Comments

Reproductive Organs and Differences of Sex Development: The Constitutional Issues Created by the Surgical Treatment of Intersex Children

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I. INTRODUCTION

Parents wait anxiously while their two-month-old daughter undergoes routine hernia surgery. During the surgery, the doctor discovers that their child has undescended testes in her stomach, and not the expected female reproductive organs. With the infant still on the operating table and under anesthesia, the doctor exits the surgery and requests that the parents give their consent to remove the testes. Can the parents consent to a surgery that substantially affects the child’s adulthood? Would the child’s testes allow her to be fertile in a traditionally masculine sense despite her outwardly feminine appearance? Could she be fertile today or in the future with medical advances?

The situation is even more complicated when a child is clearly fertile. Consider a fifteen-year-old male who is experiencing menstrual bleeding through his penis. The parents have known for some time that he has a uterus and ovaries, but no testes. However, in hopes of preserving his “male” self-image, the parents have not disclosed this information to the teen. Now, they want the doctor to perform a hysterectomy while keeping the purpose of the surgery secret from the patient. Although the teenage male is currently fertile, he would need medical intervention for fertilization and delivery in the future. In other words, this hysterectomy would sterilize him.

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2. Id.
4. Id.
5. Id.
6. A hysterectomy removes the uterus, but may additionally remove the cervix. STEDMAN’S MEDICAL DICTIONARY (27th ed. 2000).
Both of these children have differences of sex development (DSDs). DSDs are conditions that involve atypical “male” and “female” physical characteristics, but that definition depends on who is doing the defining. Scholars estimate that one in 1500 children are born with a DSD of some kind, the obviousness of which may range from those not evident to an untrained observer to a completely indeterminate sex based on physical observation. In fact, some intersex individuals may have conditions so subtle that they may never know they are intersex. One method of determining sex—as opposed to gender—depends on three physical characteristics: (1) the sex chromosome configuration, (2) the internal reproductive organs, and (3) the external reproductive organs. An inconsistency between one or more of these characteristics is a DSD. As a practical matter, however, sex is normally determined by a glance at the external genitalia immediately after birth. When the birth attendant is uncertain based on that glance, doctors analyze the various characteristics of the child to make a diagnosis, and then they assign a sex based on the likeliest outcome of that diagnosis. The traditional standard of care for

8. These conditions are also referred to as “intersex” or “disorders of sex development.” The nomenclature issue is contentious and emotional. The author has attempted to follow a middle path by using the alternative meaning for DSD, “differences of sex development,” to describe intersex conditions, while using “intersex” to refer to individuals with these conditions.

9. DSDs are physical conditions, which means that individuals with DSDs may be straight, gay, bisexual, transgender, or transsexual. INTERSEX SOCIETY OF NORTH AMERICA, HANDBOOK FOR PARENTS 15 (2006), available at http://www.dsdguidelines.org/ (“Although most women are attracted to men, and most men are attracted to women, knowing a person’s sex or gender won’t tell you his or her sexual orientation.”).

10. ALICE DOMURAT DREGER, HASTINGS CENTER, “AMBIGUOUS SEX”— OR AMBIVALENT MEDICINE? ETHICAL ISSUES IN THE TREATMENT OF INTERSEXUALITY 26 (May–June 1998) (“One quickly runs into a problem, however, when trying to define ‘key’ or ‘essential’ feminine and masculine anatomy.”).

11. See Intersex Society of North America, How Common Is Intersex?, http://www.isna.org/faq/frequency (last visited Mar. 29, 2010) (on file with the McGeorge Law Review) (“If you ask experts at medical centers how often a child is born so noticeably atypical in terms of genitalia that a specialist in sex differentiation is called in, the number comes out to about 1 in 1500 to 1 in 2000 births. But a lot more people than that are born with subtler forms of sex anatomy variations, some of which won’t show up until later in life.”); DREGER, supra note 10, at 26 (“I am persuaded by more recent, well-documented literature that estimates the number to be roughly 1 in 1,500 live births. The frequency estimate goes up dramatically, however, if we include all children born with what some physicians consider cosmically ‘unacceptable’ genitalia.”).

12. Intersex Society of North America, What Is Intersex?, http://www.isna.org/faq/what_is_intersex (last visited Jan. 24, 2011) (on file with the McGeorge Law Review) (“Though we speak of intersex as an inborn condition, intersex anatomy doesn’t always show up at birth. Sometimes a person isn’t found to have intersex anatomy until she or he reaches the age of puberty, or finds himself an infertile adult, or dies of old age and is autopsied. Some people live and die with intersex anatomy without anyone (including themselves) ever knowing.”).

13. While most people understand the terms XX and XY, many varieties exist, including XXY, forty-six XY, forty-seven XXY, XY female, XO, XYY, and mosaicism (i.e., some cells are XX and some cells are XY). Melanie Blackless et al., How Sexually Dimorphic Are We?, 12 AM. J. HUM. BIOLOGY 151, 152 (2000).

14. Id.

the treatment of DSDs often involves the removal of external and/or internal reproductive organs. External reproductive organs are primarily removed or altered to make the child’s physical appearance similar to a standardized version of the child’s assigned gender. Doctors primarily remove internal reproductive organs to prevent hormone production that might create bodily changes during and after puberty that are at odds with the outward appearance or assigned gender. Additionally, they may also remove them to reduce an elevated cancer risk (sometimes reasonably and sometimes not).

While sterilization (in the sense of the purposeful ending of fertility) is not, as a general rule, the stated intention of these surgeries, the removal of reproductive organs nonetheless raises some pertinent ethical, medical, and legal issues. Fertility is inherently speculative even when a person possesses all the “correct” reproductive organs. Sterilization involves the removal of reproductive organs. Whether or not these surgeons intend to do so, they are, in effect, sterilizing the child when they elect to remove his or her reproductive organs. This election should be considered independently of the child’s actual or predicted fertility.

The Supreme Court of the United States has recognized procreation as a fundamental constitutional right. As a result, parental consent on the child’s behalf may not be legally sufficient for surgeries that require removal of reproductive organs, even for purposes of treating DSDs. Moreover, such surgeries may violate state constitutional rights, such as the California

16. See Peter E. Lee et al., American Academy of Pediatrics, Consensus Statement on the Management of Intersex Disorders, 118 PEDIATRICS e488 (2006) [hereinafter Consensus Statement] (establishing a standardized approach to the nomenclature and treatment of DSDs). This is not a “side effect” because that would suggest an unintended result.

17. See Intersex Society of North America, Frequently Asked Questions: Osteoporosis, http://www.isna.org/node/724 (last visited Mar. 29, 2011) [hereinafter FAQ: Osteoporosis] (on file with the McGeorge Law Review) (noting that many intersex individuals are at increased risk of osteoporosis and advising them: “If you were born without functioning gonads (ovaries or testes), or if your gonads have been removed, you should be under an endocrinologist’s care and maintain hormone replacement therapy for life.”).

18. Anne Tamar-Mattis, Exceptions to the Rule: Curing the Law’s Failure to Protect Intersex Infants, 21 BERKELEY J. OF GENDER L. & JUST. 59, 67 (2006) [hereinafter Exceptions to the Rule] (“Surgeons routinely remove gonads, regardless of potential function, if they will detract from normative genital appearance or if they will produce hormones that will cause development of the ‘wrong’ secondary sexual characteristics.”); see DREGER, supra note 10, at 28 (“Physicians appear to do far more to preserve the reproductive potential of children born with ovaries than that of children born with testes. While genetically male intersexuals often have infertile testes [which may change depending on future medical advancements], some men with micropenis may be able to father children if allowed to retain their testes.”).

19. See Skinner v. Okl. ex rel Williamson, 316 U.S. 535, 541 (1942) (“There is no redemption for the individual whom the [sterilization] law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty.”); Carey v. Population Servs. Int’l, 431 U.S. 678, 685 (1977) (“The decision whether or not to beget or bear a child is at the very heart of this cluster of constitutionally protected choices. That decision holds a particularly important place in the history of the right of privacy . . . . This is understandable, for in a field that by definition concerns the most intimate of human activities and relationships, decisions whether to accomplish or to prevent conception are among the most private and sensitive.”).
Constitution’s right to privacy. However, courts may distinguish these procedures by separating them into at least four categories: (1) immediately life-preserving treatments (as in cancerous and precancerous cells); (2) potentially life-preserving treatments (as in conditions with a higher likelihood of gonadal cancer in adulthood); (3) function-preserving treatments; and (4) appearance-related treatments. Arguably, only the first category justifies immediate treatment authorized by surrogate consent.

In other kinds of medical treatment for minors and the mentally disabled, courts have decided that parental consent may be inadequate to authorize certain procedures. In those specialized situations, hospitals, doctors, and parents have utilized judicial hearings to ensure that the child’s due process rights are protected and that a neutral third party is involved in the decision-making process. These same protections can be applied to a new category of cases without the need for creating a new paradigm of protections. At a minimum, children with DSDs are being deprived of their right to bodily integrity; thus, they require procedural due process protections to preserve their right to privacy. These children are also likely deprived of the right to procreate, which is also part of the right to privacy. Normally, a parent’s medical decision is presumed to uphold the child’s constitutional rights. An essential part of this judicial hearing process is the appointment to the minor of a guardian ad litem or attorney who assumes a legal and ethical obligation to presume that the child would oppose the actions of the parents. In the DSD context, children need an independent voice to represent their future procreative interests, and the judicial hearing process can provide those substantive and procedural due process protections. Parents are making medical decisions for medical choices that will take place decades in the future and those future medical treatments could be significantly different and/or advanced from what is available today.

