent” to intersex intervention is illusory because the decision is heavily impacted by the doctor’s “unduly influential” and “culturally-biased recommendations”.<sup>57</sup> Some commentators contend that parents have a conflict of interest in making decisions to intervene surgically: they consciously or subconsciously consider social factors that are extraneous to the primary concern, the child’s long-term wellbeing. This conflict means parents cannot consent to intervention.<sup>58</sup> Kishka-Kamari Ford argues that the current medical model “fails the test for legal informed consent at every step”.<sup>59</sup> The High Court of Australia held in *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* that when “the consequences of a wrong decision are particularly grave”, court authorisation is

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48 Noa Ben-Asher “The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties” (2006) 29 Harv JL & Gender 51 at 74–75.

49 At 75.

50 See Phoebe Harrop “Balancing Rights on a Knife Edge: The Legality of Non-Therapeutic Male Circumcision” (2014) 1 PILJNZ 176.

51 Age of Majority Act 1970, s 4(1).

52 Care of Children Act 2004, s 36.

53 Ford, above n 5, at 479.

54 Paul Mason “Intersex Genital Autonomy: A Rights-Based Framework for Medical Intervention with Intersex Infants” in George C Denniston, Frederick M Hodges and Marilyn Fayre Milos (eds) *Genital Cutting: Protecting Children from Medical, Cultural, and Religious Infringements—Proceedings of the 11th International Symposium on Circumcision, Genital Integrity, and Human Rights, 29–31 July 2010, University of California, Berkeley* (Springer, Dordrecht (Netherlands), 2013) 149 at 172–173; and Contraception, Sterilisation, and Abortion Act 1977, s 7. See Skylar Curtis “Reproductive Organs and Differences of Sex Development: The Constitutional Issues Created by the Surgical Treatment of Intersex Children” (2011) 42 McGeorge L Rev 841.

55 See *Re J (An Infant): Director-General of Social Welfare v B and B* [1995] 3 NZLR 73 (HC).

56 Ford, above n 5, at 479.

57 Tamar-Mattis, above n 6, at 87.

58 At 100.

59 Ford, above n 5, at 488.

required.<sup>60</sup> Factors that increase the risk of a “wrong decision” include the complexity of the consent and the conflicting interests of parent and child.<sup>61</sup> Decisions regarding genital-normalising surgery generally involve these precise risk factors.

### *C Inadequate protection of children’s rights*

Commentators suggest that multiple rights are implicated by genital-normalising surgery. These rights include the right to liberty and bodily integrity, the right to sexual intimacy, the right to privacy, and the right to marriage.<sup>62</sup> The Convention on the Rights of the Child,<sup>63</sup> to which New Zealand is a signatory, could provide a basis for challenging the legality of intersex intervention.<sup>64</sup> Greenberg argues that current medical practices on intersex infants might contravene arts 2, 3, 12 and 16.<sup>65</sup> These articles concern protection against discrimination, the paramountcy of the best interests of the child, the child’s freedom to express his or her views and the child’s right to privacy. But Mayur Suresh points out that when doctors operate on intersex infants, they believe they are acting in the child’s best interests, potentially satisfying the “best interests of the child” standard in art 3 of the Convention and thus providing a defence to a legal challenge.<sup>66</sup>

## **V Recent Legal Activism**

The treatment of intersex infants has been gaining visibility since the 1990s, when Bo Laurent (formerly Cheryl Chase) founded activist group Intersex Society of North America to challenge the current medical model of genital-normalising surgery.<sup>67</sup> In 2005, Laurent helped draft treatment guidelines, known in short as the Consensus Statement, which are the clearest example of medical guidelines specifically addressing intersex.<sup>68</sup> Despite growing visibility of the issue, lawsuits have been rare.<sup>69</sup> Examples of past litigation include two cases in Colombia in which the ability of parents to consent to surgery on intersex infants was successfully challenged, and, more recently, an American case in which a couple sued doctors for performing genital-normalising surgery on their adopted child while he was a state ward. Greenberg predicts litigation will increase, challenging medical practices, discriminatory actions and government policies.<sup>70</sup>

This article will now briefly discuss these various legal responses.

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60 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 250.

61 At 250–252.

62 Tamar-Mattis, above n 6, at 91; Curtis, above n 54, at 844–845; and Samantha S Uslan “What Parents Don’t Know: Informed Consent, Marriage, and Genital-Normalizing Surgery on Intersex Children” (2010) 85 *Ind LJ* 301 at 311.

63 Convention on the Rights of the Child 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990).

64 Greenberg, above n 10, at 111–113.

65 At 111.

66 Suresh, above n 15, at 173–174.

67 Greenberg, above n 10, at 85.

68 See Intersex Society of North America “Cheryl Chase (Bo Laurent)” <[www.isna.org](http://www.isna.org)>; and Melanie Newbould “When Parents Choose Gender: Intersex, Children, and the Law” (2017) 24 *Med L Rev* 474 at 482.

