

PARENT VERSUS STATE: PROTECTING INTERSEX CHILDREN FROM COSMETIC GENITAL SURGERY

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ABSTRACT

Intersex conditions are variations in in utero reproductive development that often result in the child developing ambiguous genitalia. Currently, the dominant treatment method for children born with intersex conditions is surgical reconstruction of the child's genitalia. Surgical assignment in infancy can result in a host of medical and psychological problems. What parents believe to be a one-time surgery that will correct the child's condition permanently often leads to many surgeries throughout puberty and adulthood in an attempt to correct unsuccessful infant surgeries. Most importantly, in the majority of cases, surgery is entirely cosmetic, serving no legitimate medical purpose.

Parents are legally permitted to consent to their child's genital surgery in infancy. Children born with intersex conditions must live with the results of this highly invasive, irreversible surgery for their entire lives, despite having been deprived of the opportunity to grant informed consent to the procedure. The law presumes that parents act in the best interest of their children, and, as a result, parents are afforded a great deal of latitude in making medical decisions for their children. Genital surgery has strong implications for the infant's privacy rights, particularly regarding reproduction and sexual health, which support state intervention to prevent purely cosmetic surgeries.

*In order to protect children born with intersex conditions, the law must strike a careful balance between individuals' fundamental right to parent their children and the states' right to protect the health and welfare of minors. Protecting intersex children from cosmetic, life-altering surgery is a compelling state interest that would justify acting as *parens patriae* to prevent parents from consenting to the surgery on their children's behalf. The state would serve the best interests of the child by mandating that parents attend counseling with an individual educated about intersex conditions*

and requiring an independent decisionmaker to approve any surgeries requested by the parents. While the state cannot entirely usurp parental power, careful regulation of intersex surgeries would balance the states' interest in protecting the welfare of the child and the parents' interest in their family autonomy.

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INTRODUCTION

When Tony Briffa was born, doctors were not sure what to tell his parents.¹ After childbirth, most doctors immediately announce

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whether the baby is a boy or a girl; gender is also often the first question people will ask when a friend or family member has a new baby.² However, Briffa was born with a condition called Partial Androgen Insensitivity Syndrome (PAIS),³ which caused his genitalia to appear too ambiguous for doctors to immediately discern his sex.⁴ Like many intersex children, Briffa underwent genital surgery in infancy, and doctors reconstructed his genitalia and removed his testes so that he would appear biologically female.⁵ Briffa was too young to know what was happening to his body and certainly too young to consent to such a drastic procedure.⁶ As he explains, “I spent a lot of time in hospitals being examined and having tests. I was told not to talk about it because it was a secret. Over time, I learned I couldn’t have children and I’d never get periods. I was confused; I felt like a freak.”⁷

Briffa learned about his PAIS and the subsequent surgery in early adulthood, and after several years of experimentation and hormone treatments, he now identifies as both male and female.⁸ Briffa’s story reached an eventual happy ending, but many other adults who underwent similar surgery in infancy report a sense of confusion as to their gender and sexual orientation as they entered puberty and early childhood.⁹ For some, the internal discord was compounded by parents and doctors who refused to discuss, or even acknowledge, their condition.¹⁰

Physicians often recommend to parents of intersex children that the parent have the child’s genitalia surgically “corrected” in infancy.¹¹ Surgery alleviates the societal discomfort associated with

1. *Proud Intersex Person Tony Briffa Tells Story of Self Discovery*, HERALD SUN (Sept. 7, 2014, 8:27 PM) [hereinafter *Tony Briffa*], <http://www.heraldsun.com.au/lifestyle/proud-intersex-person-tony-briffa-tells-story-of-self-discovery/story-fnixw28f-1227051164954?nk=abab93b97a697c29366d6e801e0d34e5>.

2. See ANNE FAUSTO-STERLING, *SEXING THE BODY: GENDER POLITICS AND THE CONSTRUCTION OF SEXUALITY* 45 (2000).

3. See *infra* Part I.

4. *Tony Briffa*, *supra* note 1.

5. *Id.*

6. *Id.*

7. *Id.*

8. *About Tony . . .*, TONY BRIFFA, <http://briffa.org/about> (last visited Feb. 8, 2016). He was also the first openly intersexual mayor in world, serving as mayor to the town of Hobsons Bay, just outside of Melbourne, Australia, from 2011 to 2012. *Id.*

9. See SUZANNE J. KESSLER, *LESSONS FROM THE INTERSEXED* 1-4 (1990).

10. *Id.*

11. *Id.* at 23.

intersex conditions by promoting the culturally accepted “gender binary,” which mandates that an individual will be either masculine or feminine, but nothing in between.¹² The suggestion is offered as a way to protect the child from growing up feeling different, to prevent the child from being confused about his or her gender, and to alleviate the social anxiety and stress that comes with explaining that one’s child has an intersex condition.¹³ While intersex activists¹⁴ and some physicians¹⁵ have begun to question the concealment-centered model for intersex treatment, the prevailing standard of care still involves cosmetic surgery¹⁶ to place intersex infants neatly within the gender binary.¹⁷

Because gender is a fundamental aspect of one’s identity and sense of self,¹⁸ surgery without the child’s informed consent raises strong concerns about the child’s Fourteenth Amendment privacy rights.¹⁹ Arguably, there is little that is more private than a person’s biological sex and gender identity. States can combat the harmful, life-long effects of these genital surgeries by invoking the *parens patriae*, or “parent of the country,” doctrine to mandate counseling and an official judgment that the surgery would be in the child’s best

12. Julie Tilsen, David Nylund & Lorraine Grieves, *The Gender Binary: Theory and Lived Experience*, INT’L J. NARRATIVE THERAPY & COMMUNITY WORK 47, 48 (2007) (“The gender binary is a discourse which demands compulsory conformity to individual gender performances of *either* male *or* female (terms which within the gender binary are supposedly mutually exclusive).”). Within the gender binary is the inherent assumption that an individual’s gender corresponds to the individual’s biological sex. *Id.*

13. *Id.*

14. ALICE DREGER, INTERSEX SOC’Y OF N. AM., SHIFTING THE PARADIGM OF INTERSEX TREATMENT 1 (n.d.), www.isna.org/pdf/compare.pdf.

15. Peter A. Lee et al., *Consensus Statement on Management of Intersex Disorders*, 118 PEDIATRICS e488, e490 (2006).

16. Ryan L. White, *Preferred Private Parts: Importing Intersex Autonomy for M.C. v. Aaronson*, 37 FORDHAM INT’L L.J. 777, 788-89 (2014). There are some intersex conditions that do require immediate surgery for the sake of the child’s health. See DREGER, *supra* note 14. The focus of this Note is purely on those surgeries that are performed for cosmetic reasons rather than medical ones.

17. See KESSLER, *supra* note 9, at 14. “Gender” refers to the amalgam of cultural and social constructions and expectations associated with biological sex—simply, it represents the common conception of “masculine” and “feminine” behavior, dress, parlance, and occupation, among other things. Myra J. Hird, *Gender’s Nature: Intersexuality, Transsexualism and the ‘Sex’/‘Gender’ Binary*, 1 FEMINIST THEORY 347, 348 (2000).

18. See Tilsen, Nylund & Grieves, *supra* note 12, at 48.

19. U.S. CONST. amend. XIV, § 1.

interest, medically and otherwise, before the surgery can proceed.²⁰ By taking affirmative action to prevent these surgeries from taking place when they are medically unnecessary, the state can protect children with intersex conditions and ensure that private aspects of their identities and personhood are not determined by doctors and patients in infancy.²¹ Thus, the substantive due process right to privacy should serve as a basis for granting intersex children the right to informed consent—including postponing any surgery until the child is old enough to meaningfully participate in the decision—to genital surgery in cases in which surgery is purely cosmetic.

Part I of this Note explains some of the conditions that most commonly lead to cosmetic surgery in infancy and gives a history of intersex treatments in the United States.²² This history begins with an explanation of the concealment-centered approach, including its controversial genesis, and details newer proposed models for treatment.²³ Part II focuses on the right to privacy, particularly on how privacy rights have been used in abortion law pertaining to minors.²⁴ Part III discusses parents' rights to make medical decisions for their children and discusses how parental rights and the state's *parens patriae* rights can intersect and conflict.²⁵ Part IV sets forth a model for how the state can intervene as *parens patriae* to prevent unconsented-to genital surgeries and argues that the right to privacy in abortion law is precedent for the assertion that minors are entitled to make decisions concerning their future reproductive and sexual health.²⁶

I. BIOLOGY AND HISTORY OF INTERSEX CONDITIONS

Intersex case management has a controversial history: The traditional treatment used surgery and secrecy to prevent the child from learning about his or her condition, often well into adulthood.²⁷ This treatment model was developed by John Money in a famous

20. Alfred L. Snapp & Son, Inc. v. P.R. *ex rel.* Barez, 458 U.S. 592, 607 (1982).

21. *See infra* Part IV.

22. *See infra* Part I.

23. *See infra* Part I.

24. *See infra* Part II.

25. *See infra* Part III.

26. *See infra* Part IV.

27. Alice Domurat Dreger, *A History of Intersex: From the Age of Gonads to the Age of Consent*, in INTERSEX IN THE AGE OF ETHICS 5, 16-17 (Alice Domurat Dreger ed., 1999).

experimental case study involving twin boys, neither of whom was born with an intersex condition.²⁸ Since the early 1990s, intersex activists have been drawing attention to the problems with the surgical intervention model, and one such group, the Intersex Society of North America (ISNA),²⁹ has instead developed a patient-centered model for intersex case management.³⁰ A task force of medical professionals developed another treatment model in 2006 advocating a multidisciplinary approach that endorses surgery only in severe cases.³¹ However, the surgical and concealment model remains the most common method of treating intersex conditions in children.³²

A. Biology Behind Intersex Conditions

Intersex conditions, also known as Disorders of Sexual Development (DSDs), are biological variations in sexual development that result in primary, and sometimes secondary, sexual characteristics that cannot be categorized within the typical gender binary.³³ In many cases, children born with intersex conditions have ambiguous external genitalia—that is, the size of the genitalia will not fall within the “acceptable” range for the length of a newborn’s penis or clitoris.³⁴ When the infant’s genitals are considered medically unacceptable, the doctor will often seek the parent’s consent to perform genital surgery and assign the newborn to a specific sex.³⁵ While the exact figure is unknown, doctors estimate that between 1 in 1,500 and 1 in 2,000 children are born with an intersex condition.³⁶

28. JENNIFER GERMON, GENDER: A GENEALOGY OF AN IDEA 36 (2009).

29. ISNA, <http://www.isna.org/> (last visited Feb. 8, 2016).

30. See DREGER, *supra* note 14, at 1.

31. See Lee et al., *supra* note 15, at e490-91.

32. See White, *supra* note 16, at 788.

33. JULIE A. GREENBERG, INTERSEXUALITY AND THE LAW: WHY SEX MATTERS 1 (2012). These conditions can arise from variations in chromosomes, gonadal development, and hormone levels during *in utero* development. *Id.* at 13.

34. See FAUSTO-STERLING, *supra* note 2, at 58. Fausto-Sterling published a “Phall-O-Metrics” diagram that illustrates how this determination is typically made. *Id.* at 59. The average clitoris length at birth is approximately 0.85 centimeters or shorter, and the average penis length at birth is between approximately 2.5 and 4.5 centimeters. *Id.* Anything that falls between 0.85 centimeters and 2.5 centimeters is medically “unacceptable,” calling for corrective surgery. *Id.*

35. See *id.* at 58. In practice, doctors are more likely to assign an infant female than male, as it is simply easier to construct female genitalia. *Id.* at 59.

36. *How Common Is Intersex?*, INTERSEX SOC’Y N. AM., <http://www.isna.org/faq/frequency> (last visited Feb. 8, 2016).