This Comment argues that, because of the uncertainty inherent in defining such concepts as “fertility,” for twenty, thirty, or forty years in the future, judicial hearing procedures should apply to the removal of any reproductive organ, either

20. CAL. CONST. art. I, § 1. Civil rights guaranteed under the California Constitution are not dependent on the interpretation of the same rights under the federal Constitution. CAL. CONST. art. I, § 24. The California Constitution grants an explicit right to privacy that is greater in scope than the right to privacy under the federal Constitution, with no distinction between the privacy rights of adults and minors. Am. Acad. of Pediatrics v. Lungren, 16 Cal. 4th 307, 326 (1997) ("[N]ot only is the state constitutional right of privacy embodied in explicit constitutional language not present in the federal Constitution, but past California cases establish that, in many contexts, the scope and application of the state constitutional right of privacy is broader and more protective of privacy than the federal constitutional right of privacy as interpreted by the federal courts.").

21. See infra section III.A.

22. See, e.g., Tamar-Mattis, Exceptions to the Rule, supra note 18, at 93–98 (describing how courts and legislatures have made categorical exceptions to the normal legal presumption in favor of supporting parental surrogate consent).

23. U.S. CONST. amend. XIV, § 1 ("[N]or shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").
internal or external. Many states already mandate judicial hearings before approving the intentional sterilization of an individual with mental disabilities who is incapable of consenting to medical treatment. States could easily extend these protections to children with DSDs who are in danger of having reproductive organs removed. This Comment argues that the current California statutory protections for the mentally-disabled provide a workable and natural alternative to the current parental informed consent model while adequately protecting children’s constitutional rights.

This Comment’s analysis is divided into six parts. Part II provides a brief overview of the DSD standard of care and the medical standard this Comment proposes. Part III examines the constitutional legal background, and includes an overview of the parental/surrogate informed consent process that hospitals and doctors currently use to secure informed consent for surgeries removing a child’s reproductive organs. This section also discusses the fundamental rights of parents and children, and the interplay between those rights. Part IV presents the federal Constitutional backdrop of the fundamental constitutional rights of children. Part V examines the California approach to surgeries that sterilize the mentally incompetent. Part VI presents an overview of similar DSD cases in other countries. Part VII argues that surgical treatments that remove reproductive organs implicate the fundamental right to procreate for children with DSDs, and that the current parental informed consent standard is insufficient for giving up a child’s fundamental rights to bodily integrity, privacy, and procreation. This Comment ultimately concludes that a judicial hearing process with adequate procedural protections is better able to protect a child’s interests than the total lack of protections today.

II. THE MEDICAL STANDARD OF CARE

Ideally, a medical standard of care is the product of time, study, and experimentation. Unfortunately, the scientific method of testing and retesting to

24. See, e.g., In re Grady, 426 A.2d 467 (N.J. 1981) (finding that New Jersey law requires a judicial hearing to allow parents to consent to the sterilization of their mentally disabled daughter and requiring clear and convincing proof that the sterilization is in the best interest of the patient); A.L. v. G.R.H., 325 N.E.2d 501 (Ind. 1975) (finding that the common law does not authorize a parent to sterilize her brain-damaged child); In re M.K.R., 515 S.W.2d 467 (Mo. 1974) (finding that even the courts did not have jurisdiction to approve a parent’s request to sterilize a child with mental disabilities without express statutory approval); Ruby v. Massey, 452 F. Supp. 361, 366 (D. Conn. 1978) (finding that parents “may neither veto nor give valid consent to the sterilization of their children”); In re Guardianship of Hayes, 608 P.2d 635 (Wash. 1980) (finding that a parent cannot consent to the sterilization of a child with mental disabilities and that there is a “heavy presumption” against sterilization); and In re Moe, 432 N.E.2d 712 (Mass. 1982) (finding that individuals with mental disabilities enjoy the same constitutional right to privacy and procreation as any other individual; however, this finding allowed the court jurisdiction to entertain parental requests for the sterilization of their children).

determine an appropriate standard is not always readily available or practicable in certain situations. The treatment of DSDs developed largely from a single case study, Dr. John Money’s “John/Joan” study. The standard he developed recommended genital surgery and hormone treatment to “normalize” infants with DSDs, urged secrecy by both doctors and parents, and admonished parents to raise the child strictly in the assigned gender. To date, this standard still has not been proven medically or psychologically beneficial, and no patient has ever stepped forward to defend the practice despite heavy public and academic criticism.

In 1967, Money was a medical visionary. Following his own psychological theories, he believed that nurture, not nature, determined gender. A botched circumcision gave him the opportunity to test his theory. Because the damage to the infant’s penis was severe and reconstructive surgery would have been unable to restore it, Money convinced the parents to consent to the surgical creation of a vagina and the removal of the child’s testes. Because the child had an identical male twin, the experiment “came bundled with a built-in control,” making it an ideal test case. Under Money’s guidance, the parents strictly raised their son “John” as their daughter “Joan” after the surgery, thus emphasizing nurture over nature. Despite the parents’ best efforts, “Joan” rebelled against her gender assignment even as a toddler and at the age of fourteen chose to live as a male. However, Money falsified his research about “Joan,” claiming that she was a
well-adjusted and stereotypical little girl.\textsuperscript{36} Publishing his experiment as a success, he maintained that “Joan” had been lost to follow-up.\textsuperscript{37} This falsification of one incomplete case study led to the creation of a medical standard of care.\textsuperscript{38}

In 1997, “John,” now known as David Reimer, went public about the failure of his treatment in order to discredit Money and his work.\textsuperscript{39} Reimer underwent surgical procedures to reverse his childhood surgeries, including a double mastectomy and two phalloplasty operations.\textsuperscript{40} He attempted to live a normal life by getting married and adopting his wife’s children.\textsuperscript{41} Nevertheless, Reimer suffered significant depression throughout his life, which he linked to his childhood treatments. In 2004, he committed suicide at the age of thirty-eight.\textsuperscript{42}

Today, Money’s standard of care is changing, though slowly. While the traditional DSD parental informed consent model was based upon “urgency, partial and inaccurate disclosure of the conditions and risk, [and] a sense of secrecy and shame,” the medical community is backing away from that model.\textsuperscript{43} However, many believe that change is not occurring fast enough.\textsuperscript{44} Regardless of whether changes are made to the current model, the problem remains that a parent may not legally be able to consent to a DSD treatment that removes his or

\textsuperscript{36} Beh & Diamond, supra note 25, at 5–12 (noting that Dr. Money was aware of Joan’s resistance to her gender assignment as a female but did not add this information, that “might have had an impact on the developing standard of care,” to his case study). Doctors applied Money’s theories not only to children with DSDs or genital accidents like Reimer’s, but also to boys with “abnormally small genitals” and those who suffered traumatic penile injuries. Walker, supra note 31.

\textsuperscript{37} Colapinto, Gender Gap, supra note 35.

\textsuperscript{38} Beh & Diamond, supra note 25, at 5–12; Walker, supra note 31.

\textsuperscript{39} Colapinto, Gender Gap, supra note 35.

\textsuperscript{40} DREGER, supra note 10, at 25.

\textsuperscript{41} Id.

\textsuperscript{42} Colapinto, True Story of John/Joan, supra note 35; Colapinto, Gender Gap, supra note 35 (“David’s blighted childhood was never far from his mind. Just before he died, he talked to his wife about his sexual ‘inadequacy,’ his inability to be a true husband.”); Walker, supra note 31.

\textsuperscript{43} See Consensus Statement, supra note 16 (establishing a standardized approach to the nomenclature and treatment of DSDs). For a more detailed discussion of the traditional DSD standard of care, see Beh & Diamond, supra note 25, at 5–12, 34.

\textsuperscript{44} In describing the changes suggested by the Consensus Statement, the Intersex Society of North America [disbanded in 2008 and replaced by Accord Alliance], lamented that “as wonderful and historic as these changes are, no institution has fully implemented them. There are no mechanisms are [sic] in place to foster implementation nor to evaluate to what extent these changes improve health care experiences and outcomes for persons and families affected by DSDs.” Intersex Society of North America, Home Page, http://www.isna.org/ (last visited Mar. 29, 2010) (on file with the McGeorge Law Review).
her child’s reproductive organs without violating the child’s civil rights under 42 USC § 1984.\textsuperscript{45}

While Reimer did not have a DSD, his gender reassignment surgery removed his functional testes.\textsuperscript{46} This Comment argues that if doctors and parents decide that surgical removal of a child’s reproductive organs (either internal or external) is necessary or beneficial,\textsuperscript{47} the law should require a judicial hearing process to provide adequate procedural and substantive due process protections for the child. This argument is stronger for the removal of internal reproductive organs than for the alteration or removal of external reproductive organs because one can tie those reproductive organs closer to the likelihood of fertility due to being the source of eggs and sperm. While there is a key distinction to be made between fertility and sterilization, to date, that distinction has not been part of the discourse on DSD treatment.

III. CURRENT LEGAL AUTHORITY FOR THE MEDICAL CARE OF CHILDREN

A. Parental Authority and Substituted Consent

The current legal standard for DSD treatments is parental informed consent.\textsuperscript{48} Nearly every medical treatment of a minor relies on the parental informed consent model.\textsuperscript{49} Parental informed consent is entirely removed from the judicial process and requires no approval by a neutral third party.\textsuperscript{50} While medical ethicists argue that young children should assent to medical care and teenagers should consent,\textsuperscript{51} the law requires neither.\textsuperscript{52} The Supreme Court of the United States recognizes a legal presumption that a parent acts in the best interest of his

\textsuperscript{45} Doctors who perform these procedures may also be liable for violations of the child’s civil right to procreate in the future under the same statute. 42 USC § 1984.