69 Greenberg, above n 10, at 107.

70 At 107–109.

### A *Consensus Statement*

In 2006, intersex activists and medical experts collaborated to create guidelines regarding the treatment of intersex conditions, including surgical treatment of intersex infants. The result of this collaboration was the “Consensus Statement on Management of Intersex Disorders”.<sup>71</sup> The Statement marked a conscientious shift from hasty and unconsidered decisions regarding surgical intervention to a more cautious approach, and it “remains the benchmark for medical management of intersex today”.<sup>72</sup> But Tamar-Mattis notes that medical guidelines are not binding, and the pace of change in medical treatment is far too slow.<sup>73</sup>

### B *Constitutional Court of Colombia and MC v Amrhein*

In 1999, two cases regarding intersex infants were heard together before the Constitutional Court of Colombia, Colombia’s highest court.<sup>74</sup> The doctors in the cases supported genital-normalising surgery but would not proceed with only the parents’ consent on the child’s behalf.<sup>75</sup> The court concluded valid consent required the parents to establish that the surgery was truly in the child’s best interest, creating a new “qualified and persistent informed consent” standard.<sup>76</sup> This is similar to the test set out in *Marion’s Case*. To meet this standard, parents must receive full disclosure as to the advantages and disadvantages of surgery and give their consent in writing. Further, the consent process must happen in stages to ensure both that the infant’s intersex is not treated as a medical emergency and that consent is not given as a shock reaction.<sup>77</sup> Greenberg calls the new standard a “compromise approach” because the Constitutional Court of Colombia neither allowed parents the ability to consent unrestrictedly nor prohibited the medical practice altogether.<sup>78</sup> Of course, the Colombian approach is not binding on New Zealand courts. Nevertheless, it provides a helpful example of guidelines for court intervention in gender-normalising surgery on infants.<sup>79</sup>

In the first case of its kind, adoptive parents, the Crawfords, of a minor child, MC, filed a complaint on behalf of MC against doctors who surgically assigned him as female while he was in state care.<sup>80</sup> MC later rejected the assigned gender. The United States District

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71 Peter A Lee and others “Consensus Statement on Management of Intersex Disorders” (2006) 118 *Pediatrics* e488; and Erin D Thorn “Drop the Knife! Instituting Policies of Nonsurgical Intervention for Intersex Infants” (2014) 52 *Family Court Review* 610 at 612.

72 Kennedy, above n 47, at 820.

73 Tamar-Mattis, above n 6, at 78.

74 *Sentencia SU-337/99* Constitutional Court of Colombia, 12 May 1999; and *Sentencia T-551/99* Constitutional Court of Colombia, 2 August 1999.

75 Angela Kolbe “Intersex, a Blank Space in German Law?” in Morgan Holmes (ed) *Critical Intersex* (Ashgate Publishing, Farnham (UK), 2009) 147 at 158.

76 Manuel José Cepeda Espinosa and David Landau *Colombian Constitutional Law: Leading Cases* (Oxford University Press, New York, 2017) at 73.

77 Kolbe, above n 75, at 159.

78 Julie Greenberg “Legal Aspects of Gender Assignment” (2003) 13 *The Endocrinologist* 277 at 279.

79 Nina Baumgartner “Intersex Parenting: Ethical and Legal Implications of the Treatment of Intersex Infants and the Ramifications for Their Families” (2017) 1(3) *Women Leading Change* 45 at 50.

80 *MC v Amrhein* 4th Cir 13-2178, 26 January 2015. See Emily Largent “MC v Aaronson—Update” (5 March 2015) Bill of Health <<http://blog.petrieflom.law.harvard.edu>>; and Michael Cook “Parents sue over intersex surgery” (15 August 2015) BioEdge <[www.bioedge.org](http://www.bioedge.org)>.



Court for the District of South Carolina accepted there was an arguable case, but the Court of Appeals for the Fourth Circuit reversed the lower court's ruling and dismissed the case on the basis that the doctors did not have "fair warning ... that they were violating [MC's] clearly established constitutional rights".<sup>81</sup> The Court of Appeals was careful to acknowledge the trauma MC suffered, but declined MC's federal constitutional claim against the doctors due to their lack of knowledge. The court did suggest, however, that MC may be able to pursue the claim under state law.<sup>82</sup> Joshua C Albritton considers the case to be a "hallmark for intersex rights": it opens the door to "the *possibility* that intersex children may have their fundamental rights protected when it comes to genital-normalization surgeries".<sup>83</sup>

## VI Recommendations for New Zealand Reform

Denise Steers of the University of Otago is currently undertaking a study to understand the experiences and treatment of intersex children in New Zealand, as well as the experiences of their parents and medical professionals.<sup>84</sup> This is crucial research because very little data exists on the precise medical practice in New Zealand in this area. The shortage of data and lack of clarity as to the legal position of intersex intervention is unsatisfactory. The following section proposes four recommendations for New Zealand to provide clarity in this area and improve the protection of vulnerable intersex infants.