Two intersex conditions that are often treated with genital surgery are Congenital Adrenal Hyperplasia (CAH) and Androgen Insensitivity Syndrome (AIS).³⁷ In cases of CAH, a female fetus with XX chromosomes is exposed to high levels of adrenal androgens during development, resulting in masculinization of the external genitalia.³⁸ In cases of AIS, an infant with XY chromosomes develops partially or completely feminized external genitalia.³⁹ Infants with AIS either lack androgen receptors or do not have fully functional androgen receptors; as a result, they develop male internal gonads and feminized external genitalia.⁴⁰ These conditions serve as evidence that sex development is far more complex than merely examining chromosomes or genitalia: During the long process of *in utero* sexual development, hormonal variations, chromosome recombination, and environmental factors can all contribute to the formation of an infant's biological sex.⁴¹ However, the concealment-based method of treatment for intersex children is largely based on the work of one psychologist, John Money, who believed that a child who underwent genital surgery in infancy could successfully be socialized to the assigned gender.⁴²

B. Development of Concealment-Based Treatment

The concealment-based model for intersex case management requires that the intersex child be assigned a sex soon after birth.⁴³ After assignment, the parents are instructed to raise their child as the assigned gender and never disclose the intersex condition to the child.⁴⁴ This model was made famous by John Money, a psychologist

37. See FAUSTO-STERLING, *supra* note 2, at 51.

38. N.K. Alizai et al., *Feminizing Genitoplasty for Congenital Adrenal Hyperplasia: What Happens at Puberty?*, 161 J. UROLOGY 1588, 1588 (1999).

39. See FAUSTO-STERLING, *supra* note 2, at 52. An infant may have either Complete AIS or Partial AIS. Infants with CAIS develop entirely female external genitalia; in infants with PAIS, the external genitalia may be more ambiguous because of the shortage of androgens in development. *Id.* at 52-53.

40. *Id.* at 52.

41. *Id.* at 52-53.

42. GERMON, *supra* note 28, at 36-37.

43. See Dreger, *supra* note 27, at 16-17.

44. *Id.* In fact, under the concealment model, the parents themselves may not be given all the information necessary to make an informed choice about their child's surgery. *Id.* Doctors may instead choose to give the parents minimal information on their child's condition in order to prevent confusion and anxiety. See *id.* at 12.

at Johns Hopkins University, in the 1950s.⁴⁵ Money proposed that there was a “critical period” for gender acquisition in a child’s life, and during that period the child could be successfully assigned to either gender.⁴⁶ The critical period would last for the first eighteen months of the child’s life; during that time, the child was more susceptible to environmental stimuli, and gender identity could be permanently shaped by exposure to masculine or feminine stimuli.⁴⁷ Money believed that the appearance of external genitalia was the most significant factor to consider when assigning gender.⁴⁸

Money was granted the opportunity to test his hypothesis when he was approached by the parents of Bruce Reimer, an infant who had his penis burnt off during a circumcision.⁴⁹ Thus, the surgery and concealment-based model for intersex case management was based on a case study of an individual who was not actually born with an intersex condition.⁵⁰ The case provided a particularly compelling opportunity for Money to test his hypothesis because Bruce had an identical twin brother, Brian, who had not suffered from a botched circumcision.⁵¹ Thus, Money advised the parents to have Bruce surgically assigned to the female sex and to raise him as a girl.⁵² Money saw the accident as an opportunity to compare gender development of the two twins in tandem and ultimately hoped to show that gender identity is based entirely on childrearing, as opposed to biology.⁵³ In what became the famous John–Joan case study, Money met with both children regularly in early childhood to

45. See FAUSTO-STERLING, *supra* note 2, at 66.

46. See generally GERMON, *supra* note 28.

47. *Id.* at 36-37.

48. *Id.* at 41. Money acknowledged that other factors, such as chromosomes and gonads, play a role in gender determination, but nevertheless chose to emphasize the appearance of external genitalia as the most determinative factor. *Id.*

49. Hazel Glenn Beh & Milton Diamond, *An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?*, 7 MICH. J. GENDER & L. 1, 6 (2000); Alison Davidian, *Beyond the Locker Room: Changing Narratives on Early Surgery for Intersex Children*, 26 WIS. J.L., GENDER & SOC’Y 1, 6 n.30 (2011).

50. See *id.*

51. *Id.*

52. As Bruce Reimer eventually rejected the gender assignment, changed his name to “David,” and began living as a male, I use male pronouns to refer to him throughout this paper. Davidian, *supra* note 49, at 6-7.

53. *Id.* at 5-6.

observe how Bruce, renamed “Brenda,” adjusted to his female role in comparison to his twin brother.⁵⁴

However, Money’s experiment failed to produce the results that he had expected.⁵⁵ Even though Money had instructed the parents never to tell “Brenda” about his sex at birth, Brenda rejected the female gender role from early on in his life.⁵⁶ From an early age, Brenda had avoided playing with “girl” toys, like dolls; had refused to wear dresses; and was teased at school for standing up to urinate.⁵⁷ By age fourteen, Brenda informed his father that he had always felt that he was a boy.⁵⁸ Eventually, Brenda changed his name to “David” and underwent surgery and hormone replacement to reassign his body as male.⁵⁹ Even though Money knew that his experiment had failed, he misrepresented his findings and widely reported the sex reassignment as a success.⁶⁰ The idea that gender was purely determined by socialization was embraced by sociologists, psychologists, and feminists.⁶¹ Finally, in 1997, it was revealed that David had always rejected his gender assignment and that Money had misrepresented the success of the experiment for decades.⁶² However, by this time, Money’s model for early surgical intervention had become so entrenched in the medical literature that it remained the standard of care for children born with intersex conditions, despite the failure of the very experiment on which the standard was based.⁶³ However, attempts by intersex activists and

54. SHARON E. PREVES, INTERSEX AND IDENTITY: THE CONTESTED SELF 96 (2003). When Money published his findings on this case, he referred to it as the “John/Joan” case, signifying that the child born male, or “John,” had been successfully transformed into a female, or “Joan.” Beh & Diamond, *supra* note 49, at 6-7.

55. See Beh & Diamond, *supra* note 49, at 10-11.

56. See *id.* at 8.

57. See *id.* at 10-11 (citing Milton Diamond & H. Keith Sigmundson, *Sex Reassignment at Birth: Long-Term Review and Clinical Implications*, 151 ARCHIVES PEDIATRIC ADOLESCENT MED. 298, 299-300 (1997)).

58. *Id.* at 11.

59. *Id.*

60. See generally PREVES, *supra* note 54.

61. See *id.* at 96. The study was viewed as a nail in the coffin of biological determinism, proving that “nature” was more important than “nurture.” See KESSLER, *supra* note 9, at 23-24 (stating that since proliferation of Money’s theory of gender identity development, physicians advise parents that “providing the appropriate social conditions [will] produce the ‘real’ gender”).

62. See PREVES, *supra* note 54, at 96; Davidian, *supra* note 49, at 7. As an adult, David Reimer had a wife and adopted children before committing suicide at age thirty-eight. *Id.*

63. Davidian, *supra* note 49, at 8.

medical professionals to change the current standard of treatment have been gaining traction in the past decade.⁶⁴

C. Moving Away from Surgical Intervention

The surgical-intervention model for intersex case management is based on intersex conditions constituting a “social emergency.”⁶⁵ In one study, physicians reported that genital surgery in infancy was necessary to put parents at ease with their child, encourage bonding between parent and child, and allow parents to avoid the discomfort of explaining their child’s condition to family and friends.⁶⁶ However, surgery in infancy does not provide the permanent “fix” parents and doctors seek when choosing to surgically assign a newborn’s sex,⁶⁷ in fact, many children who undergo surgery in infancy require further genital surgeries as they enter puberty and adulthood.⁶⁸ In addition to the possible requirement of additional surgery, genital surgery on infants may result in sterilization or loss of sensation.⁶⁹ These negative consequences, coupled with the fact

64. See *infra* Section I.C.

65. *Evaluation of the Newborn with Developmental Anomalies of the External Genitalia*, 106 PEDIATRICS 138, 138 (2000) [hereinafter *Developmental Anomalies*].

66. KESSLER, *supra* note 9, at 32 (stating that parental anxiety and discomfort with having to explain their infant’s intersex condition has been cited by doctors as one reason to perform sex assignment surgery in infancy).

67. See, e.g., Alizai et al., *supra* note 38, at 1588 (“[S]ince the 1970s, the philosophical basis for the surgical management of congenital adrenal hyperplasia has centered on the assumption that [genitoplasty and vaginoplasty] can be achieved with a 1-stage procedure during infancy.”).

68. See, e.g., *id.* at 1590 (finding that vaginoplasty should be postponed to adolescence, as surgery in infancy “may be counter-productive by provoking scarring and fibrosis”); Sarah M. Creighton, Catherine L. Minto & Stuart J. Steele, *Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood*, 358 LANCET 124, 125 (2001) (finding that the majority of patients in a sample of intersex individuals who had surgery in infancy needed further vaginoplasty or clitoral surgery in adolescence); Catherine L. Minto et al., *The Effect of Clitoral Surgery on Sexual Outcome in Individuals Who Have Intersex Conditions with Ambiguous Genitalia: A Cross-Sectional Study*, 361 LANCET 1252, 1256 (2003) (finding that women who had undergone clitoral surgery for ambiguous genitalia were substantially more likely to be aorgasmic than control group women). *But see* H.F.L. Meyer-Bahlburg et al., *Attitudes of Adult 46,XY Intersex Persons to Clinical Management Policies*, 171 J. UROLOGY 1615, 1617 (2004) (finding that a majority of the intersex adults were satisfied with their gender assignment and would not recommend postponing surgery to adulthood).

69. GREENBERG, *supra* note 33, at 32-35.

that the surgeries are purely cosmetic, suggest that surgical treatment in infancy is not only unnecessary, but also irresponsible.⁷⁰

In response to criticisms of intersex case management, the Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology created a task force of physicians to analyze the issue and develop a new treatment method.⁷¹ In the Consensus Statement released in 2006, the task force recognized that genital surgery is unnecessary in many cases and that gender is not determined solely by the appearance of the child's genitals.⁷² The treatment scheme that the task force developed eschews the concealment-centered approach in favor of open communication with parents and patients and counseling as to how the parents can address their child's intersex condition with family and friends.⁷³ Most importantly, the statement would limit surgical intervention to times when it is necessary for the child to have fully functional genitalia; purely cosmetic surgeries are to be avoided.⁷⁴ The statement recommends surgery only to correct hypospadias,⁷⁵ to

70. See *id.*; see also *supra* note 67 and accompanying text.

71. See generally Lee et al., *supra* note 15.

72. *Id.* at e491 (“Factors that influence gender assignment include diagnosis, genital appearance, surgical options, need for lifelong replacement therapy, potential for fertility, views of the family, and, sometimes, circumstances relating to cultural practices.”).

73. *Id.* at e492-93. The committee's Consensus Statement identifies five key factors for successful intersex case management:

- (1) gender assignment must be avoided before expert evaluation in newborns;
- (2) evaluation and long-term management must be performed at a center with an experienced multidisciplinary team;
- (3) all individuals should receive a gender assignment;
- (4) open communication with patients and families is essential, and participation in decision-making is encouraged; and
- (5) patient and family concerns should be respected and addressed in strict confidence.

Id. at e490.

74. *Id.* at e491 (“Because orgasmic function and erectile sensation may be disturbed by clitoral surgery . . . [e]mphasis is on functional outcome rather than a strictly cosmetic appearance.”).