\textsuperscript{46} This surgery left Reimer infertile. See, e.g., Colapinto, Gender Gap, supra note 35 (noting that Money told Reimer’s parents that their child would grow up to be a “sterile woman,” but capable of heterosexual intercourse).

\textsuperscript{47} The author does not argue that all children with DSDs are entitled to this judicial hearing process, only those children whose reproductive organs may be removed should be constitutionally entitled to these procedural protections.

\textsuperscript{48} Beh & Diamond, supra note 25, at 37–38; Alicia Ouellette, Shaping Parental Authority Over Children’s Bodies, 85 Ind. L.J. 955, 966–69 (2010) [hereinafter Ouellette, Shaping] (arguing that a parent should not have the unlimited ability to “size, shape, sculpt, or mine their children’s body for social, aesthetic, familial, or cultural reasons”); Exceptions to the Rule, supra note 18, at 78.

\textsuperscript{49} Beh & Diamond, supra note 25, at 37–38; Ouellette, Shaping, supra note 48, at 966–69; Tamar-Mattis, Exceptions to the Rule, supra note 18, at 78.

\textsuperscript{50} Beh & Diamond, supra note 25, at 37–38; Ouellette, Shaping, supra note 48, at 966–69; Tamar-Mattis, Exceptions to the Rule, supra note 18, at 78.

\textsuperscript{51} Sometimes a teenager’s consent is sufficient for medical care, though a parent may override that consent in most cases, which will be discussed later in this section. See infra Part III.B.

\textsuperscript{52} Ouellette, Shaping, supra note 48, at 968 (“In most cases, the child’s wishes are essentially irrelevant.”).
or her child when choosing the appropriate course of medical treatment, subject only to a few exceptions. Generally, parents have a constitutional right to control the conduct and upbringing of their children. This right includes a legal presumption that the parent is the child’s medical decision-maker until the child reaches legal age and is able to consent. So long as the parents and doctors agree on a treatment plan involving an accepted standard of care, courts have traditionally deferred to parental choice and declined to intervene. The courts will always intervene, however, when the child’s life or well-being is in danger and the parents are not providing “standard medical care.” Nonetheless, the courts will generally defer to the parents’ choice of treatment so long as the proposed treatment is considered acceptable medical care—even if endorsed by only a small minority of medical practitioners.


54. Some of the exceptions (which are generally irrelevant to children treated for DSDs with the removal of reproductive organs) include: limiting a parent’s ability to enroll his or her child in an experimental treatment, a parent’s ability to institutionalize his or her child without neutral approval, a parent’s ability to limit his or her child’s education, and a parent’s refusal of life-saving medical treatment for the child. See 45 C.F.R. §§ 46.401–409 (2009) (limiting non-therapeutic experimental research protocols that parents may choose for their children); Parham, 442 U.S. at 606 (finding that a mother did not have the unilateral right to institutionalize her six-year-old son without an inquiry by a “neutral factfinder”); Wisconsin v. Yoder, 406 U.S. 205, 213 (1972) (noting that there is “no doubt as to the power of a State” to regulate a “basic education,” including a required minimum duration of education (citing Pierce v. Soc’y of Sisters, 268 U.S. 510, 534 (1925)); Douglas S. Diekema, Parental Refusals of Medical Treatment: the Harm Principle as a Threshold for State Intervention, 25 THEORETICAL MED. & BIOETHICS 243 (2004) (arguing that the “best interests” standard is insufficient to protect a minor’s interests in medical decisions and is not the standard used by the courts and medical practitioners).

55. See, e.g., Prince v. Mass., 321 U.S. 158, 166 (1944) (“It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.”); Parham, 442 U.S. at 602 (noting that “parents generally have the right, coupled with the high duty, to recognize and prepare their children for additional obligations . . . . Surely, this includes a ‘high duty’ to recognize symptoms of illness and to seek and follow medical advice.” (internal citations and quotations removed)); Meyer v. Nebraska, 262 U.S. 390 (1923) (finding that parents have the right to instruct and educate their children as they see fit); Pierce v. Soc’y of Sisters, 268 U.S. 510, 534–35 (1925) (finding that parents have the right to choose to send their children to private schools that reinforce the moral and religious education chosen by the parents).

56. See, e.g., Parham, 442 U.S. at 602 (“The law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children.”).

57. Tamar-Mattis, Exceptions to the Rule, supra note 18, at 79.

58. See, e.g., Guardianship of Phillip B., 188 Cal. Rptr. 781, 791–92 (1st Dist. 1983) (holding that parents’ continuing care would result in harm to the minor). See Prince, 321 U.S. at 166 (“The right to practice religion freely does not include liberty to expose . . . the child . . . to ill health or death.”).

59. Tamar-Mattis, Exceptions to the Rule, supra note 18, at 80; Ouellette, Shaping, supra note 48, at 969.

Parental choice is the rule in shaping cases. The exceptions do not apply. The use of shaping
The two most common exceptions to the parental presumption are organ donation procedures and procedures with the primary purpose of sterilization (generally of the mentally disabled or mentally ill). There are three primary concerns that cause the courts to override parental consent: (1) the parents’ potential conflict of interest; (2) the impairment of the child’s fundamental rights; and (3) the lack of medical benefit to the child. Arguably, all three concerns exist in the cases addressed by this Comment. Part VI addresses the first two concerns. The third concern is better left to other authors and activists, though there is a short discussion in Part V(A) that may independently justify the removal of treatment decisions from parents. One should note that the calls for a moratorium on childhood DSD treatment tend to focus on external genital interventions does not deprive a child of lifesaving treatments or involve drug treatment, abortion, or institutionalization. Although shaping interventions implicate a child’s rights to bodily integrity, they do no more than other cases involving the use of medical and surgical interventions. And where a parent chooses to use medicine or surgery for a child (as opposed to when a parent refuses medicine or surgery) courts are generally unwilling to consider the child’s best interests when the desired intervention has the support of even one licensed medical provider.

Id. 60. In the organ donation context, courts are hesitant when one minor child is being asked to donate to a sibling, fearing that the parents are unable to consider the best interests of both children. See, e.g., Little v. Little, 576 S.W.2d 493 (Tex. Civ. App. 1979) (involving a mother seeking to get a kidney donation from her fourteen-year-old daughter with Down’s Syndrome for her little brother); Michele Goodwin, My Sister’s Keeper: Law, Children, and Compelled Donation, 29 W. NEW ENG. L. REV. 357, 358 (2007) (“The Essay scrutinizes whether and under what circumstances parents’ rationalization for compelling organ and tissue donation from their children is ever proper or legitimate. In other words, when and under what circumstances can parents impose that duty—to rescue—on their children to save the life of another.”).


62. Id. For another version of the factors a court will consider to override parental consent to a child’s medical care, see Beh & Diamond, supra note 25, at 41 (“1) [T]he decisional capacity of the minor; 2) the burden and risk of treatment; and 3) the effectiveness of the treatment.”).

63. See, e.g., Tamar-Mattis, Exceptions to the Rule, supra note 18 (arguing for a moratorium on childhood genital surgery as a treatment for DSDs); Intersex Society of North America, What Does ISNA Recommend for Children with Intersex?, http://www.isna.org/faq/patient-centered (last visited Mar. 29, 2010) (on file with the McGeorge Law Review) (“Surgeries done to make the genitals look “more normal” should not be performed until a child is mature enough to make an informed decision for herself or himself.”); Milton Diamond & H. Keith Sigmundson, Management of Intersexuality: Guidelines for Dealing with Persons with Ambiguous Genitalia, 151 ARCHIVES PEDIATRIC ADOLESCENT MED. 1046 (1997) (calling for a moratorium on childhood genital surgery); Nancy Ehrenreich & Mark Barr, Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of “Cultural Practices,” 40 HARV. C.R.-C.L. L. REV. 71, 131–32 (2005) (arguing that DSD external genital surgery should be treated consistently with the modern American outrage against female genital mutilation, which is discussed briefly in Part III). But see Laura D. Hermer, A Moratorium on Intersex Surgeries?: Law, Science, Identity, and Bioethics at the Crossroads, 13 CARDOZO J.L. & GENDER 255, 255–56 (2007) (arguing that a moratorium is unnecessary because of three primary reasons: (1) that it “would also hobble, if not eliminate, the burgeoning scientific investigation of the best treatment practices for different intersex conditions which seeks to gather information from broad and objectively chosen groups of individuals;” (2) that it “would remove a surgical option that, according to data in a number of studies, has benefited and satisfied numerous patients;” and (3) that these “solutions to the problem of early surgeries do nothing to constructively address the deep-seated and often murky social, interpersonal and psychological reasons such surgeries take place”).
surgery rather than on the internal ramifications. Many of the cases examined by this Comment do not require external genital surgery. For example, female-gendered children with androgen insensitivity syndrome (AIS) require no external genital surgery, although doctors would likely seek to remove internal undescended or partially-descended testes. If doctors or courts adopt a moratorium on infant external genital surgery without developing an overarching legal framework, children such as these may continue to have hormonally-motivated surgeries to remove their internal reproductive organs before reaching the age of consent.