### A *Guidelines for medical practitioners*

To date, there has been a clear deference to doctors regarding intersex conditions.<sup>85</sup> As long as doctors continue to recommend surgical intervention, parents will continue to elect it for their infants.<sup>86</sup> As previously discussed, parents and doctors often have a culturally induced and irrationally uncomfortable reaction to nonconforming genitalia. To alleviate the effects of this reaction, there should be clear guidelines to assist medical practitioners. Medical practitioners should be made aware of the wealth of anecdotal evidence that shows that although they believe they are acting in the child's best interests, adults who underwent genital-normalising surgery as an infant do not feel "normalised" and would prefer the surgery never to have happened.

Intersex activist group Intersex Awareness New Zealand endorses guidelines developed in 2006 by a consortium of medical practitioners with expertise in intersex conditions and experience working with intersex adults and their families.<sup>87</sup> The guidelines firmly state that genital-normalising surgery is medically unnecessary, parental discomfort should be addressed by counselling rather than surgery on the infant, and any surgery

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81 *MC v Amrhein*, above n 80, at 5.

82 At 16; and Baumgartner, above n 79, at 52.

83 Joshua C Albritton "Intersexed and Injured: How *MC v Aaronson* Breaks Federal Ground in Protecting Intersex Children from Unnecessary Genital-Normalization Surgeries" (2015) 24 Tul JL & Sex 163 at 169 (emphasis in original).

84 Denise Steers "Understanding diverse sex development/intersexuality in NZ" University of Otago <[www.otago.ac.nz](http://www.otago.ac.nz)>.

85 Tamar-Mattis, above n 6, at 81.

86 At 81.

87 Consortium on the Management of Disorders of Sex Development *Clinical Guidelines for the Management of Disorders of Sex Development in Childhood* (Intersex Society of North America, 16 August 2006).

should be delayed until the child can participate in the decision.<sup>88</sup> The guidelines also include scripts for medical practitioners when talking to parents.<sup>89</sup>

### B *Court authorisation*

Due to parents' conflict of interest and the serious potential ramifications of genital-normalising surgery, the decision should be removed from parents and subjected to judicial oversight in the same manner as sterilisation decisions. Some commentators argue that "[j]udges carry biases and cultural conditioning just as doctors and parents do."<sup>90</sup> However, the true benefit of court authorisation is an improved *decision-making process* rather than *decision-maker*.<sup>91</sup> Courts are well-versed in difficult balancing exercises and best placed to protect intersex infants. The unique jurisdiction of Australia's Family Court to make orders relating to the welfare of children provides a helpful example for dealing with non-therapeutic and contentious surgical intervention on minors.<sup>92</sup> Procedures requiring Family Court authorisation include treatment for people with DSD or gender identity disorder and sex assignment surgery.<sup>93</sup> Kennedy believes this supervisory role of the Australian Family Court has broad scope but has been underutilised.<sup>94</sup>

### C *Express legislation*

The lack of clarity around the precise legal status of genital-normalising surgery is unfair on the medical profession. There is a small but unlikely chance that s 204A of the Crimes Act 1961 prohibits non-consensual genital-normalising surgery as it does not benefit physical or mental health as required by the section. The position should be clarified in express legislation. Reform could be made through an amendment to the Contraception, Sterilisation, and Abortion Act 1977 such as to include intersex intervention.

### D *Increased awareness and research*

As discussed above, the practice of intersex intervention developed as a result of cultural influence and normative gender and sexuality ideas. To abandon genital-normalising surgery as the dominant treatment model, there must be a cultural shift such that there is less societal discomfort with non-conforming bodies and thus less pressure to "normalise" bodies. This societal shift will require continued activism and increased awareness of genital and sexual variation and the ramifications of surgery. A moratorium on surgery would be "short-sighted" because it would not address the underlying reasons parents and doctors seek to "correct" intersex infants.<sup>95</sup>

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88 At 25 and 28.

89 At 37–39.

90 Tamar-Mattis, above n 6, at 102.

91 At 103.

92 Family Law Act 1975 (Cth), s 67ZC.

93 Steven Strickland "To treat or not to treat: legal responses to transgender young people" (paper presented to Association of Family and Conciliation Courts 51st Annual Conference, Toronto, May 2014) at 8.

94 Kennedy, above n 47, at 814.

95 Ammaturo, above n 2, at 605.

## VII Conclusion

Intersex children remain vulnerable and at risk of undergoing genital-normalising surgery with lifelong, negative repercussions. Parents' ability to consent to intersex intervention is increasingly being questioned because of clear conflicts of interest, power imbalances and strong arguments that genital-normalising surgery may not be in the child's best interests. There is also evidence that parents do not always receive full disclosure of the ramifications of surgery from medical practitioners and so consent is not fully informed. From a legal perspective, the current medical practice regarding intersex infants is unsatisfactory and there is more the law could be doing. Recommendations for reform include adopting guidelines for medical practitioners on intersex intervention, empowering courts to authorise and oversee clinical decisions related to intersex intervention, drafting express legislation and increasing awareness of intersex and the ramifications of surgery.