75. Hypospadias—a condition in which the urethra is not located at the tip of the penis—provides a stark example of how determinations of “normal” in genital construction can be arbitrary decisions. KESSLER, *supra* note 9, at 49-50. It is medically unnecessary to conduct surgery for the sole reason of correcting hypospadias. *Id.* at 69-70 (“[N]one of the 150 different surgical techniques to repair hypospadias are medically necessary to reduce pain or prevent illness.”). To further illustrate how intersex conditions can be viewed as more of a social problem than a medical one, a study revealed that the urethral opening was only located in the “normal” area in 55% of men. FAUSTO-STERLING, *supra* note 2, at 57 (citing J. Fichter et al., *Analysis of Meatal Location in 500 Men: Wide Variation Questions*

remove testes of AIS patients, or to correct “severe virilization,” which refers to a larger phallus in female infants.⁷⁶ Any further vaginoplasty or phalloplasty can be postponed until adolescence, allowing the patient a greater opportunity to participate in the decision.⁷⁷ Thus, the Consensus Statement is a far less extreme method of intersex case management than the traditional concealment-based model despite still advocating for genital surgery in some cases.⁷⁸

One intersex advocacy group, ISNA, proposed a patient-centered intersex case-management system in which all medically unnecessary surgery is postponed until the child can consent to treatment.⁷⁹ ISNA does recommend that parents and doctors work together to choose one gender of rearing, but maintains that sex assignment surgery is not necessary to development of a healthy gender identity.⁸⁰ ISNA’s patient-centered treatment model prohibits all medically unnecessary treatment, even in cases of severe virilization.⁸¹ Simply, ISNA’s proposed treatment model and mission as an organization emphasizes that biological variations in genital construction occur naturally and should not, absent any adverse complications, be considered medical problems.⁸²

Need for Meatal Advancement in All Pediatric Anterior Hypospadias Cases, 154 J. UROLOGY 833, 833-34 (1995)). Based on these results, Fausto-Sterling suggests that correcting hypospadias is less a medical decision for the child than a social decision to put parents and peers at ease with the child. *Id.* at 58.

76. Lee et al., *supra* note 15, at e491-92. The Consensus Statement acknowledges that even when surgery is limited to a few specific types of DSD, it is likely that most patients will require further surgery in puberty. *Id.* at e492.

77. *Id.* at e491-92.

78. *Id.*

79. DREGER, *supra* note 14. In fact, ISNA suggests that surgery should not be considered until the person with the intersex condition actually requests the surgery, is fully informed of all risks, and has had the opportunity to speak with other individuals who have undergone the surgery. *Id.* ISNA also emphasizes that parents and doctors should not hide the intersex condition from the child, as this type of concealment can ultimately harm, rather than help, the child. *Id.* (“Secrecy and lack of information lead to shame, trauma, and medical procedures that may be dangerous to the patient’s health.”).

80. *Id.* (“We advocate assigning a male or female gender because intersex is not, and will never be, a discreet biological category any more than male or female is, and because assigning an ‘intersexed’ gender would unnecessarily traumatize the child.”). However, parents should be aware that their child may choose a different gender identity later in life. *See id.*

81. *Id.*

82. *See id.*

The 2006 Consensus Statement and ISNA's patient-centered treatment model both represent a considerable step forward in intersex case management, but neither system is mandated within the medical field.⁸³ The American Academy of Pediatrics has endorsed the 2006 Consensus Statement's treatment model, but many doctors and health care organizations do not currently adhere to this model.⁸⁴ The Accord Alliance, an intersex activist group that replaced ISNA in 2008⁸⁵ to advocate for implementation of the Consensus Statement model, has provided resources online and worked with different health care teams to implement the new strategy.⁸⁶ However, many physicians still employ the surgical treatment method.⁸⁷

II. PRIVACY AND SELF-DEFINITION

The right to privacy is derived from the Substantive Due Process Clause of the Fourteenth Amendment,⁸⁸ which protects rights that are deemed "fundamental."⁸⁹ Substantive due process has been the subject of considerable debate since its inception, as the rights it has been invoked to protect are not explicitly enumerated in the

83. See Lee et al., *supra* note 15, at e496; Davidian, *supra* note 49, at 11.

84. See *FAQs*, ACCORD ALLIANCE, <http://www.accordalliance.org/learn-about-dsd/faqs> (last visited Feb. 8, 2016).

85. *Dear ISNA Friends and Supporters*, INTERSEX SOC'Y N. AM., http://www.isna.org/farewell_message (last visited Feb. 8, 2016). After the Consensus Statement was published, ISNA hoped to aid in implementation so that the proposed model could become the reality for treatment. *Id.* However, ISNA had little success because "there [was] concern among many healthcare professionals, parents, and mainstream healthcare system funders that ISNA's views are biased or that an association with ISNA will be frowned upon by colleagues and peers." *Id.* As a result, ISNA worked with clinicians and intersex advocates to help form the Accord Alliance, a non-profit with the sole purpose of aiding in implementation of the new model and advocating for health care organizations to adopt the American Association of Pediatrics's recommendation of the new treatment model. *Id.*; *Our Mission: A New Standard of Care*, ACCORD ALLIANCE, <http://www.accordalliance.org/about-accord-alliance/our-mission> (last visited Feb. 8, 2016).

86. See ACCORD ALLIANCE, *supra* note 84.

87. See Davidian, *supra* note 49, at 11.

88. The clause prohibits states from "depriv[ing] any person of life, liberty, or property, without due process of law." U.S. CONST. amend. XIV, § 1.

89. See *Washington v. Glucksberg*, 521 U.S. 702, 719-20 (1997) ("[I]n addition to the specific freedoms protected by the Bill of Rights, the 'liberty' specially protected by the Due Process Clause includes the rights to marry; to have children; to direct the education and upbringing of one's children; to marital privacy; to use contraception; to bodily integrity; and to abortion." (citations omitted)).

Constitution.⁹⁰ Nevertheless, the right to not have the government intrude on citizens' private, intimate moments is perhaps one of the most important rights retained by the people.⁹¹ This right was originally established to provide protections for marital privacy between consenting adults, as well as privacy in the doctor-patient relationship.⁹² The right has since been extended to minors in cases dealing with abortion and contraception to guarantee a degree of privacy from government and parents in making important decisions about reproductive health.⁹³

A. The Early Privacy Doctrine

The substantive due process right to privacy was first articulated by Justice Douglas in *Griswold v. Connecticut*.⁹⁴ In *Griswold*, the Court struck down a Connecticut statute that prohibited citizens from using contraceptives and from counseling or aiding another person in obtaining contraceptives.⁹⁵ The *Griswold* Court found that privacy is implicated in the First, Third, Fourth, Fifth, and Ninth Amendments.⁹⁶ Justice Douglas noted that each of these amendments have "penumbras" creating a zone of privacy protected from intrusion by the government outside those of which are enumerated in the amendments.⁹⁷ Since recognizing privacy as a

90. For a discussion of the history of substantive due process and the arguments for and against recognizing the doctrine, see E. THOMAS SULLIVAN & TONI M. MASSARO, *THE ARC OF DUE PROCESS IN AMERICAN CONSTITUTIONAL LAW* 123-25 (2013).

91. *Griswold v. Connecticut*, 381 U.S. 479, 484-85 (1965).

92. *Id.*

93. See, e.g., *Hodgson v. Minnesota*, 497 U.S. 417, 418 (1990); *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977).

94. 381 U.S. at 486. Though this is the first case in which the right to privacy was specifically identified, one commenter notes that *Meyer v. Nebraska*, 262 U.S. 390 (1923), and *Pierce v. Soc'y of Sisters*, 268 U.S. 510 (1925), are considered "the true parents of the privacy doctrine." Jed Rubenfeld, *The Right to Privacy*, 102 HARV. L. REV. 737, 743 (1989). These cases, which dealt with the rights of parents in deciding the type of education their children would receive, are discussed in more detail in Part III of this Note.

95. 381 U.S. at 485. This case reached the Supreme Court after two physicians were convicted under the statute after giving medical advice and prescribing contraceptives to married couples. *Id.* at 480.

96. *Id.* at 484.

97. *Id.* at 484-85. For example, the Third and Fourth Amendments carried an implicit guarantee of privacy in one's own home, such that the government could not intrude to quarter soldiers or conduct unreasonable searches and seizures. *Id.* at 484.

fundamental right, the Court has used the privacy right in numerous cases involving sexual relationships, family relationships, the doctor–patient relationship, and medical decision-making.⁹⁸

Ultimately, these decisions can be viewed as a right to self-determination, or the idea that there are certain fundamental aspects of identity, such as sexuality, parenthood, or marital status, on which the state may not intrude.⁹⁹ One academic refers to the abstract concept of “personhood” as underlying privacy jurisprudence and providing the basis for protecting self-definition as a part of the basic right to privacy, and this abstract principle is supported in the Court’s privacy jurisprudence as it has developed over the years.¹⁰⁰ In *Lawrence v. Texas*, the Court stated that “[l]iberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct.”¹⁰¹ These aspects of identity are so essential to individual personhood that even though self-determination is not enumerated within the Constitution these aspects cannot be redefined or dictated by the state without offending the most basic societal beliefs about the role of government in democracy.¹⁰² Privacy has then been read somewhat expansively to protect unenumerated, or implicit, rights; however, at the same time, the Court has traditionally only invoked the privacy doctrine in reference to particularly impactful aspects of identity.¹⁰³ The Supreme Court recognized the importance of this amorphous concept of self-determination, without interference by the state, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*:

98. *Lawrence v. Texas*, 539 U.S. 558, 578 (2003) (holding that the state cannot criminalize private, consensual sexual conduct); *Zablocki v. Redhail*, 434 U.S. 374, 386 (1978) (stating that the right to privacy includes the right to define an intimate relationship through marriage); *Roe v. Wade*, 410 U.S. 113, 153 (1973) (holding that the right to privacy encompasses the right to decide whether to reproduce); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (“If the right of privacy 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.”).

99. *See, e.g.*, Rubenfeld, *supra* note 94, at 753.

100. *Id.* at 752-53.

101. 539 U.S. at 562.

102. *See* Rubenfeld, *supra* note 94, at 753 (“[S]ome acts, faculties, or qualities are so important to our identity as persons—as human beings—that they must remain inviolable, at least as against the state.”).

103. *See, e.g.*, *Lawrence*, 539 U.S. at 562 (analyzing right to sexual intimacy without intrusion by state); *Roe*, 410 U.S. at 153 (applying privacy to the decision to reproduce).

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence¹⁰⁴

Justice O'Connor's opinion in *Casey* recognizes that certain decisions, such as whether to have a child or get married, have far-reaching consequences for the individual that would caution against allowing the government to play a dispositive role in the decision-making process.¹⁰⁵ Therefore, while it can be difficult to truly define privacy and self-determination, the Court has acknowledged that certain parts of human identity are so sacred that the state has an obligation to refrain from interfering with the individual's right to shape his or her own identity.¹⁰⁶

The Court's consistent treatment of life-altering reproductive choices as within the scope of the individual right to privacy indicates that medical decisions about one's own body—such as the decision to use contraceptives or to terminate a pregnancy—are respected by the Court as personal, private choices upon which a state may not intrude at will.¹⁰⁷ For example, the decision to become a parent has a strong influence on an individual's day-to-day life, as well as on the development of identity; in *Roe v. Wade*, the Court held that such an important decision should be left to the woman and her doctor, not to the state.¹⁰⁸ More abstractly, the medical choices the Court has recognized as within the purview of the right to privacy involve personal autonomy and the "right to be free from unwanted invasion of his or her person."¹⁰⁹ These medical decisions follow the individuals throughout their lives and have a lasting impact beyond consent to the average medical treatment or procedure.¹¹⁰ Tonsil surgery or wisdom tooth removal, for example, simply do not carry the same significance to individual identity in the

104. 505 U.S. 833, 851 (1992) (plurality opinion).

105. *Id.*

106. *See id.*; Rubinfeld, *supra* note 94, at 753.

107. *See, e.g., Roe*, 410 U.S. at 114; *Eisenstadt v. Baird*, 405 U.S. 438, 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 480 (1965).

108. 410 U.S. at 164.

109. Sara A. Aliabadi, Note, *Gender Assignment Surgery for Intersexed Infants: How the Substantive Due Process Right to Privacy Both Supports and Opposes a Moratorium*, 12 VA. J. SOC. POL'Y & L. 170, 184 (2004).