B. The Rights of Children

The Supreme Court has recognized that children have full constitutional rights that co-exist with parental rights. However, parents sometimes exercise these constitutionally-protected rights on their child’s behalf, particularly those rights that relate to their ability to consent to or decline medical treatment. No person may be deprived of “life, liberty, or property, without due process of law.” Due to cases like *Griswold v. Connecticut* and *Roe v. Wade*, the rights to privacy and procreation are considered liberties under the Fourteenth Amendment, and children are considered “persons” for due process purposes. Because the law considers children to be legally incompetent persons, their rights are exercised through legal surrogates who consent on the child’s behalf. These rights include the right to autonomy, the right to privacy, the right to bodily...
integrity (which many states have interpreted to limit the parental “right” to consent to the purposeful sterilization of his or her child), and the right to some limitation on parental involvement when a minor wishes to obtain an abortion. The Court has also found that children have “a significant liberty interest in not being confined unnecessarily for medical treatment.” Further, it appears that children have “exclusive rights to make certain fundamental decisions for themselves, and parents cannot make choices that will deprive the child of the opportunity to make those choices as an adult,” which should include the right to decide if and when to remove or alter one’s reproductive organs.

One federal statute embodies many of the important policy issues that legislatures will likely consider in the DSD context. In 1996, Congress passed the Criminalization of Female Genital Mutilation Act, which criminalizes the circumcision, excision, and infibulation of “the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years,” unless the procedure is medically necessary for the health of the patient. While intended to address cultural and religious female genital mutilation, this statute potentially criminalizes DSD treatment surgeries that reduce the size of an enlarged clitoris, yet no such prosecutions are known to

75. See Youngberg v. Romeo, 457 U.S. 307, 320 (1982) (finding, among other constitutional rights, a freedom from bodily restraints); Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 849 (1992) ("[T]he Constitution places limits on a State’s right to interfere with a person’s most basic decisions about family and parenthood . . . as well as bodily integrity . . . ." (internal citations omitted)).

76. See, e.g., Ruby v. Massey, 452 F. Supp. 631 (D. Conn. 1978) (finding that parents had neither the authority to consent to their child’s sterilization nor the veto power to prevent it); A.L. v. G.R.H., 325 N.E.2d 501 (Ind. 1975) (finding that the common law does not authorize a parent to sterilize her child with brain damage); In re Guardianship of Hayes, 608 P.2d 635 (Wash. 1980) (finding that a parent cannot consent to the sterilization of a child with mental disabilities and that there is a “heavy presumption” against sterilization).

77. See Danforth, 428 U.S. 52 (finding that a state cannot require parental consent for a minor’s abortion during the first twelve weeks of pregnancy); Bellotti, 443 U.S. 622 (finding that a third-party cannot have an absolute veto right over a minor’s abortion); Casey, 505 U.S. at 899 ("[A] State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is adequate judicial bypass procedure.").


79. Ouellette, Shaping, supra note 48, at 981.


81. Infibulation is the “[c]losure of the vaginal vestibule by creating a fusion of the labia majora; typically done after excision of the labia minora and clitoris and incision of the labia majora to create raw surfaces that can be surgically joined by pinning so that they will eventually grow together; done for cultural, not medical, reasons.” STEDMAN’S MEDICAL DICTIONARY (27th ed. 2000).


83. Female Genital Mutilation Act, Pub. Law No. 104–208, § 645(a)(1)–(3), 110 Stat. 3009-546 (1997) ("Congress finds that (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; [and] (3) such mutilation infringes upon the guarantees of rights secured by Federal and State law, both statutory and constitutional.").
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have occurred. Though this statute does not affect reproductive organs per se, it shows Congress’ concern for the bodily integrity of female children.

C. The Rights of the Patient Unable to Provide Consent

For over forty years, courts and legislators have considered the quandary of how to protect the procreative rights of those individuals with mental disabilities who are unable to manifest informed consent for birth control and sterilization procedures. The right to procreate is the personal right to make an informed choice whether to have children.

In the usual DSD case, the only incapacity suffered by the patient is infancy, which is an incapacity that cures itself with time—time these children generally have. The only DSD that potentially presents a medical emergency at birth or soon thereafter is virilizing congenital adrenal hyperplasia (virilizing CAH).

84. See Exceptions to the Rule, supra note 18, at 107 n.356.

There are several political and practical problems with this strategy. These include the fact that the statute’s language seems to exclude some, and arguably all, genital-normalizing surgeries on intersex infants. Another problem is that it is a criminal statute—it seems unlikely that the public would approve criminal sanctions on the doctors who perform [DSD] surgeries. . . . (Notwithstanding the American public’s willingness to apply criminal sanctions to practitioners who cut non-intersex female babies’ genitals in order to align their bodies with their families’ cultural norms). A civil strategy seems more promising.

85. See, e.g., Thornburgh v. Am. Coll. of Obstetricians & Gynecologists, 476 U.S. 747, 772 (1985), overruled in nonrelevant part by Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 (“Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman’s decision— with the guidance of her physician and within the limits specified in Roe—whether to end her pregnancy.”).

86. See Tamar-Mattis, Exceptions to the Rule, supra note 18, at 65 (“Although the vast majority of these babies have no medical condition that will result in physical harm, doctors act quickly to assign a gender, and often pressure parents to consent to immediate surgery to conform the genitals [and gonads] to this assigned gender.”).

87. For instance, children with CAH have difficulties producing cortisone, which is easily treatable but may result in death if left untreated. Intersex Society of North America, Congenital Adrenal Hyperplasia (CAH) Medical Risks, http://www.isna.org/faq/medical_risks/cah (last visited Mar. 29, 2010) [hereinafter CAH Risks] (on file with the McGeorge Law Review). CAH occurs when “the adrenal glands, while trying to make cortisone, . . . make an unusually high level of other hormones that are ‘virilizing’ That is, they can make XX embryos have larger than average clitorises, or even a clitoris that looks rather like a penis, or labia that look
While gonadal cancer can also arise with various DSDs, it typically presents only a “slight” risk before early adulthood, depending on the condition. On the other hand, “[f]unctioning gonads, even partially functioning gonads, are a big advantage over hormone replacement therapy.” However, even partially functioning testes should generally be removed before puberty for an intersex child with a female gender in order to prevent male secondary sex characteristics. This surgery can be delayed until the child is able to meaningfully participate in the decision-making process—there is no need for the surgery to take place when the child is an infant or toddler.

It is important to note that if the gonads have already developed cancerous cells, no court approval is necessary for parents to consent to their removal because, in this case, the surgery is a medical necessity. Therefore, if no precancerous or cancerous cells have yet developed, parents should seek judicial approval for the removal of the testes. Along the same lines, if there is no medical emergency and the child is still incapable of providing meaningful consent at the age when puberty is expected, puberty can be temporarily delayed with medication in order to allow the child to participate more meaningfully in the medical decision-making process at a later date.

The Supreme Court has not directly confronted the sterilization of individuals with mental disabilities. It did, however, deny a patient’s demand to lift judicial immunity for the judge who “fail[ed] to comply with elementary principles of procedural due process” by authorizing a mother’s petition for her daughter’s sterilization, and grant full immunity to all parties involved. Without like a scrotum.” Intersex Society of North America, Congenital Adrenal Hyperplasia (CAH), http://www.isna.org/faq/conditions/cah (last visited Mar. 29, 2010) (on file with the McGeorge Law Review).

88. Intersex Society of North America, FAQ: Gonadal Tumors, http://www.isna.org/node/737 (last visited Mar. 29, 2010) [hereinafter Gonadal Tumors] (on file with the McGeorge Law Review); Tamar-Mattis, Exceptions to the Rule, supra note 18, at 67 n.58. On the other hand, removal of the gonad tissue (a gonadectomy) greatly increases the risk of osteoporosis. A patient with a gonadectomy will require hormone replacement therapy for life. The former Intersex Society of North America recognized the even greater risk of osteoporosis for patients with DSDs, who usually develop a distrust of doctors and therefore, will not seek the hormone treatment they need. FAQ: Osteoporosis, supra note 17. (“Many people with intersex conditions, having developed a distrust or aversion for medical people, avoid medical care and drop hormone replacement therapy which was prescribed during puberty.”).

89. CAH Risks, supra note 88.

90. CAH Risks, supra note 88 (“If it is difficult to determine the child’s gender identity or wishes, puberty can be temporarily delayed with the drug Lupron. This is not a permanent solution, but a delaying tactic.”).

91. Tamar-Mattis, Exploring Gray Areas, supra note 1 (“When gonadectomy or hysterectomy is elective—that is, not necessary to preserve life or limb—we enter a legal gray area . . . .”).

92. CAH Risks, supra note 88. One such drug is Lupron, but research on the long-term effects of this or other puberty-suppressing drugs is incomplete. See Lupron.com, Important Safety Information, http://www.lupron.com/important-safety-information.cfm (follow the hyperlink “CHILDREN Central Precocious Puberty”) (last visited Mar. 29, 2010) (on file with the McGeorge Law Review) (“Studies have not been completed in children to determine the full reversibility of fertility suppression.”).

reaching the merits of the patient’s constitutional claims,94 the Court (while noting the lack of any procedural protections such as notice, a hearing, or the appointment of a guardian ad litem) held that all judicial acts are nonetheless granted judicial immunity.95 Three dissenting justices agreed that the circuit judge’s approval “was beyond the pale of anything that could sensibly be called a judicial act” and appeared to find the trial judge’s analysis of the underlying sterilization claim shocking and unconstitutional.96 Although it is simply dicta, the Court’s commentary is likely predictive of how American courts would analyze this issue and the procedural requirements that they would likely require.

IV. THE CONSTITUTIONAL BACKDROP

The concept of eugenics97 was welcomed in a “progressive,” industrialized America.98 In Buck v. Bell, the Supreme Court upheld the desirability of eugenics as a state interest and noted that this interest outweighed the mentally disabled community’s interest in bodily integrity.99 Notably, when Buck was decided, the Court had not yet recognized a fundamental right to procreate.100 However, after the horrors wrought by Hitler’s admiration of American eugenic practices,101 the

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94. The plaintiff claimed the following nine constitutional violations:
1. [T]hat the actions [of the judge] were arbitrary and thus in violation of the due process clause of the Fourteenth Amendment; 2. that [plaintiff] was denied procedural safeguards required by the Fourteenth Amendment; 3. that the sterilization was permitted without the promulgation of standards; 4. that the sterilization was an invasion of privacy; 5. that the sterilization violated [plaintiff]’s right to procreate; 6. that the sterilization was cruel and unusual punishment; 7. that the use of sterilization as punishment for her alleged retardation or lack of self-discipline violated various constitutional guarantees; 8. that the defendants failed to follow certain Indiana statutes, thus depriving [plaintiff] of due process of law; and 9. that defendants violated the equal protection clause, because of the differential treatment accorded [plaintiff] on account of her sex, marital status, and allegedly low mental capacity.

Id. at 354 n.2.
95. Id. at 360.
96. Id. at 365 (Stewart, J., dissenting).

98. See id.

99. 274 U.S. 200 (1927). The Court approved the sterilization of a woman born of a mother with mental disabilities who had given birth to a daughter with mental disabilities. As memorably stated by Justice Holmes, “Three generations of imbeciles are enough.” Id. at 207. But see Nancy Gibbs, Pillow Angel Ethics, TIME, Jan. 22, 2007, available at http://www.time.com/time/magazine/article/0,9171,1576833,00.html (quoting disability rights expert Arlene Mayerson: “Benevolence and good intentions have been among the biggest enemies of disabled people over the course of history. . . . Many things that were done under a theory of benevolence were later seen as wrongheaded violations of human rights.”). Buck v. Bell has not been explicitly overruled.

100. The right to procreate was initially recognized in dicta in Skinner v. Okl. ex rel Williamson, though it was not fully developed until Roe v. Wade, 316 U.S. 535 (1942); 410 U.S. 113 (1973).

101. See, e.g., Sterilization of America, supra note 98; Edwin Black, Hitler’s Debt to America, THE GUARDIAN, Feb. 6, 2004, available at http://www.guardian.co.uk/uk/2004/feb/06/trace.usa (on file with the
Court in *Skinner v. Oklahoma* recognized procreation as a fundamental right, albeit in dicta.\(^{102}\)

In later cases where the Court aimed to define fundamental rights protected by substantive due process, it heartily endorsed *Skinner*’s dicta recognizing a fundamental right to procreate.\(^{103}\) While procedural due process rights are explicitly stated in the Fourteenth Amendment, substantive due process rights are not.\(^{104}\) Even though the justices of the Supreme Court do not always agree whether substantive due process rights exist, the Court has stated that substantive due process differs from procedural protections because the Fourteenth Amendment “bar[s] certain governmental actions regardless of the fairness of the procedures used to implement them.”\(^{105}\)

The Supreme Court has held that the procreative rights of minors can outweigh the parents’ interest in acting as the child’s medical decision-maker.\(^{106}\) In *Roe v. Wade*, the Court guaranteed a woman’s right to privacy, as applied to procreative rights.\(^{107}\) *Roe* also declared that a state infringement on procreative freedom is subject to strict scrutiny analysis.\(^{108}\) In *Thornburgh v. American*
College of Obstetricians and Gynecologists, the Court further supported a woman’s rights to bodily integrity and self-determination. Memorably, the Court noted that in the procreative context, there is a “moral fact that a person belongs to himself and not to others nor to society as a whole.” While the Thornburgh court addressed the marital relationship, this principal arguably applies within the parent/child relationship where a parent’s decision to remove his or her child’s internal reproductive organs would also sterilize the child, regardless of whether a secondary purpose also exists. Doctors often call these surgeries “secondary sterilizations” and treat the sterilization as an undesirable side effect. However, the intent of the surgery should not matter since the act of sterilization itself is the constitutional violation.

The most recent controversy to raise these issues is the 2004 case of Ashley X. Ashley has severe mental and physical disabilities of unknown origin, and doctors predict she will never develop past the mental age of a young infant. When Ashley was six, her parents sought a hysterectomy for her to prevent menstruation, removal of her breast buds to prevent future breast growth, and growth attenuation therapy to keep her small enough to easily care for at home. While Ashley’s physicians agreed with her parents’ wishes, they sought the opinion of the hospital’s ethics committee. The committee decided that these interventions were ethical, but advised the parents to seek judicial approval. However, the parents did not do so.

110. Id. at 777 n.5 (Stevens, J., concurring).
111. Legal scholars continue to debate the proper characterization of the parent/child legal relationship, and different areas of the law tend to use different models. For more information on the varying models of the parent/child relationship, see Ouellette, Shaping, supra note 48, at 985–91.
112. Alicia Ouellette, Growth Attenuation, Parental Choice, and the Rights of Disabled Children: Lessons from the Ashley X Case, 8 Hous. J. Health L. & Pol’y 207, 211–12 (2008) [hereinafter Ouellette, Lessons from Ashley X]; Gibbs, supra note 100 (“‘Ashley’s smaller and lighter size,’ her parents write on the blog defending their decision, ‘makes it more possible to include her in the typical family life and activities that provide her with needed comfort, closeness, security and love: meal time, car trips, touch, snuggles, etc.’ They stress that the goal was ‘to improve our daughter’s quality of life and not to convenience her caregivers.’”). But see Shaping, supra note 48, at 983.
Ashley’s parents stunted her growth and removed her organs to improve their own lives by creating a child who was, in effect, easier to operate than the one to which they gave birth. . . . Children are not cars. They are not kitchens. They are not a parental possession to be crafted. Children are persons who should not be treated as objects of design or instruments of ambition. Objectifying children denies their personhood and subordinates their present and future interests. Parental overreaching is especially troubling in the health-care context because the impact on the child’s bodily integrity is immediate and irrevocable.

114. Id. at 212–13.
115. Id. at 214.
116. Id. (“Having received the blessing of the Committee, the treatment was implemented without judicial or further review.”).
After Ashley’s doctors performed the requested procedures in her home state of Washington, disability activists were outraged and raised public awareness for Ashley’s case. Today, Ashley’s doctors admit they should have sought judicial approval before they performed her hysterectomy, if nothing else. Washington State already required judicial approval for the sterilization of the mentally disabled.

Children have some rights that cannot be exercised until an older age. For instance, all Americans are constitutionally guaranteed the right to vote as a method of participating in American democracy, but may not do so until the age of 18. However, the government may not take away the right to vote so long as it takes the right away before the child reaches the age of 18. This latent right to vote exists, even though it cannot be readily exercised. As another example, a child is not legally competent to marry, but the child’s right to choose a spouse upon attaining the age of consent cannot be infringed by parents “irrevocably [betrothing the child] to someone.” Likewise, parents cannot force a child to marry, even if state law permits the teen to marry with parental consent. Similarly, a young child has the right to procreate, even though he or she may not yet be physically capable of doing so. While constitutional law limits a parent’s ability to force or deny an abortion, it does not currently forbid parents from preventing procreation in the first place by removing the reproductive organs.

V. THE CALIFORNIA APPROACH TO STERILIZATION

In contrast to the lack of federal guidelines, section 1958 of the California Probate Code, and other related California statutes, provide individuals with mental disabilities all three of the procedural protections mentioned by the Court, in addition to others. When a mentally disabled individual’s parent (or guardian

117. Doctors also removed Ashley’s appendix as a preventative measure for fear that Ashley would not be able to inform her parents of the abdominal pain that precedes the bursting of an appendix. The “Ashley Treatment”: Towards a Better Quality of Life for “Pillow Angels,” http://ashleytreatment.spaces.live.com/ (last visited Mar. 29, 2010) (on file with the McGeorge Law Review); Ouellette, Lessons from Ashley X, supra note 113, at 215.


119. Carol M. Ostrom, Children’s Hospital Says It Should Have Gone to Court in Case of Disabled 6-year-old, SEATTLE TIMES, May 8, 2007.


122. U.S. CONST. amend. XXVI, § 1 (“The right of citizens of the United States, who are eighteen years of age or older, to vote shall not be denied or abridged by the United States or by any State on account of age.”).

123. Ouellette, Shaping, supra note 48, at 989.

124. Id.

125. In 1985, California led the world in the forced sterilization of convicted criminals, the mentally ill,
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or conservator) feels that sterilization is in the patient’s best interest, the California Legislature has provided for a neutral third-party approval process. This process is a natural alternative to the parental informed consent required for the removal of reproductive organs in childhood DSD surgery.

A. When Is an Individual with Mental Disabilities Able to Consent to Sterilization?

The ability of an individual with mental disabilities to consent to sterilization is defined by statute. In California, the average sterilization patient must consent voluntarily and fully understand the nature and consequences of sterilization. Anyone capable of consenting to sterilization (or potentially able to consent in the future) cannot be sterilized with substituted consent under the procedures outlined below. Consent is determined by whether the individual fully understands the nature and consequences of sterilization.