110. *See Roe*, 410 U.S. at 164.

contemporary cultural milieu as the decision to become, or not become, a parent.¹¹¹ Ultimately, minors are even more influenced by the life-altering effects of certain medical decisions, such as the choice to terminate a pregnancy, and the Court has taken steps to protect their privacy rights notwithstanding parents' general authority to make medical decisions for their children.¹¹² These decisions, described below, are strong indication that the Court considers even minors to have rights, separate from parental control, to make decisions that are highly impactful on their futures.¹¹³

B. Privacy Rights of Minors

The Court has made clear that minors are entitled to a degree of privacy in making important medical decisions that will have lasting effects on their lives and sense of self.¹¹⁴ In particular, the Court's numerous decisions requiring judicial bypass procedures for minors who wish to obtain an abortion without parental notification strongly suggest that minors are entitled to a degree of privacy in deciding whether to reproduce.¹¹⁵ More importantly, the fact that the Court has mandated judicial bypass procedures in abortion statutes as applied to minors indicates that the decision to reproduce is important enough that a minor's right to participate in the decision cannot be infringed.¹¹⁶ Rather, the state can place limited restrictions on the minor's right to make the decision to reproduce, such as imposing parental notification requirements, but the state cannot go so far as to prevent minors entirely from obtaining abortion sans parental consent.¹¹⁷

111. See Aliabadi, *supra* note 109, at 184 (describing the significance of certain intrusions by the state upon the individual's body).

112. See *infra* Part III.

113. See *infra* Section II.B.

114. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 899 (1992) (plurality opinion) (holding that one parent veto power is constitutional as long as the state provided judicial bypass for minors who do not wish to inform their parents); *Hodgson v. Minnesota*, 497 U.S. 417, 423 (1990) (holding that states may not require a minor to notify both parents before seeking an abortion, even when judicial bypass is another available option); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 694 (1977) (holding that the state cannot impose on a minor's right to privacy by making it nearly impossible for the minor to obtain contraception).

115. See *Casey*, 505 U.S. at 899; *Hodgson*, 497 U.S. at 423; *Bellotti v. Baird*, 443 U.S. 622, 643 (1979).

116. See, e.g., *Lambert v. Wicklund*, 520 U.S. 292, 295-96 (1997) (*per curiam*).

117. See *Hodgson*, 497 U.S. at 423.

In *Bellotti v. Baird*, the Court held that a state may create laws to encourage minors to tell their parents that they would like to have an abortion, but the state cannot make parental consent a prerequisite for every minor seeking an abortion.¹¹⁸ Rather, the state must have in place some alternative procedure for minors who do not wish to notify their parents that they are seeking an abortion so that the minor can prove that she is either mature enough to make the decision on her own or that the abortion would be in her best interest.¹¹⁹ The *Bellotti* test then balances a state's important interest in protecting its minors with the minor's interest in maintaining bodily autonomy and shaping his or her own lifelong identity.¹²⁰ This is a fact-specific inquiry, and states may not fashion a system in which virtually all such requests are rejected by default.¹²¹ In an earlier case invalidating a law requiring parental consent for a minor's abortion, the Court stated that the parents' interest in their daughter's abortion does not outweigh the daughter's right to privacy.¹²² Thus, when confronted with three competing interests—those of the state, the parent, and the minor—the Court determined that notwithstanding the limitations on minors' rights, the right to privacy with respect to abortion can outweigh the interests of the state and the parent.¹²³

The Court also emphasized in *Bellotti* that while the decision to reproduce might more desirably be made in adulthood, a minor who is seeking an abortion does not have the luxury of waiting until she reaches the age of majority to decide whether to terminate the pregnancy.¹²⁴ In that situation, a serious, life-changing decision must be made to the best of the minor's ability without the added wisdom or security that comes with adulthood.¹²⁵ The Court noted that there are few decisions a minor can make that would have such "grave and indelible" consequences.¹²⁶ Thus, while preferable that minors speak with their parents about the decision, it is also important to allow them to make the decision to terminate a pregnancy, if necessary,

118. See 443 U.S. at 643.

119. See *id.* at 643-44.

120. See *id.* at 642-43.

121. See *id.* at 643-44, 653 n.23. In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 74 (1976), the Court found unconstitutional a judicial bypass procedure that essentially guaranteed that all requests would be denied.

122. *Danforth*, 428 U.S. at 75.

123. *Bellotti*, 443 U.S. at 643-44.

124. See *id.* at 642.

125. See *id.*

126. *Id.*

without consulting their parents.¹²⁷ The gravity of the decision on the minor's life in the long term rendered it simply unconstitutional to mandate that a third party, the parent, hold a "veto" power over the minor's decision.¹²⁸ Today, thirty-eight states require some form of parental involvement before a minor can obtain an abortion, but all of those states have a judicial bypass procedure in place.¹²⁹ When deciding whether to allow the minor to proceed with the abortion without parental consent, judges assess factors such as the minor's emotional state and her understanding of the consequences of terminating a pregnancy.¹³⁰ Thirteen states require the judge to determine that the minor is mature by the elevated standard of clear and convincing evidence.¹³¹ Simply put, "emotional state" and "understanding of the consequences" are factors that require the judge to determine the minor's maturity.¹³²

The limited right to privacy for minors is not restricted to termination of pregnancy; in holding that a state may not prohibit minors from buying and using hormonal contraception, the Court spoke more broadly about the "important decisions" the right to privacy protects.¹³³ These "important decisions" are those that have a long-term, meaningful impact on the individual's life, regardless of the fact the decision was made during infancy.¹³⁴ In *Carey v. Population Services International*, the Court explicitly stated that the right to privacy, including the right to make general decisions about reproduction, extended to minors even outside of the abortion context.¹³⁵ In striking down the statute that prohibited the sale of contraception to minors, the Court emphasized past decisions about abortion, noting that the decision to terminate a pregnancy has more drastic physical and mental-health implications than the decision to

127. *Id.* at 640-43. The Court also noted that deciding to obtain an abortion may raise moral and religious concerns that a minor could best address by speaking with her parents. *Id.*

128. *See id.* at 639-40; *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976).

129. GUTTMACHER INST., STATE POLICIES IN BRIEF: PARENTAL INVOLVEMENT IN MINORS' ABORTIONS 1 (2015), http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf.

130. *Id.*

131. *Id.*

132. *See id.*; *Bellotti*, 443 U.S. at 642-44.

133. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684-86 (1977) (quoting *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977)).

134. *See id.*

135. *Id.* at 693.

use contraception.¹³⁶ Because states could not require minors to obtain parental consent before an abortion, the Court held that the state also could not prohibit minors from taking the less drastic step of using hormonal contraception.¹³⁷ The latter was a logical extension of the former—if children were allowed to go so far as to terminate a pregnancy without notifying their parents, then children must also be allowed to make the safer, less drastic reproductive health decision to use contraceptives.¹³⁸

In addition to holding that states may not grant parents the right to unilaterally veto a minor's decision to have an abortion, the Court has emphasized that minors have a First Amendment right to self-determination and to defining their own identity.¹³⁹ Thus, the concept of personhood that undergirds much of privacy law extends to the identity and self-definition of minors as well as adults.¹⁴⁰ Perhaps the most important reasoning the Court has offered to support allowing minors to make reproductive health decisions was the urgency argument raised in *Bellotti*: Having a child is an enormous decision and responsibility, and the decision is complicated by being time sensitive.¹⁴¹ While children might be best off consulting with a parent before making this life-altering decision, time is not always on the child's side.¹⁴² The Court recognized that when time was of the essence, the child's right to privacy in making the decision must be prioritized over the parents' interest in remaining informed and involved in their child's decisions.¹⁴³ With time as a factor, the minor's right to privacy trumped the parents' right to participate in the decision and the states' right to discourage underage abortions.¹⁴⁴ The "grave and indelible" consequences of having a child do not affect a minor's future and identity any less than they affected those

136. *Id.* at 694.

137. *Id.* (citing *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) (striking down a statute that granted a parent or guardian an absolute veto power over the child's decision to obtain an abortion)).

138. *Id.* ("Since the State may not impose a blanket prohibition, or even a blanket requirement of parental consent, on the choice of a minor to terminate her pregnancy, the constitutionality of a blanket prohibition of the distribution of contraceptives to minors is a fortiori foreclosed.")

139. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) (plurality opinion).

140. Rubenfeld, *supra* note 94, at 753 (citing *Bowers v. Hardwick*, 478 U.S. 186, 205 (1986) (Blackmun, J., dissenting)).

141. *See Bellotti v. Baird*, 443 U.S. 622, 642 (1979).

142. *Id.*

143. *Id.*

144. *See id.*

of an adult.¹⁴⁵ This basis for extending the right to privacy as self-definition to minors in the abortion context can provide support for extending a similar right to privacy for children born with intersex conditions so that these children can self-define one central aspect of their identity: gender.¹⁴⁶

III. MEDIATING BETWEEN PARENTAL AND STATE RIGHTS

The Supreme Court has consistently held that the Due Process Clause protects “the fundamental right of parents to make decisions concerning the care, custody, and control of their children.”¹⁴⁷ This deference to parents is largely based on the principle that parents will always be better able to act in their children’s best interests than the state.¹⁴⁸ The Court recognized this principle nearly a century ago, and it continues to remain an important aspect of family law and the relationship between the individual and the state.¹⁴⁹ However, parental rights are somewhat tempered by the state’s right to act as *parens patriae* to protect the well-being of its children.¹⁵⁰ Both the parent and the state have important interests in the well-being of the child and exercise a degree of control and responsibility for the child’s care.¹⁵¹ However, parents and the state are not always in agreement regarding the care of the child.¹⁵² Tensions between the parental right and the state right have already emerged in cases in

145. *Id.*

146. GERMON, *supra* note 28, at 66-67 (discussing gender as a core identity influencing how the individual navigates the world).

147. *See* *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality opinion).

148. *See* Emily A. Bishop, Note, *A Child’s Expertise: Establishing Statutory Protection for Intersexed Children Who Reject Their Gender of Assignment*, 82 N.Y.U. L. REV. 531, 562 (2007); Skylar Curtis, *Reproductive Organs and Differences of Sex Development: The Constitutional Issues Created by the Surgical Treatment of Intersex Children*, 42 MCGEORGE L. REV. 841, 849-50 (2011).

149. *See* *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (including the right to “establish a home and bring up children” without state interference as one important protected liberty interest within the Fourteenth Amendment due process clause); *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 534-35 (1925) (holding that the state cannot infringe upon the parents’ right to choose private education for their children by requiring that all children attend public schools); *Troxel*, 530 U.S. at 66 (holding that the state cannot allow a judge to make a determination about a child’s best interest without granting any deference to the parent).

150. Jim Ryan & Don R. Sampen, *Suing on Behalf of the State: A Parens Patriae Primer*, 86 ILL. B.J. 684, 684 (1998).

151. *See id.*

152. *See id.*

which the child needs certain medical treatment to which the parents are unwilling to consent, often for religious reasons.¹⁵³

A. Parental Rights Over Children's Medical Care

In *Parham v. J.R.*, the Court recognized that parents and children may disagree on the child's medical care, but in many instances the parent's wishes are given precedence over the child's opinion.¹⁵⁴ In particular, the Court held that the parental right to make decisions for children extends to the drastic decision to have the child involuntarily committed to a mental-health institution.¹⁵⁵ *Parham* involved a class-action suit challenging a Georgia statute allowing parents to have their children committed to psychiatric hospitals against the child's wishes.¹⁵⁶ The statute in question allowed parents to submit applications for commitment of children under the age of eighteen to the superintendent of any of the state's mental-health facilities.¹⁵⁷ While the specific admittance policies and criteria varied from facility to facility, in all cases the superintendent of the facility could choose to accept the child or deny the parent's request.¹⁵⁸ After commitment, hospital staff or administrators reviewed the decision, and the hospital was not required to consider the child's wishes when determining whether to keep the child in treatment.¹⁵⁹ A child who was received into a facility could be kept for observation and treatment until the facility had determined that the child had adequately recovered and no longer required hospitalization.¹⁶⁰ Alternatively, a parent or guardian could choose to discharge the child after the child had been hospitalized for at least five days.¹⁶¹

In upholding the statute, the Court emphasized the parental right to make decisions about childrearing without significant interference from the state, even though children have a protected liberty interest under the Fourteenth Amendment in not being

153. See *infra* Section III.C; see also Barry Nobel, *Religious Healing in the Courts: The Liberties and Liabilities of Patients, Parents, and Healers*, 16 U. PUGET SOUND L. REV. 599, 654 (1993).