Because procreation is a personal right and choice, courts do not allow another person to consent to sterilization on behalf of a temporarily incapacitated patient. California law requires that the patient’s “incapacity is in all likelihood permanent.” If medical evidence suggests that the patient may eventually develop the ability to consent to medical treatment, courts have shown a willingness to protect the patient’s ability to choose his or her own medical care.

and the disabled. See In re Conservatorship of Valerie N., 40 Cal.3d 143 (1985) (finding that California statutes that prohibited anyone from consenting to the sterilization of the mentally disabled deprived these individuals of their right to privacy and liberty, specifically by not allowing females with mental disabilities to have the same procreative right to sterilization as other females). Notably, in the earliest stages of sterilization law, the goal was to "asexualize" a prison or mental institution inmate, which was extended to the mentally disabled in 1917. See Stats. 1909, ch. 720, § 1, pp. 1093–94 ("[I]f in their opinion, or in the opinion of any two of them, asexualization will be beneficial to such inmate, patient, or convict, they may perform the same . . . . "). California, "a pioneer in the field," performed nearly eighty percent of the statutory sterilizations in the United States during the years 1907–1921. Valerie N., 40 Cal.3d at 151–52. "Although challenged on a variety of constitutional grounds, principally denial of due process and equal protection, most of these statutes were upheld, if adequate procedural safeguards, including a hearing for the patient, were afforded." Id.

126. The Supreme Court of California has consistently held that the freedom from sterilization is encompassed within the California Constitution’s explicit right to privacy. See Valerie N., 40 Cal.3d at 148 ("[T]he present statutory scheme denies incompetent developmentally disabled persons rights which are accorded all other persons in violation of state and federal constitutional guarantees of privacy."); Id. at 162 ("The interests of the incompetent which mandate recognition of procreative choice as an aspect of the fundamental right to privacy and liberty do not differ from the interests of women able to give voluntary consent to this procedure.").

128. Id. § 1951(a).
129. Id. § 1951(b)(3).
132. Id.
To date, the Supreme Court has been unwilling to extend to parents a veto over their child’s procreative choices.\(^{133}\)

When a patient cannot consent to necessary or beneficial medical care, however, this right may be delegated to another in order to secure treatment.\(^{134}\) Otherwise, the patient would remain untreated indefinitely. Interestingly, in order to allow substituted consent, California law implicitly requires that an individual with mental disabilities must have reached the age of majority.\(^{135}\) This minimum age requirement suggests that the Legislature sought to ensure that the patient is permanently unable to consent to medical treatment, particularly since the procreative “risks”\(^{136}\) may exist as much as a decade before this minimum age.

Notably, one California statute provides that no institutionalized minor may be sterilized.\(^{137}\) The presumed legislative intent of this statute is that the sterilization decision is one that is better left to an adult to make for him- or herself. On the other hand, in the case of intersex children, parents and doctors generally contend that early surgical intervention (before school age) is beneficial because they hope to give children “normal” childhoods—a benefit that would be lost by waiting until the child reaches the age of consent.\(^{138}\) Other articles maintain, however, that these contentions are based upon false assumptions, such as the fact that American schools have almost universally abandoned the “gym class changing room/shower” scene that plagues the minds of these doctors and popular society.\(^{139}\) The question then becomes whether a “normal childhood” outweighs the constitutional rights of the child.

**B. The Substantive Due Process Protections for an Adult with Mental Disabilities Facing Sterilization**

To secure judicial approval for the sterilization of an individual with mental disabilities, the court must make several findings beyond a reasonable doubt.\(^{141}\)


\(^{134}\) Beh & Diamond, supra note 25, at 37–38.

\(^{135}\) The statutes exclusively refer to the conservator/conservatee relationship, not the guardian/ward relationship. See, e.g., CAL. PROB. CODE § 2105(c) (“If there are two appointed conservators, both must agree to the treatment; if there are more than two appointed conservators, a majority of the conservators must agree.”). Per other statutory provisions, the conservator/conservatee relationship may only begin at the age of majority. Id. § 1820(b) (“If the proposed conservatee is a minor, the petition may be filed during his or her minority so that the appointment of a conservator may be made effective immediately upon the minor’s attaining the age of majority.”).

\(^{136}\) Namely, pregnancy.

\(^{137}\) See CAL. PROB. CODE § 2356 (governing involuntary medication and institutionalization).


\(^{139}\) See supra note 63 and accompanying text (sampling the articles that call for a moratorium on childhood DSD surgeries).

\(^{140}\) Tamar-Mattis, What About the Locker Room?, supra note 139.

\(^{141}\) CAL. PROB. CODE § 1958.
First, it must find that children with DSDs are unable to consent to medical treatment. Second, it must conclude that “reasonable medical evidence” shows that the child is “fertile and capable of procreation.” Third, the court must make a determination that the proposed surgery “entails the least invasion of the body of the individual.”Fourth, it must determine that the “current state of scientific and medical knowledge does not suggest” that a less invasive or less permanent solution will soon be available.

Doctors may only provide the least invasive form of birth control or sterilization that is medically and practicably possible. For example, California law does not authorize a hysterectomy or castration as an acceptable method of sterilization unless it is independently considered “a medically necessary treatment.” However, even if the procedure is considered medically necessary, the conservator is still required to secure judicial approval to proceed with a surgery to remove the uterus or gonads.

One section of the California Probate Code explicitly removes the protections for surgeries in which sterilization may result as a side effect. The section states, “[this chapter does not prohibit medical treatment or surgery required for other medical reasons and in which sterilization is an unavoidable or medically probable consequence, but is not the object of the treatment or surgery.” In this case, the Legislature appears to recognize that when overall health is involved, the right to procreate may be compromised. While medically necessary treatment should override the right to procreate, several scholars argue that the prompt sterilization of a child is generally not medically necessary or even medically indicated for psychological or physical reasons.

C. The Procedural Due Process Protections for an Adult with Mental Disabilities Facing Sterilization

The California Legislature has enacted extensive and mandatory procedures to protect those unable to personally consent to medical care. If a court grants a
sterilization request, the judge must issue a written decision of the factual and legal conclusions for each finding required by statute. Regardles, the order for sterilization is automatically appealed without any action by the patient. Furthermore, these appeals take precedence over other cases in the court of appeal. Until the final determination on appeal is made, the sterilization order is stayed. If upheld on appeal, the sterilization procedure must be performed within one year or the order expires. If all the findings required by section 1958 have not been proven beyond a reasonable doubt, the petition can be re-filed only upon a showing of a material change in circumstances.

VI. HOW COURTS IN OTHER COUNTRIES HAVE ADDRESSED THE STERILIZATION OF CHILDREN

While no on-point American case law exists dealing with the removal of the reproductive organs of intersex children, a look to other jurisdictions may provide insight on how the Supreme Court of the United States might approach such a case. The Court has shown some willingness to consider foreign law when determining which activities constitute fundamental rights requiring Constitutional protection. Both the United Kingdom and Australia have considered the issue of sterilizing minor children, and both nations have a similar jurisprudential foundation and Anglo-American concept of fundamental rights. While foreign judgments are never dispositive, the Supreme Court would likely afford them considerable weight.

(2009); (2) an investigation and written report from the regional center for the developmentally disabled, id. § 1955(a); (3) two examinations of the conservatee, including one by a psychologist or clinical social worker, id. § 1955(b); (4) the examiners should only recommend sterilization if there is no suitable alternative, id. § 1955(c); (5) the presence of the conservatee is required at the hearing except for “medical inability” or if attending the hearing is likely to cause “serious and immediate physiological damage” to the conservatee, id. § 1956; (6) a written decision by the judge; (7) an automatic appeal if sterilization is authorized, id. § 1962(a); (8) the appeal has automatic precedence over “over other cases in the court in which the appeal is pending,” id. § 1962(b); (9) a stay on the procedure until the order is upheld on appeal, id. § 1962(b); and (10) an automatic expiration date for the court order, after which a new approval must be secured if the procedure is delayed for whatever reason, id. § 1965.

152. Id. § 1962(a).
153. Id. § 1962(b).
154. Id.
155. Id. § 1965.
156. Id. § 1964.
157. Id. § 1966. If the petition for sterilization is granted, the doctor’s and conservator’s legal liability is limited to negligence or willful misconduct. Id.
158. See Lawrence v. Texas, 539 U.S. 558 (finding persuasive both English law and the European Court of Human Rights); Atkins v. Virginia, 536 U.S. 304, 316 (2002) (considering “consistency” between legislative evidence and foreign law in order to determine whether there is “a consensus among those who have addressed the issue.”) The Court also quotes Thompson v. Oklahoma, 487 U.S. 815, 830, 831 n.31 (2002), which found the laws of other Anglo-American nations worth considering. Atkins, 536 U.S. at 316.
In 1986, the British House of Lords ruled that no person could give consent for any sterilization procedure on behalf of a mentally disabled minor, but did not speak of parents specifically. However, one Lord explicitly stated that sterilization was “outside the scope of parental power” and should only be decided by a judge. Like the United States, the United Kingdom recognizes the right to procreate as a basic human right.

In 1993, the High Court of Australia, considered whether parents could consent to the removal of their mentally disabled daughter’s uterus and ovaries. In excessing the parameters of the case at bar, the Court held that parents must seek judicial approval from the Family Court for any and all proposed sterilizations of minor children unless the sterilization is incidental to an exceptional case, such as a life-threatening illness.