154. 442 U.S. 584, 602 (1979).

155. See *id.* at 601-02.

156. See *id.* at 588 n.3.

157. See *id.*

158. See *id.* at 591.

159. See *id.* at 588 & n.3, 589.

160. See *id.*

161. See *id.* at 591.

involuntarily committed.¹⁶² Of course, the statute also delegated some power to the state by requiring administrative approval of any involuntary commitment by hospital personnel before the child could be officially accepted into the hospital's care.¹⁶³ The interests of the three implicated parties were then characterized as follows: The parents hold the initial right to determine that the child needs care and to seek institutionalization; the state reviews the parent's decision and, in most cases, accepted the child into the institution,¹⁶⁴ and the child remained powerless in the proceeding, despite the strong liberty interest in not being confined.¹⁶⁵ This parental right allowed parents to make medical decisions in the child's best interests, regardless of the child's expressed preferences.¹⁶⁶ While primary decision-making power rested with the parents, this right was nonetheless tempered by the hospital administration's ability to refuse to admit a child when necessary.¹⁶⁷

The *Parham* Court reached its decision in part on the basis that children are incompetent to make their own medical decisions.¹⁶⁸ Ultimately, this incompetency was weighted more heavily than the child's admitted protected liberty interest in not being involuntarily confined.¹⁶⁹ Competency determinations take into account the

162. See, e.g., *id.* at 602 (citing *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 535 (1925); *Prince v. Massachusetts*, 321 U.S. 158 (1944)). "It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment and that the state's involvement in the commitment decision constitutes state action under the Fourteenth Amendment." *Id.* at 600.

163. See *id.* at 588 & n.3, 589, 591.

164. See *id.*

165. See *id.* at 600.

166. See *id.* at 604 ("The fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority to decide what is best for the child."). In a concurring opinion, Justice Stewart argued that children should be afforded the same due process protections that the Court had afforded to adults being involuntarily committed to a mental institution. *Id.* at 627 (Stewart, J., concurring) ("Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors as well as adults are protected by the Constitution and possess constitutional rights."). Justice Stewart argued that children should be afforded the same right that adults have to a formal hearing in front of a neutral decision maker before being involuntarily committed. *Id.* at 627, 630 (citing *Specht v. Patterson*, 386 U.S. 605, 610 (1967)).

167. See *id.* at 591 (majority opinion).

168. *Id.* at 603 ("Most children, even in adolescence, simply are not able to make sound judgments . . .").

169. See *id.* at 600.

person's ability to communicate his or her choices to others: whether the person understands the medical condition, treatment options, and potential consequences of treatment; whether the person can understand the information necessary to make an informed decision; and whether the person can rationally consider the information.¹⁷⁰ Children, particularly young children, are generally not considered competent to make their own medical decisions.¹⁷¹ The presumption of children's incompetence, combined with the "social emergency" created by the birth of an intersex child, has led to the widespread practice of parents consenting to life-altering surgery on infants who would not be considered competent to participate in the determination of their own gender for nearly two decades.¹⁷²

B. The Doctrine of *Parens Patriae*

In defining the doctrine of *parens patriae*, the Court has held that the state will always have a "quasi-sovereign interest in the health and well-being—both physical and economic—of its residents in general."¹⁷³ States commonly invoke the doctrine of *parens patriae* to protect the safety and well-being of children in cases concerning child abuse, such as allowing a state worker to remove the child from the parents' home as a precautionary measure to protect against further abuse.¹⁷⁴ Thus, when the well-being of the child is at stake,

170. See Anthony W. Austin, Note, *Medical Decisions and Children: How Much Voice Should Children Have in Their Medical Care?*, 49 ARIZ. L. REV. 143, 150 (2007).

171. See *id.* at 152; see also Gary B. Melton, *Children's Competence to Consent: A Problem in Law and Social Science*, in CHILDREN'S COMPETENCE TO CONSENT 5, 10 (Gary B. Melton, Gerald P. Koocher & Michael J. Saks eds., 1983) (criticizing the majority in *Parham* for basing its holding about children's competence on "largely unsupported empirical assumptions" about mental health, psychology, and the family).

172. See *Developmental Anomalies*, *supra* note 65, at 138; Marie Fox & Michael Thomson, *Cutting It: Surgical Interventions and the Sexing of Children*, 12 CARDOZO J.L. & GENDER 81, 85 (2005).

173. *Alfred L. Snapp & Son, Inc. v. P.R. ex rel. Barez*, 458 U.S. 592, 607 (1982). This was the first of two categories of quasi-sovereign interests the Court identified. *Id.* The second quasi-sovereign interest of the state was in "not being discriminatorily denied its rightful status within the federal system." *Id.*

174. *Thomason v. SCAN Volunteer Servs., Inc.*, 85 F.3d 1365, 1373 (8th Cir. 1996) ("Where a treating physician has clearly expressed his or her reasonable suspicion that life-threatening abuse is occurring in the home, the interest of the child (as shared by the state as *parens patriae*) in being removed from that home setting to a safe and neutral environment outweighs the parents' private interest in familial integrity as a matter of law." (emphasis added)). Government officials can

the state retains an interest that can trump that of the parents, even given the heavy weight the Court has traditionally afforded family privacy and integrity.¹⁷⁵ The state can also act as *parens patriae* to pass broader legislation protecting the health and well-being of a child, in addition to using the power to intervene in the family through the courts or administrative agencies.¹⁷⁶

The Supreme Court articulated the states' right to act as *parens patriae* of its resident children in *Prince v. Massachusetts*, in which the plaintiff, a Jehovah's Witness, brought her nine-year-old niece with her to sell pamphlets to passersby on the street.¹⁷⁷ Because the two were attempting to sell the pamphlets, rather than distributing them for free, the petitioner was arrested under a state statute that prohibited parents and guardians from allowing girls under the age of eighteen to engage in child labor.¹⁷⁸ The young girl in fact did not make any money selling the pamphlets on the night in question, but this was irrelevant to the Court's analysis.¹⁷⁹ While the Court acknowledged that the law does not usually allow the state to intervene in the private affairs of a family,¹⁸⁰ it stated that in limited situations, "the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting child labor, and in many other ways."¹⁸¹ Thus, in *Prince*, two of the plaintiff's fundamental rights were at issue: The right, as articulated in *Meyer*,¹⁸² of the plaintiff to raise her child as she saw fit; and the First Amendment right of the plaintiff to exercise her religious

also use their power under *parens patriae* to simply remove a child from her home for questioning when the officials believe that the child would have trouble discussing abuse in front of the parents. *J.B. v. Wash. Cty.*, 127 F.3d 919, 925 (10th Cir. 1997) ("[C]onsiderable deference should be given to the judgment of responsible government officials in acting to protect children from perceived imminent danger or abuse." (quoting *J.B. v. Wash. Cty.*, 905 F. Supp. 979, 986 (D. Utah 1995))).

175. See *Thomason*, 85 F.3d at 1373.

176. See, e.g., *Prince v. Massachusetts*, 321 U.S. 158, 160-61 (1944); see also CAL. BUS. & PROF. CODE § 865 (West 2013).

177. *Prince*, 321 U.S. at 159. The plaintiff was the girl's legal guardian at the time. See *id.* at 160.

178. See *id.* at 161.

179. See *id.* at 162.

180. *Id.* at 165-66 (citing *W.V. State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943); *Pierce v. Soc'y of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923)).

181. *Id.* at 166 (footnotes omitted).

182. *Meyer*, 262 U.S. at 399.

beliefs through distributing pamphlets to the public.¹⁸³ The Court firmly held that, regardless of the plaintiff's personal religious beliefs and parental autonomy, she could not violate the statute by allowing her child to engage in prohibited labor.¹⁸⁴ The Court stated that parents cannot "make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."¹⁸⁵ Regardless of the protection afforded the family and the adult's First Amendment rights, the government retained the right to intervene to protect the child from being exploited for labor.¹⁸⁶

As seen in *Prince*, it can be difficult to reconcile the state's interest in protecting the well-being of children with the overarching parental right to choose how to raise children, particularly when additional constitutional rights are implicated.¹⁸⁷ In a more recent example of this balancing of interests, California, acting as *parens patriae*, passed a statute prohibiting parents from requiring their children to undergo "sexual orientation change efforts," otherwise known as conversion therapy, in an attempt to "convert" a homosexual child to heterosexuality.¹⁸⁸ "Sexual orientation change effort" is defined in the statute as "any practices by mental health providers that seek to change an individual's sexual orientation."¹⁸⁹ The statute prohibits all mental-health providers from having individuals under the age of eighteen undergo conversion therapy.¹⁹⁰ Thus, while the statute is directly aimed at regulating mental-health professionals, in practice, it serves its purpose by undercutting parents' traditional right to make medical decisions, including mental-health decisions, on behalf of their children.¹⁹¹ In passing the bill, the California legislature listed numerous studies by professional organizations, such as the American Psychological Association and the American Psychiatric Association, in which researchers found that conversion therapy often results in depression, suicidal ideation,

183. *Prince*, 321 U.S. at 167.

184. *Id.* at 170.

185. *Id.*

186. *See id.* at 167-68.

187. *See id.* at 166-67 (weighing constitutional rights of parents against state's right to act as *parens patriae* in prohibiting certain forms of child labor).

188. CAL. BUS. & PROF. CODE § 865.1 (West 2013).

189. *Id.* § 865(b)(1).

190. *Id.* § 865.1.

191. *See, e.g., Parham v. J.R.*, 442 U.S. 584, 602 (1979) (affirming parental right to have minor children involuntarily committed to mental-health institutions).

substance abuse, and low self-esteem.¹⁹² The session laws for California's act specify that the state has a "compelling interest in protecting the physical and psychological well-being of minors" that justified limitations on parents' rights to seek this professional treatment for their children.¹⁹³

In reviewing the law, the Ninth Circuit held that California had not unduly intruded upon parental rights by prohibiting mental-health professionals from providing minors with conversion therapy.¹⁹⁴ In *Pickup v. Brown*, parents and mental-health providers brought suit seeking an injunction against the law, claiming, *inter alia*, that it violated parents' fundamental right to make decisions about their children's medical treatment.¹⁹⁵ The court rejected this argument.¹⁹⁶ While the court acknowledged that parents have a general right to dictate their children's medical care, the court also found that "the fundamental rights of parents do not include the right to choose a specific type of provider for a specific medical or mental health treatment that the state has reasonably deemed harmful."¹⁹⁷ Thus, despite challenges made by medical professionals involved in the suit, the court deferred to the legislature's research indicating that the therapy is ultimately harmful.¹⁹⁸ In so holding, the court recognized that the legislature is capable of making judgments

192. 2012 Cal. Stat. 6569 ("Being lesbian, gay, or bisexual is not a disease, disorder, illness, deficiency, or shortcoming. The major professional associations of mental health practitioners and researchers in the United States have recognized this fact for nearly 40 years.").

193. *See id.* at 6569-71 (summarizing the professional research conducted on conversion therapy and explaining that the state has the right to protect minors from "exposure to serious harms" caused by conversion therapy).

194. *Pickup v. Brown*, 740 F.3d 1208, 1235 (9th Cir. 2014) (denying petition for rehearing en banc). This case consolidated two challenges to the law brought in California district courts. *Id.* at 1224-25. In the first case, the court granted the plaintiffs an injunction against the law after holding that the law violated the First Amendment and was likely to fail strict scrutiny. *Welch v. Brown*, 907 F. Supp. 2d 1102, 1105 (E.D. Cal. 2012). In the second case, the court denied the plaintiffs' motion for an injunction after finding that the law regulated conduct, not speech, and was subject only to rational basis review. *Pickup v. Brown*, 42 F. Supp. 3d 1347, 1375-77 (E.D. Cal. 2012).

195. 740 F.3d at 1235. The suit also challenged the law as overbroad and as a violation of mental-health providers' and minor patients' rights to free speech under the First Amendment. *Id.* at 1222.

196. *Id.* at 1236.

197. *Id.*

198. *See id.*

regarding medical care with the aim of keeping children safe.¹⁹⁹ The state's judgment about the safety and efficacy of conversion therapy was well supported by the evidence enumerated in the session law.²⁰⁰

In 2013, the New Jersey legislature passed a ban on conversion therapy,²⁰¹ relying on the same sources the California legislature listed in its session laws.²⁰² Citing the Ninth Circuit's opinion in *Pickup*, the district court held that fundamental parental rights do not extend to allow parents to seek medical treatment for their children that the legislature "has reasonably deemed harmful or ineffective."²⁰³ Much like the Ninth Circuit, the district court granted deference to the determination made by the legislature as to the well-being of children and the merits of conversion therapy generally.²⁰⁴ The court cited cases from other circuits holding that, in general, adult patients do not have a constitutional right to obtain a particular type of medical treatment or to be treated by a specific health care provider.²⁰⁵ Because adults do not have expansive constitutional rights to medical care of their choosing, the court stated that finding an unlimited parental right to choose health care for children would be inconsistent with the decisions concerning adults.²⁰⁶ Thus, while parents do retain the fundamental right to make decisions regarding the "care, custody, and control of their children,"²⁰⁷ the state can nevertheless prevent parents from choosing medical treatments it has

199. See *id.* ("[T]o recognize the right Plaintiffs assert would be to compel the California legislature, in shaping its regulation of mental health providers, to accept Plaintiffs' personal views of what therapy is safe and effective for minors.").

200. See 2012 Cal. Stat. 6569-71 (listing official statements condemning conversion therapy from the American Psychiatric Association, the American Academy of Pediatrics, the American School Counselor Association, the National Association of Social Workers, the American Medical Association Council on Scientific Affairs, and the American Academy of Child and Adolescent Psychiatry, among others).

201. N.J. STAT. ANN. § 45:1-55 (West 2013).

202. Compare Cal. Stat. 6569-71, with N.J. STAT. ANN. § 45:1-55 (relying on the same sources finding that conversion therapy is ultimately harmful to children); Lisa Leff, *California's 'Ex-Gay' Reparative Therapy Ban Details Sought, Shared in Other States*, HUFFPOST QUEER VOICES (Oct. 2, 2012, 1:51 PM), http://www.huffingtonpost.com/2012/10/02/california-ex-gay-reparative-therapy-ban-information-shared_n_1933025.html.

203. *Doe v. Christie*, 33 F. Supp. 3d 518, 530 (D.N.J. 2014).

204. See *id.*

205. See *id.* at 529-30. (citing Nat'l Ass'n for the Advancement of Psychoanalysis v. Cal. Bd. of Psychology, 228 F.3d 1043, 1050 (9th Cir. 2000); Mitchell v. Clayton, 995 F.2d 772, 775 (7th Cir. 1993)).

206. See *id.* at 529-30.

207. *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality opinion).

found to be contrary to the children's best interests.²⁰⁸ The New Jersey and the California cases indicate that states can constitutionally outlaw care they find unreasonably harmful based on existing research and professional opinions, even if a portion of the professionals in the field do support the form of care.²⁰⁹

C. Tension Between the Parent and the State

Because the state has broad police power to legislate and protect the well-being of its citizens, states have been able to use *parens patriae* standing in the past to intervene when parents denied consent to medical treatment for their children.²¹⁰ Even though courts are generally reluctant to interfere with the parental right to raise children as the parent sees fit, courts have carved out an exception to this deference in cases in which parents refuse to consent to life-saving treatment for their child.²¹¹ In many cases, the parents refuse treatment based on their religious beliefs, and the courts must weigh the parents' First Amendment right to freedom of religion and family autonomy with the child's interest in obtaining the life-saving treatment.²¹² Courts may also weigh the burden of the procedure on the child with the probability of the procedure's success to determine whether to intervene and order the medical treatment.²¹³

In *People ex rel. Wallace v. Labrenz*, the Illinois Supreme Court held that a child could be placed in the custody of a guardian when the child's parent refused to consent to a life-saving blood transfusion on religious grounds.²¹⁴ The parents, who were Jehovah's Witnesses, refused to consent to a blood transfusion for their daughter despite doctors' advice that she would either die or become severely mentally disabled without the transfusion.²¹⁵ The court held

208. See 2012 Cal. Stat. 6569-72; N.J. STAT. ANN. § 45:1-55 (West 2013).

209. See *Doe*, 33 F. Supp. 3d at 530; *Pickup v. Brown*, 740 F.3d 1208, 1236 (9th Cir. 2014).

210. See *infra* Section II.C.

211. SAMUEL M. DAVIS, *CHILDREN'S RIGHTS UNDER THE LAW* 75 (2011); Nobel, *supra* note 153, at 654 (noting a general trend to overrule religious objections to medical treatment when a court believes treatment is in the best interest of the minor).

212. *Id.* at 639-40.

213. *Id.* at 636-37, 639 (citing *In re Phillip B. v. Warren B.*, 156 Cal. Rptr. 48, 51 (Cal. Ct. App. 1979); *Newmark v. Williams*, 588 A.2d 1108, 1117 (Del. 1991)).

214. 104 N.E.2d 769, 773 (Ill. 1952).

215. *Id.*

that the state was permitted to exercise its power as *parens patriae*²¹⁶ to remove the child from the custody of her parents because the child was considered neglected.²¹⁷ The court stated that the refusal to consent to the blood transfusion was sufficient evidence to show that the child had been neglected even though the parents were acting in accordance with their religious beliefs because the parents' actions would almost certainly result in the child's death.²¹⁸ Even though the parents' religious beliefs were sincere, the strength of their beliefs was insufficient to outweigh the state's valid interest in the safety and well-being of its minor citizens.²¹⁹

Similarly, the state was permitted to intervene in *In re Willmann* when a minor's parents refused to consent to surgery to have a malignant tumor removed from their son's arm.²²⁰ After the son underwent chemotherapy that reduced the size of the tumor, the father informed physicians that he had faith that his son had been healed and would not consent to surgery to remove the tumor.²²¹ Once again, the parent's religious beliefs were sincere, but those beliefs nonetheless endangered the life of a child that the state had a valid interest in protecting.²²² In language similar to that invoked in *Prince*,²²³ the court held that the parents' decision to deny their son treatment was not protected under the Constitution because the decision was not in the child's best interest.²²⁴ The state was

216. See *supra* Section III.B.

217. *Labrenz*, 104 N.E.2d at 773.

218. *Id.* (“[I]t is of no consequence that the parents have not failed in their duty in other respects. We entertain no doubt that this child, whose parents were deliberately depriving it of life or subjecting it to permanent mental impairment, was a neglected child within the meaning of the statute.”); see also *Niebla ex rel. Niebla v. Cty. of San Diego*, No. 90-56302, 1992 WL 140250, at *4 (9th Cir. June 23, 1992) (holding that a trial court's order compelling blood transfusion for a child of two Jehovah's Witnesses was valid because the state has a compelling interest in protecting the health of its children).

219. *Labrenz*, 104 N.E.2d at 773.

220. 493 N.E.2d 1380, 1383 (Ohio Ct. App. 1986).

221. *Id.* at 1384.

222. See *id.*

223. *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944).

224. *Id.* at 1389-90 (“[The Willmanns] may, under the Constitution of the United States and the Constitution of the state of Ohio, be free to deny themselves whatever medical care they choose, but it does not, and cannot here, follow that they are free to impose that denial upon [their child].”); see also *In re D.L.E.*, 645 P.2d 271, 275 (Colo. 1982) (holding that the state could consider the son “dependent” and remove him from the home or assign a nurse to ensure that he complied with court-ordered treatment). In *In re D.L.E.*, the state intervened when a mother refused medical treatment for her epileptic son, choosing instead to rely on prayer and faith

empowered to intervene in the parents' decision because the child's welfare was at stake—regardless of parental rights to medical decision-making for children, the state was not required to stand idly by while the life of a minor was at risk.²²⁵

The Pennsylvania Supreme Court, in *Commonwealth v. Nixon*, also upheld the use of *parens patriae* for imposing criminal sanctions on parents for failure to fulfill a legal duty to care for a child.²²⁶ In *Nixon*, two parents were convicted of involuntary manslaughter and endangering the welfare of children after they chose to treat their daughter's sickness by "anointing" her in the church.²²⁷ The daughter fell into a coma and later died of diabetes acidosis; her death could have been prevented if her parents had taken her to the hospital rather than relying entirely on spiritual care.²²⁸ Citing *Prince*,²²⁹ the court stated that the state was well within its right to act as *parens patriae* when it passed legislation creating an affirmative duty for parents to care for their children and make reasonable medical decisions to protect their children.²³⁰ Thus, not only could the state intervene to prevent harm to the child, as seen in *Labrenz*²³¹ and *Willmann*,²³² but the state could also impose sanctions after the fact to punish parents who did not adequately protect their child's best interests.²³³

However, courts will not intervene in all cases in which the child's life is at stake; in *In re Hofbauer v. Hofbauer*, the court refused to allow the state to intervene on behalf of a terminally ill child because the parents' preferred course of treatment had been recommended by a licensed physician.²³⁴ After the child was diagnosed with Hodgkin's disease, doctors in New York recommended that the child undergo radiation or chemotherapy.²³⁵ The parents chose instead to take their son to a clinic that would treat

healing. *Id.* at 272. The son then refused to comply with treatment and continue medication to manage his condition, and the court held that the child was dependent and neglected. *Id.* at 276.

225. *In re Willmann*, 493 N.E.2d at 1390.

226. 761 A.2d 1151, 1153 (Pa. 2000).

227. *Id.* at 1152.

228. *Id.*

229. *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944).

230. *Nixon*, 761 A.2d at 1153.

231. 104 N.E.2d 769, 773 (Ill. 1952).

232. *In re Willmann*, 493 N.E.2d 1380, 1383 (Ohio Ct. App. 1986).

233. *Nixon*, 761 A.2d at 1153.

234. 393 N.E.2d 1009, 1011 (N.Y. 1979).

235. *Id.*

him with nutritional and metabolic therapy.²³⁶ The court held that the parents had not neglected their son because the treatment they chose had been recommended by a licensed physician, even though the course of treatment was not the most widely accepted in the medical community.²³⁷ Thus, the court gave higher deference to the physician than to the state in deciding the case, even though the physician who had provided the treatment was in a very small minority of doctors who would not have recommended the radiation or chemotherapy.²³⁸ The court stressed that complicated medical decisions rarely have truly “right” or “wrong” answers.²³⁹ Given the inherent uncertainty to these complex medical decisions, the state could not simply substitute the parents’ judgment for the decision the court felt was more prudent.²⁴⁰

Further, not all courts have required that the child’s life be in danger before the state can protect the child’s best interests.²⁴¹ In *In re Sampson v. Taylor*, a New York appeals court ordered that a child with a congenital disease that resulted in an overgrowth of tissue on one side of his face undergo corrective surgery.²⁴² The child’s mother was a Jehovah’s Witness who was religiously opposed to the blood transfusions necessary during the procedure, although she did not otherwise object to having the growth surgically removed.²⁴³ While the condition was not fatal, the court stated that the state was justified in intervening to order the surgery, as the procedure was necessary for the child to have “anything resembling a normal

236. *Id.* The son was originally diagnosed in the family’s home state of New York, but the family flew to a clinic in Jamaica for this alternative treatment. *Id.* The suit for neglect was brought against the family after they returned to New York a month later. *Id.*

237. *Id.* at 1014 (“[T]he court’s inquiry should be whether the parents . . . have provided for their child a treatment which is recommended by their physician and which has not been totally rejected by all responsible medical authority.”); see also *In re Matthews*, 650 N.Y.S.2d 373, 378 (N.Y. App. Div. 1996) (holding that a parental decision to refuse a feeding tube for their son was reasonable because it was based on the opinion of a licensed medical professional and did not deprive him of life-sustaining treatment).

238. See *In re Hofbauer v. Hofbauer*, 393 N.E.2d at 1014.

239. *Id.*

240. *Id.* (“Nor can a court assume the role of a surrogate parent and establish as the objective criteria with which to evaluate a parent’s decision its own judgment as to the exact method or degree of medical treatment which should be provided . . .”).