The Court began its analysis by recognizing the right to bodily integrity for all, including children, and admonishing that the best interests of a child are a limit on parental power. The Court was particularly concerned that parents and doctors may underestimate the child’s “present or future capacity to consent” to medical treatment. Interestingly, the Court declined to assume that the sterilization was a “medical treatment,” and found instead that “it is the very fact that sterilization implies more than medical, or surgical, treatment that is


160. The court did not distinguish between procedures with sterilization as the primary purpose or as an unavoidable side-effect, and it is unclear whether the court intended such a distinction. Secretary, Department of Health & Community Services v. JWB & Anor, (1992) 175 C.L.R. 218, 245 (Austl.) [hereinafter Marion’s Case].

161. Id.

162. Id.

163. Id.

164. Marion’s Case, supra note 160 (finding that parents could not obtain a hysterectomy and ovariectomy for their fourteen-year-old daughter with severe mental and physical disabilities. However, the court did not reach the issue of whether the sterilization procedures were in the patient’s best interests).


166. Marion’s Case, supra note 160, at 233.

167. Id. at 240. For instance, the Australian court noted that parents may not cut off their child’s foot in order to earn money begging because it is “inconceivable” that this decision is in the best interest of the child. Id. As noted in Part III, the Supreme Court of the United States has also recognized children’s right to bodily integrity. See Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 849 (1992) (“[T]he Constitution places limits on a State’s right to interfere with a person’s most basic decisions about family and parenthood . . . as well as bodily integrity . . . .” (internal citations omitted)); see also Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976); Prince v. Mass., 321 U.S. 158, 167 (1944) (“The state has a wide range of power for limiting parental freedom and authority in things affecting the child’s welfare, and such power includes to some extent matters of conscience and religious conviction.”)). This is the principle behind American courts’ exceptions to the parental informed consent presumption. See supra Part III.

168. Marion’s Case, supra note 160, at 250.
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crucial . . .” Indeed, the removal of reproductive organs reaches far beyond the DSD treatment itself and can affect the child’s adulthood in irreparable ways.169

Two years after the Australian case, Colombia’s Constitutional Court confronted its own “John/Joan case” and held that parents cannot consent to genital “correction” at all.170 Colombia’s Court found that intersex children are a minority suffering from discrimination and that “[s]urgery may actually be a violation of autonomy and bodily integrity, motivated by parents’ intolerance of their own children’s sexual difference.”171 Like the United States, Colombia has a legal presumption that parents act in the best interest of their children in medical matters; however, the Colombia Court noted that parents may make the decision to “correct” their child’s genitals based on their own fears rather than on the best interests of the child.172

International courts that have examined whether a parent can consent to sterilization on behalf of a minor have consistently found that the right to consent to this form of medical care is beyond the scope of parental power. Because these countries recognize a right to procreation and bodily integrity similar to those recognized by the United States Supreme Court, United States courts would likely come to a similar conclusion if faced with similar facts.

VII. ARGUMENT

As with individuals with mental disabilities, surgeries that remove the reproductive organs of children with DSDs impact several of their fundamental liberties. Therefore, due process procedural protections are likely necessary under the due process clause of the Fourteenth Amendment.

To date, there are no known cases in the United States of litigation to prevent the “gender normalization surgery” of a child with a DSD, or of an adult litigating over childhood harms. However, there is a growing community of intersex individuals seeking answers and apologies for the “medical treatments”

169. Id. at 232.
170. For example, reduced sexual function and sensitivity. See Tamar-Mattis, Exceptions to the Rule, supra note 18, at 69–70 (“Many intersex people who have undergone surgery report inability to orgasm, chronic pain, and insensitivity caused by scar tissue—problems which can cause a lifetime of sexual impairment.”); Ehrenreich & Barr, supra note 63 at 105–14 (“[S]ome long-term follow-up studies of intersex surgery have found a documented failure rate for sexual sensation of twenty to thirty percent. At a minimum, the reduced skin sensitivity that can result from scarring of both the clitoris and the (usually reconstructed) vagina seems likely to impair sexual enjoyment for many people.”).
171. Julie A. Greenberg & Cheryl Chase, Background of Colombia Decisions, Intersex Society of North America (last visited Mar. 29, 2010) [hereinafter Background of Colombia Decisions] (on file with the McGeorge Law Review) (noting that the court held that parents were legally unable to consent to DSD surgery on their child). No full English translation of the decision exists, though a few authors have translated portions of the decision.
172. Id.
173. Id.
they received as children. Without existing precedent on-point, one must analogize to other areas of the law. The judicial treatment of the sterilization of individuals with mental disabilities may be particularly appropriate for anticipating how a court would reason through a case with an intersex child. Each state has approached this issue differently—some with legislation, some with case law. Because California has a more formal system than many states, consisting both of statutes and case law, it is a good place to look for an alternative method for regulating the sterilization of intersex children.

Sterilization is the permanent removal of the reproductive organs. Rather than make arbitrary distinctions without any medical training, this Comment argues that doctors should avoid the removal of any reproductive organ, because the permanent removal of reproductive potential implicates fundamental rights. The fertility of children with DSDs is particularly difficult to define because their bodies may have both male and female reproductive organs, either of them, or they may lack them altogether. In some cases, the children may be assuredly infertile or assuredly fertile with functioning reproductive organs. However, many children fall somewhere in between. A child with limited or unexpected reproductive organs may be able to procreate with the assistance of current or future medical technology, but no one can predict what medical technology will be available in twenty or thirty years, precisely at the age when these children will likely seek to have children of their own. Therefore, sterilization, not the removal of fertility, should be the standard.

Although it is possible for any child with a DSD to be infertile, some conditions have higher probabilities of infertility. For instance, female children with Swyer Syndrome are infertile because they are born without any functional gonads. On the other end of the scale, children diagnosed with micropenis

174. One such practice is medical display, which many liken to sexual abuse. During medical display, intersex children are placed on exhibit for medical students. Ehrenreich & Barr, supra note 63, at 105–10.
175. Determining when and if a child is fertile is beyond the scope of this Comment, but “fertility” is not the issue; sterilization is. Further, it is beyond the scope of this Comment to determine which situations merit court intervention. While a variety of medical conditions exist, it is possible to generalize about many of the most common conditions. Doing so will allow courts to develop a framework to provide guidance in instances where more unusual conditions are presented.
176. For instance, children born with androgen insensitivity syndrome (AIS) have either undescended or partially descended testes. Future medical advances may allow for these testes to be fertile. Currently, children with AIS are considered infertile, however future medical advances may allow these testes to become fertile. Androgen Insensitivity Syndrome, http://www.isna.org/faq/conditions/ais (last visited Mar. 29, 2010) (on file with the McGeorge Law Review). As another example, children with Turner’s Syndrome have non-functioning ovaries but a normal uterus and vagina. These women are able to have a normal pregnancy and vaginal childbirth with a donated egg, but related cardiac issues may counsel against pregnancy. The Turner Syndrome Society, Turner Syndrome—The Basics, http://www.turnersyndrome.org/index.php?option=com_content &task=view&id=40&Itemid=63 (last visited Mar. 29, 2010) (on file with the McGeorge Law Review).
generally have functional male genitals. While XX children born with Congenital Adrenal Hyperplasia (CAH) are sometimes assigned a male gender, they often still have potentially fertile female internal reproductive organs. Whether or not actual fertility is at stake, a person still may not constitutionally consent to sterilization on behalf of another, even if that other is his or her minor child.

Because sterilization surgeries implicate a mentally disabled individual’s fundamental rights by violating his or her bodily integrity and autonomy, procedural protections are usually constitutionally guaranteed by the states. Similarly, DSD surgeries regularly take away the autonomy and procreative potential of children. These procedural due process protections for the mentally disabled are procedures that ensure that the patient has notice and the opportunity to protect his or her liberties—protections that intersex children currently do not enjoy.

Doctors should pursue judicial approval for the surgical removal of reproductive organs using an approach substantially similar to California’s system for the sterilization of individuals with mental disabilities. California law requires that a probate court take several steps before the court can approve a procedure that will result in sterilization, presumably in order to protect (1) the patient’s right to bodily integrity, (2) the patient’s right to privacy, (3) the

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178. See Justine M. Reilly & C.R.J. Woodhouse, Small Penis and the Male Sexual Role, 142 J. OF UROLOGY 569 (1989) (publishing data on the fertility of men with micropenis who were allowed to retain their testes).


180. As noted in the Introduction, “Fertility is inherently speculative even when a person possesses all the ‘correct’ reproductive organs, while sterilization is the removal of the reproductive organs.”

181. See, e.g., In re Grady, 426 A.2d 467 (N.J. 1981) (finding that New Jersey law requires a judicial hearing to allow parents to consent to the sterilization of their mentally disabled daughter and requiring clear and convincing proof that the sterilization is in the best interest of the patient); A.L. v. G.R.H., 325 N.E.2d 501 (Ind. 1975) (finding that the common law does not authorize a parent to sterilize her brain-damaged child); In re M.K.R., 515 S.W.2d 467 (Mo. 1974) (finding that even the courts did not have jurisdiction to approve a parent’s request to sterilize a child with mental disabilities without express statutory approval); Ruby v. Massey, 452 F. Supp. 361, 366 (D. Conn. 1978) (finding that parents “may neither veto nor give valid consent to the sterilization of their children”); In re Guardianship of Hayes, 608 P.2d 635 (Wash. 1980) (finding that a parent cannot consent to the sterilization of a child with mental disabilities and that there is a “heavy presumption” against sterilization); and In re Moe, 432 N.E.2d 712 (Mass. 1982) (finding that individuals with mental disabilities enjoy the same constitutional right to privacy and procreation as any other individual; however, this finding allowed the court jurisdiction to entertain parental requests for the sterilization of their children).