241. *In re Sampson v. Taylor*, 323 N.Y.S.2d 253 (N.Y. App. Div. 1971).

242. *Id.* at 254-55.

243. *Id.* at 255.

life.”²⁴⁴ The court also noted that the operation could not “be performed without substantial risk,” but stated that the child had already been unable to attend school and could not lead a productive life without the surgery.²⁴⁵ In this case, the court placed great importance on the fact that the child’s doctors had recommended surgery, even though the child’s mother disagreed.²⁴⁶ Further, *quality* of life, not the mere *maintenance* of life, was used to justify the surgery even though it was not strictly necessary to save the child’s life.²⁴⁷

Thus, while parents do retain the right to the “care, custody, and control”²⁴⁸ of their children, this right is not inviolable.²⁴⁹ The state, acting as *parens patriae*, can curtail parental rights in those limited circumstances in which state intervention is found to be within the child’s best interest.²⁵⁰ Generally, when parents choose to refuse treatment for religious reasons to the detriment of their child, courts will allow the state to intervene to provide the child with life-saving treatment.²⁵¹ In determining whether to allow the state to intervene in the family decision, courts engage in a careful balancing process, taking into consideration the seriousness of the child’s medical condition; consequences of treatment, including possible risks; and the maturity of the child.²⁵² However, the crux of the analysis revolves around the best interests of the child, which, particularly in the medical context, can be viewed through the lens of the substantive due process right to privacy.²⁵³

IV. CHOOSING GENDER: THE IMPORTANCE OF PRIVACY AND INFORMED CONSENT

While it is often safe to assume that parents will act in their child’s best interest when making medical decisions, this presumption should not extend to cases in which the child’s long term fundamental rights, such as the substantive due process right to

244. *Id.*

245. *Id.*

246. *See id.*

247. *See id.*

248. *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality opinion).

249. *See, e.g., Pickup v. Brown*, 740 F.3d 1208, 1235 (9th Cir. 2014).

250. *See, e.g., id.; Doe v. Christie*, 33 F. Supp. 3d 518, 530 (D.N.J. 2014).

251. *See Nobel*, *supra* note 153, at 640.

252. *Id.* at 636.

253. *See Pickup*, 740 F.3d at 1235; U.S. CONST. amend. XIV.

privacy, are implicated.²⁵⁴ Genital surgery in infancy implicates the child's substantive due process right to privacy by depriving the child of the opportunity to define his or her gender, an aspect of identity that will shape the child's growth and have a continuing impact throughout the child's life.²⁵⁵ Surgery often serves more of a social than a medical purpose, allowing doctors, parents, and society to avoid the discomfort of conceptualizing gender outside of the strict gender binary.²⁵⁶ In order to protect the child's well-being, the states should intervene as *parens patriae* to prevent genital assignment surgery until the child is old enough to meaningfully participate in the decision.²⁵⁷ As recommended by ISNA, states should require that hospitals have available at least one social worker who has training and education regarding intersex conditions.²⁵⁸ The social worker would provide counseling and advice to the parents of a child born with an intersex condition.²⁵⁹ If necessary to resolve disputes, the case can be referred to a hospital ethics board or administrative judge to determine whether genital assignment surgery is in the child's best interest.²⁶⁰ These social workers could rely in part on the 2006 Consensus Statement and advocate for families to refrain from surgery until the child is, at minimum, old enough to understand the procedure.²⁶¹ States have the right to intervene as *parens patriae* in these cases not only because the surgeries affect the child's health and well-being,²⁶² but also because the surgeries have strong implications for the child's fundamental right to privacy. Further, requiring consultation with a professional, and possibly a neutral decisionmaker, states would be intruding only

254. See Bishop, *supra* note 148; Curtis, *supra* note 148.

255. See Rubinfeld, *supra* note 94, at 752-53; Beh & Diamond, *supra* note 49, at 2 (describing interviews with two men who had been assigned female at birth and spent their teen and young adult lives reconstructing their sex through surgery and assuming male gender identities).

256. KESSLER, *supra* note 9, at 31 ("The belief that gender consists of two exclusive types is maintained and perpetuated by the medical community in the face of incontrovertible physical evidence that this is not mandated by biology.").

257. See Alfred L. Snapp & Son, Inc. v. P.R. *ex rel.* Barez, 458 U.S. 592, 600 (1982) (defining state's rights as *parens patriae*).

258. See DREGER, *supra* note 14 (outlining ISNA's proposed treatment model for intersex case management).

259. See *id.*

260. See *id.*

261. See Lee et al., *supra* note 15.

262. Alfred L. Snapp & Son, Inc., 458 U.S. at 607.

minimally on the parent's right to make medical decisions on behalf of the child.²⁶³

A. Long-Term Consequences of Genital Assignment Surgery

The parental right to make decisions about childrearing has remained sacrosanct throughout the years, and it is too deeply embedded in constitutional jurisprudence to be displaced.²⁶⁴ However, state intervention to ensure that children are protected from unwanted genital surgeries would not result in the legislature usurping the parents' power to make choices about the care and well-being of their child.²⁶⁵ In protecting parental rights, the Court has continued to cite *Meyer v. Nebraska*²⁶⁶ and *Pierce v. Society of Sisters*²⁶⁷ for the proposition that parents have a fundamental right to make decisions regarding their children.²⁶⁸ The opinions in both *Meyer* and *Pierce* contained strong language affirming parental rights in childrearing, emphasizing the importance of preventing the state from interfering in the private family realm.²⁶⁹ However, choosing to have a child learn a foreign language before the eighth grade or attend parochial school rather than public school, as was at issue in those cases, is fundamentally different from choosing the child's sex.²⁷⁰ The parental decisions at stake in *Meyer* and *Pierce* affected the children for a finite amount of time, after which the children would be free to continue their education as they saw fit.²⁷¹ In contrast, genital assignment surgery has long-term health consequences for the child,²⁷² and many children who were operated on at birth report serious negative psychological outcomes from

263. See *Parham v. J.R.*, 442 U.S. 584, 589-91 (1979) (describing administrative decision-making process for involuntary mental institutionalization that balances parental rights against state wishes); see also *supra* Section III.A.

264. See, e.g., *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality opinion).

265. Ryan & Sampen, *supra* note 150.

266. 262 U.S. 390 (1923).

267. 268 U.S. 510 (1925).

268. E.g., *Troxel*, 530 U.S. at 66.

269. See *Meyer*, 262 U.S. at 401 (“[T]he Legislature has attempted materially to interfere . . . with the power of parents to control the education of their own.”); *Pierce*, 268 U.S. at 535 (“The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.”).

270. *Meyer*, 262 U.S. at 400; *Pierce*, 268 U.S. at 534-35.

271. *Meyer*, 262 U.S. at 399; *Pierce*, 268 U.S. at 535.

272. See *supra* note 68 and accompanying text.

having their condition hidden from them throughout their lives.²⁷³ David Reimer, the young boy who John Money used to try and prove that gender could be determined through childrearing and socialization, serves as just one example.²⁷⁴ Thus, while the Court's earlier childrearing decisions focused on cultural and educational choices, consenting to genital reconstruction surgery is fundamentally different in that the parents' decision will continue to impact the child profoundly throughout the child's entire life.²⁷⁵

While parents might believe that a single surgery in infancy will "fix" their child, in reality, many of the surgeries performed in infancy require even further surgery as the child develops.²⁷⁶ Simply, it is difficult, if not impossible, to construct genitals on a one-year-old child that will look and function well when the child begins puberty and again when the child enters adulthood.²⁷⁷ Another consequence that most parents may not consider when consenting to genital surgery on the infant is that the surgery can reduce sensation in the genitals; in fact, adults who reported having the surgery in infancy are more likely than the general population to experience anorgasmia.²⁷⁸ Because of the severe and drastic possible consequences of genital assignment surgery in infancy, the decision to have a child undergo the surgery implicates far more of the child's rights than the decisions at issue in *Meyer*²⁷⁹ and *Pierce*.²⁸⁰ When it comes to genital assignment surgery, parents are not simply "direct[ing] the upbringing and education of children under their

273. Beh & Diamond, *supra* note 49, at 2; KESSLER, *supra* note 9, at 1-4; Bishop, *supra* note 148, at 541; Alyssa Connell Lareau, Note, *Who Decides? Genital-Normalizing Surgery on Intersexed Infants*, 92 GEO. L.J. 129, 133-34 (2003).

274. See *supra* Section I.B. While he was not born with an intersex condition, David Reimer's assignment surgery under the direction of John Money is perhaps the most vivid example of the possible long-term consequences of genital surgery in infancy and the concealment-centered treatment model. See *supra* Section I.B.

275. See Beh & Diamond, *supra* note 49, at 2.

276. Alizai et al., *supra* note 38, at 1590; Creighton, Minto & Steele, *supra* note 68, at 125.

277. See Alizai et al., *supra* note 38 (discussing the physical complications that arise throughout life for children who were assigned female at birth and needed further surgery in adolescence).

278. Minto et al., *supra* note 68, at 1256. "Anorgasmia" is the inability to achieve orgasm. Cindy M. Meston et al., *Disorders of Orgasm in Women*, 1 J. SEXUAL MED. 66, 67 (2004).

279. *Meyer v. Nebraska*, 262 U.S. 390, 400 (1923).

280. *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 534-35 (1925).

control.”²⁸¹ Rather, they are making a virtually irreversible decision that will impact the child every day for the rest of his or her life and will play a central role in shaping the child’s identity.²⁸² Genital assignment surgery is not simply a parenting decision, and removing the decision from the sole discretion of the parents promotes the child’s right to future self-determination as described within the Court’s privacy jurisprudence.²⁸³ The state is well within its rights to intervene in a limited way to ensure that these surgeries, at the very least, are well-considered and subject to neutral determination before the child’s life is irreversibly altered.²⁸⁴

B. Successful Mediation Between the Parent and the State

Parham v. J.R. illustrates a statutory framework under which the state can, acting as *parens patriae*, create procedures in hospitals to prevent uninformed, cosmetic genital surgeries on infants by requiring the decision to be independently approved by a professional trained to act in the child’s best interests.²⁸⁵ In *Parham*, parents had a statutory right to have their children involuntarily institutionalized if the parents could not treat or care for a child with a mental illness.²⁸⁶ However, the statute required hospital staff to develop procedures to evaluate each child after the parent had the child committed, thus ensuring that children were not needlessly institutionalized.²⁸⁷ After the parent checked the child into the hospital, several levels of administration in the facility reviewed the decision.²⁸⁸ In one hospital, children were interviewed three times by members of the admission team before being received into

281. *Id.*

282. *See, e.g.,* Rubinfeld, *supra* note 94, at 753 (defining “personhood” and discussing the intersection between privacy and self-determination).

283. *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992) (plurality opinion) (discussing fundamental questions of identity that the right to privacy implicitly protects).

284. *See supra* note 263 and accompanying text.

285. *See* 442 U.S. 584, 592-93 (1979) (detailing procedural safeguards in place under a Georgia statute allowing parents to institutionalize their minor children involuntarily).

286. *See id.* at 602.

287. *See id.* at 591.

288. *Id.* at 590-96. While the statute established minimum procedural safeguards, each individual facility was free to develop its own procedure that would comply with the statute. *Id.* at 591.

treatment.²⁸⁹ In another, each child had to first be evaluated by a separate mental-health clinic and recommended to the hospital for treatment, after which hospital and clinic staff would consult with each other to determine whether the child should be admitted.²⁹⁰ Once the hospitals complied with the most basic guidelines set forth in the statute, the different institutions were able to develop individual procedures for admission that would best fit the facility.²⁹¹ Before children could be deprived of their fundamental liberty interest under the Fourteenth Amendment's Due Process Clause, the state took multiple steps to ensure that the decision to institutionalize the child was in the child's best interest.²⁹²

While the *Parham* case provides an illustration of the power parents hold over their children, it is also a salient example of how the state and the parent can exercise their rights in tandem to the benefit of the child.²⁹³ The children's rights at stake in *Parham* were protected as a matter of procedural due process,²⁹⁴ but when the right at issue concerns traits as personal and fundamental as sex, gender, and bodily integrity, the state would be justified in intervening on the basis of the substantive due process right to privacy.²⁹⁵ The Court has a history of allowing the state to intervene on substantive grounds to both establish and protect substantive due process rights.²⁹⁶ Like the procedural requirements for commitment in *Parham*, state legislatures must develop minimum requirements for hospitals to meet when informing new parents of their child's intersex condition and discussing the ongoing course of treatment.²⁹⁷ Such a law would effectively do away with the concealment-based method of intersex case management,²⁹⁸ instead allowing parents to understand their

289. *Id.* at 590. The statute in question also allowed for the child who had spent at least five days in the institution to be discharged upon request of a parent or guardian. *Id.* at 591.