182. See, e.g., Tamar-Mattis, Exceptions to the Rule, supra note 18, at 92 (noting that “intersex people[] are declaring the right of intersex children to control their own destiny in this most intimate and personal of areas.”).

183. See, e.g., CAL. PROB. CODE § 1958 (providing procedural due process protections to California’s individuals with mental disabilities).

184. Id.
patient’s right to procreate, and (4) the patient’s right to autonomy. Children with DSDs have substantially similar constitutional concerns, and a substantially similar process is likely to protect those concerns as it has for decades in the mentally disabled community.\footnote{185}

A. The Sterilization of Children with DSDs Raises the Same Policy Concerns as the Sterilization of the Mentally Disabled

1. The Fundamental Right to Procreate and Other Constitutional Concerns

Like individuals with mental disabilities, children with DSDs should, at a minimum, enjoy procedural due process protections before having their reproductive organs removed without their personal consent. However, procedural protections alone may not be sufficient to pass due process muster. British and Colombian courts have found that parents cannot consent to the removal of a child’s reproductive organs, even with judicial approval.\footnote{186} Similarly, American courts may find that these children’s fundamental rights are so important that even procedural protections cannot justify allowing substituted consent when the child may one day be capable of consent personally. “If the right [to procreate] means anything, it is the right of the individual, married or single to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”\footnote{187} However, this proposal suggests governmental intrusion into the parent-child relationship, where courts have presumed that a parent acts in the best interest of the child. On the other hand, courts have been hesitant about a parent’s ability to consider the child’s best interest when the child’s reproductive interests are on the line.\footnote{188}

The latent right to procreate should be judicially protected on behalf of the child and the interest in protecting his or her autonomy in making personal decisions in the future. “Children are not legally capable of defending their own


\footnote{186. \textit{Marion’s Case}, supra note 161; \textit{Background of Colombia Decisions}, supra note 171.}


\footnote{188. \textit{Supra} section III.A.}
future interest against present infringement by their parents, so that task must be performed for them [by the State]."

2. The Inability to Consent

California law expressly requires that the patient’s inability to consent to a medical procedure must be permanent in order for him or her to forfeit that right, which is almost never the case with the average DSD patient. While the legislative goal was not spelled out, one could presume that this law was created to allow a person with disabilities to delay a personal reproductive decision if there is any chance that individual will eventually develop the capacity to decide personally. Once it is determined that the individual will not gain capacity, the individual will receive little benefit from delaying a procedure deemed beneficial. In other words, parental or surrogate consent will be required for the procedure either now or later, so why delay? In the DSD context, when the child presumptively will gain capacity through the natural aging process, there is a choice between surrogate consent and the individual’s personal consent. Therefore, it is likely that courts and legislatures would prefer to delay sterilizations in cases when a child may eventually be capable of consenting to the procedure.

3. Whether the Parents Have the Best Interests of the Child in Mind

No one wants to question the perceptions or motives of a parent. However, in difficult medical situations, parents may not always be capable of considering their child’s needs before their own. While this may be a rare situation, society should be willing to inconvenience the many to protect such a fundamental right of the few when a child’s fundamental rights are involved. There is no way to ascertain the unspoken thought process and emotional reactions of parents during a doctor’s procurement of consent, but all children with DSDs will benefit from the due process protections of a judicial hearing process.

Like the Colombian Constitutional Court, some American scholars and practitioners question the ability of parents to make the decision to pursue sex organ surgery to treat a child with a DSD. One scholar, Anne Tamar-Mattis,

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189. Feinberg, supra note 121, at 128.
191. See, e.g., Guardianship of Phillip B., 188 Cal. Rptr. 781 (1st Dist. 1983) (finding that emotionally detached parents are not in the best position to protect the best interests of the child).
192. See Tamar-Mattis, Exceptions to the Rule, supra note 18, at 89–90 (arguing for the adoption of a judicial hearing for any genital surgery on a child unable to consent). Tamar-Mattis defines parental “conflict of interest” by noting that “parents may be responding to multiple conscious or unconscious needs—the child’s, their own, other people’s—that may make it confusing and difficult to weigh all aspects of this decision objectively. This very confusion and pressure may make it tempting to opt for, and believe in, the ‘magic wand’
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primarily focuses on fulfilling the psychological needs of the parents and argues that “the decision to perform surgery may be centered more around the needs of caregivers than the needs of the child.” Tamar-Mattis highlights an important contradiction: the foundation of the surgical treatment model is that the parents will be alienated from a “different” child until and unless the surgery is performed. However, potential parental alienation is the precise reason that many courts doubt the parents’ ability to consider the best interests of a healthy child’s organ donation or the purposeful sterilization of a mentally disabled child. Parents may also have difficulty protecting a child’s future procreative ability because of the discomfort of imagining their child as an adult with sexual needs. Because of these concerns, the most important procedural protection for children in the judicial hearing process is the appointment of a guardian ad litem who must presume that the child would oppose the procedure. Without such representation, the court could become a rubber stamp to a decision made by the parent and doctors without meaningful neutral consideration.

B. The Inability to Reinterpret the Existing Laws Governing the Sterilization of Individuals with Mental Disabilities to Extend the Protections to Intersex Children

It would be difficult to simply reinterpret existing law to apply to children with DSDs because current law contemplates that the mentally disabled are permanently unable to consent. Put simply, if a state regulates the sterilization of the mentally disabled, its laws are usually expressly limited to that portion of the population and to medical treatments with the primary purpose of sterilization. However, it is possible to read the statutes more broadly as recognizing that procreation is a fundamental right and as a result, the permanent removal of fertility is an extraordinary procedure that falls outside the scope of the parental/surrogate consent presumptions.

of surgery, so they can get on with loving and nurturing their baby.” Id. at 89 n.216.

193. Id. at 89.
194. Id. at 89–90.
195. Id. See supra note 188 and accompanying text (describing the parents’ potential conflict of interest that could cloud their ability to make treatment decisions for a child with a DSD).
196. Tamar-Mattis, Exceptions to the Rule, supra note 18, at 83–84 (“Parents may be hampered in making decisions that affect their child’s adult sexual life because they may be uncomfortable thinking about the child as a sexual or potentially sexual being.”).
197. Id. at 104 (“As in the case of child sterilization or organ donations, this representative should be charged with arguing vigorously against the proposed surgery in order to assure a meaningful adversarial process.”).
In the DSD context, sterilization is rarely the stated purpose of surgery. However, the procedures do necessarily sterilize the child by removing his or her reproductive organs.

C. Why Judicial Review Is Better than Parental Informed Consent

The judicial hearing process protects children by ensuring that their reproductive organs are removed only when a neutral decision-maker confirms that it is in their best interest. While surgeries without the child’s personal consent may qualify as child abuse in the most literal sense, “the interventions are presumed to be in the children’s best interests because parents and doctors are involved.” However, removing a child’s reproductive organs can have far-reaching effects on the child’s adulthood. As noted by Tamar-Mattis, allowing the informed consent model to continue would “carry the implication that it would be acceptable for parents to authorize the surgery for any reason—parental discomfort, embarrassment over raising a son with a small penis or a daughter with a noticeable clitoris, desire for one gender or another—as long as they were fully informed of the risks.” Many of the potential reasons behind a parent’s informed consent to DSD treatment do not outweigh the child’s fundamental rights, and the judicial hearing process provides the proper procedural and substantive protections to assure that those rights are safeguarded. As noted by the Colombian Constitutional Court, parents may be unknowingly acting upon their own fears or intolerance.

VIII. CONCLUSION

Surgery to remove a child’s reproductive organs currently affects his or her fundamental rights without independent representation of what the child might want if he or she were able to consent. This type of unilateral and fundamental invasion of a child’s bodily integrity is offensive to the American notion of due

198. See supra note 176 and accompanying text and Introduction (“Whether or not these surgeons intend to do so, they are, in effect, sterilizing the child when they elect to remove his or her reproductive organs. This election should be considered independently of the child’s actual or predicted fertility.”).
199. See Child Welfare Information Gateway, What Is Child Abuse and Neglect?, Apr. 2008, http://www.childwelfare.gov/pubs/factsheets/whatiscan.pdf (on file with the McGeorge Law Review) (defining abuse as inflicting a “physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child . . . .” regardless of parental intent); David, I Am Not Alone!, in HERMAPHRODITES WITH ATTITUDES, 1 INSA 1, 5 (Cheryl Chase ed., 1995), available at http://www.isna.org/files/hwa/winter1995.pdf (“What is done to these children, what was done to me, is legally and scientifically sanctioned traumatic sexual abuse.”).
200. Ouellette, Shaping, supra note 48, at 973.
201. Tamar-Mattis, Exceptions to the Rule, supra note 18, at 88.
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process, but can be sufficiently protected by a simple judicial process that has already proven workable in the mentally disabled community.

While the government should not interfere with the right to parent one’s child, which includes the right to make most medical decisions, the government should step in when the rights of the child outweigh those of the parent. Governments already do this through child protective services,203 child labor laws,204 and school enrollment requirements.205 When a child’s fundamental rights are at risk, the parent’s wishes to have the child’s reproductive organs removed should give way to the child’s rights. Given time, the child can manifest informed consent independently if he or she chooses to pursue the proposed treatment.

203. See, e.g., Parham v. J.R., 442 U.S. 584, 601–02 (1979) (“[W]e have recognized that a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.”).

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