290. *Id.* at 592.

291. *Id.* at 591.

292. *See id.* at 590-96.

293. *See id.* at 604 ("Parents in Georgia in no sense have an absolute right to commit their children to state mental hospitals; the statute requires the superintendent of each regional hospital to exercise independent judgment as to the child's need for confinement.").

294. *Id.* at 600; *see also* U.S. CONST. amend. XIV.

295. *See generally* *Griswold v. Connecticut*, 381 U.S. 479 (1965) (establishing a substantive due process right to privacy).

296. *See supra* Part III.

297. *Griswold*, 381 U.S. at 531 (Stewart, J., dissenting).

298. *See GERMON, supra* note 28, at 36; *see also supra* Section I.B.

child's medical condition and avoid any adverse psychological impact that the concealment-based model has traditionally caused.²⁹⁹

Throughout the *Parham* opinion, the Court emphasized that a parent's right to have a child involuntarily committed was in part predicated on the fact that the parent was the best judge of whether the medical decision was in the child's best interest.³⁰⁰ However, evidence suggests that this justification does not hold true in the context of genital surgery for children with intersex conditions.³⁰¹ Physicians report that they believe surgery is necessary for the parent to be able to bond with their child,³⁰² and the American Pediatric Association's perspective on intersex treatment tends to support this view by referring to intersex conditions as "social emergencies" rather than medical ones.³⁰³ Regardless, parental discomfort with a child's intersex condition should not be sufficient to support the decision to consent to life-altering sex assignment surgery,³⁰⁴ particularly given the medical problem commonly arising from these surgeries³⁰⁵ and the growing movement to change the standard of care for children born with intersex conditions.³⁰⁶ Creating additional statutory procedures to keep parents well-informed about intersex conditions would serve as the same type of check the hospital administrators performed on parental decisions in *Parham*.³⁰⁷ A third party could also provide a more objective view of the child and the duties the parent will undertake to raise the child without framing the

299. KESSLER, *supra* note 9, at 32.

300. See *Parham v. J.R.*, 442 U.S. 584, 604 (1979).

301. See KESSLER, *supra* note 9, at 21.

302. See *id.* at 32. Kessler's interviews with various endocrinologists who work in intersex case management revealed that many of the doctors advised the parents to not refer to the child by pronouns at all until gender could be surgically assigned. *Id.* Parents were also told to deflect questions about the child's gender when asked by friends and family, and instead to explain that the child was "having problems" that prevent them from announcing the gender just yet. *Id.* at 21-22. However, one endocrinologist admitted that he did not think it was possible for a parent to truly think of their child as genderless until surgery was performed: This admission suggests that parental discomfort is likely, regardless of whether genital surgery is performed in infancy. See *id.* at 21.

303. See *Developmental Anomalies*, *supra* note 65, at 138.

304. See KESSLER, *supra* note 9, at 32 (noting that physicians worry that parents will not be able to form emotional bonds with a child with an intersex condition who has not undergone genital assignment surgery).

305. See *supra* note 68; *supra* Part I.

306. See Lee et al., *supra* note 15 (describing recommended changes to intersex case management adopted in the Consensus Statement).

307. *Parham v. J.R.*, 442 U.S. 584, 591 (1979).

discussion in the more clinical terms parents would expect to hear from a doctor.³⁰⁸ In its proposed treatment method for children born with intersex conditions, ISNA suggests that parents be given the opportunity to speak directly with adults who were born with intersex conditions.³⁰⁹ Meeting with adults with intersex conditions would allow parents to hear a first-hand perspective regarding the benefits and harms of postponing surgery.³¹⁰ Even the change in tone, from that of a doctor to that of a social worker, could put new parents more at ease.³¹¹

As seen in cases involving a parent's religious objection to life-saving medical treatment for a child, many hospitals already have counselors and social workers on staff to ensure that children receive necessary medical care notwithstanding parental objections.³¹² One illustrative example is *People ex rel. Wallace v. Labrenz*, in which a hospital assigned a child to a legal guardian after her parents refused to consent to a life-saving blood transfusion.³¹³ Refusing to allow the child to receive treatment was tantamount to neglect, and the state was justified in acting as *parens patriae* to remove the child from her parent's custody and have her undergo the blood transfusion.³¹⁴ The parents' fundamental right to make decisions regarding the "care, custody, and control"³¹⁵ of their child could not outweigh the value of the child's life and the state's interest in protecting it.³¹⁶ So too is the rationale with genital reconstruction surgeries for children born with intersex conditions: Gender will affect a child's day-to-day interactions and activities for the child's entire life, and it does not serve the child's interest for parents to consent to surgery without the child granting any form of meaningful consent.³¹⁷ Compared to the Court's history in developing privacy law, invasive genital surgeries implicate the same concerns regarding self-determination and

308. See FAUSTO-STERLING, *supra* note 2, at 64.

309. See DREGER, *supra* note 14.

310. See *id.*

311. See FAUSTO-STERLING, *supra* note 2, at 64.

312. See *supra* Section III.C (describing court intervention to permit treatment over parents' religious objections).

313. 104 N.E.2d 769, 771, 773 (Ill. 1952).

314. *Id.* at 773.

315. *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality opinion).

316. See *Labrenz*, 104 N.E.2d at 773.

317. See FAUSTO-STERLING, *supra* note 2, at 85-87 (describing adverse physical and psychological outcomes for intersex individuals who were treated under the concealment-based method of intersex case management).

personhood as the decisions in *Roe*,³¹⁸ *Bellotti*,³¹⁹ and *Carey*.³²⁰ Just as privacy rights were at issue in those and other cases, particularly for minors, so too is the right to privacy implicated when a child is deprived of the right to choose to undergo an invasive surgery that will impact the entirety of the child's life.³²¹

While the medical consequences of the parents' actions in *People ex rel. Wallace v. Labrenz* were more drastic than those presented in the average intersex case management scenario, the state was nonetheless acting as *parens patriae* to prevent parents from making irreversible decisions that would fundamentally impact the child's entire life without the child's consent.³²² Further, at least one court has allowed the state to authorize a medical procedure over the parents' objection even though the child's illness, an outgrowth of facial tissue, was not fatal.³²³ The New York Appellate Division in *In re Sampson* found that the state could intervene and order a nonfatal medical procedure for a child against the parents' wishes.³²⁴ In placing a strong emphasis on allowing the child to live a "normal life," the court's decision illustrates that the state may serve a child's best interests by intervening to protect the child's external identity.³²⁵ Indeed, the value of living a life without a debilitating condition is much the same as the value of living a life free from multiple invasive surgeries over a long period of time.³²⁶

An individual's identity and sense of self is as much intertwined with personal conception of gender and sex as it is with the outward appearance the person presents to the world.³²⁷ Gender plays a fundamental role in how children socialize; interact in the

318. See *Roe v. Wade*, 410 U.S. 113, 153 (1973).

319. See *Bellotti v. Baird*, 443 U.S. 622 (1979).

320. See *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977).

321. See *supra* Section II.B (discussing the right to privacy as applied to minors seeking abortions).

322. See *supra* Section II.B; see also Nobel, *supra* note 153, at 652; Lareau, *supra* note 273.

323. *In re Sampson v. Taylor*, 323 N.Y.S.2d 253, 254-55 (N.Y. App. Div. 1971).

324. See *id.* (ordering that a tissue overgrowth be surgically removed from the child's face in contravention of the mother's religious objections to blood transfusions).

325. See *id.* at 255.

326. See *id.*

327. See GERMON, *supra* note 28, at 66-67. See generally JUDITH BUTLER, *GENDER TROUBLE* (1990).

world; and are viewed by friends, family, and future colleagues.³²⁸ For better or worse, the gender binary has a strong influence on daily life.³²⁹ Children who are erroneously assigned gender at birth must then navigate the complex waters of gender expression or reassignment later in life, and much of the associated confusion could be avoided by simply postponing surgery until the child has formed a more complete gender identity and sense of self.³³⁰ State intervention in cases such as *Labrenz* and *In re Sampson* indicate that parents do not always have sole discretion to make life-altering medical decisions for their children,³³¹ and this principle should extend to genital assignment surgery for intersex case management.

The California and New Jersey laws³³² prohibiting conversion therapy for children under the age of eighteen serve as another example of the state acting as *parens patriae* to protect the child's right to self-determination.³³³ These statutes are relevant to the analysis of intersex case management not only because they limit a parent's right to make treatment decisions for a child,³³⁴ but also because conversion therapy involves another central aspect of an individual's identity: sexual orientation.³³⁵ State intervention in these cases indicates that not only does the state have a right to intervene as *parens patriae* to protect a child's physical well-being, but also to protect the child from the psychological harm that comes from attempting to alter a fundamental part of identity.³³⁶ In the case of

328. See Carolyn Jackson & Jo Warin, *The Importance of Gender As an Aspect of Identity at Key Transition Points in Compulsory Education*, 26 BRIT. EDU. RES. J. 375, 379 (2000).

329. See *id.* (“[T]he self-concept [of gender] itself becomes assimilated to the gender schema; that is to say that judgements about the self are strongly associated with judgements about gender.”).

330. See *supra* note 79 (explaining ISNA's proposed framework for allowing children to participate in determining their gender before undergoing any surgery).

331. See *People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769, 773 (Ill. 1952); *In re Sampson*, 323 N.Y.S.2d at 254-55.

332. CAL. BUS. & PROF. CODE § 865.1 (West 2013); N.J. STAT. ANN. § 45:1-55 (West 2013).

333. Cf. *In re Sampson*, 323 N.Y.S.2d at 255.

334. See CAL. BUS. & PROF. CODE § 865.1 (prohibiting mental-health providers from performing conversion therapy on minors); N.J. STAT. ANN. § 45:1-55 (same).

335. See Juliet Richters, *Understanding Sexual Orientation: A Plea for Clarity*, 6 REPROD. HEALTH MATTERS 144, 145 (1998).

336. See 2012 Cal. Stat. 6569-71 (citing research from numerous professional organizations condemning conversion therapy as causing depression, substance abuse, self-harm, and other emotional problems).

genital assignment surgery, both the child's physical and psychological well-being are put at risk when the child is operated on, without consent, at birth.³³⁷

Conversion therapy, much like cosmetic genital surgery, is an elective process, often initiated by the minor's parent, that is not necessary to the child's survival but allows the parent and society at large to place the child within comfortable societal bounds.³³⁸ In reviewing the California ban on conversion therapy, the Ninth Circuit held that the state did not violate fundamental parental rights by prohibiting parents from placing their children in therapy that ultimately does more harm than good.³³⁹ Based on the numerous studies detailing the long-term physical and psychological effects of infant genital surgery,³⁴⁰ states could reasonably determine that these surgeries are more likely to harm, rather than help, the child.³⁴¹ In making the reasonable determination based on the available evidence, states would be well within their power to act as *parens patriae* by imposing administrative restraints and restricting genital surgeries to only those situations in which they are medically necessary.³⁴²

C. Privacy As an Existing Basis for Intersex Rights

The substantive due process right to privacy is an amorphous, "penumbral" right that has not been clearly defined by the Court.³⁴³ However, the Court has stated that implicit in the right to privacy are several fundamental aspects of identity and self-determination that cannot be abridged by the state.³⁴⁴ One clear trend that has arisen in

337. See KESSLER, *supra* note 9, at 21.

338. See *id.* (implying that the goal of conversion therapy is to "cure" homosexuality); *supra* note 302 (describing interviews with endocrinologists who stated that early genital assignment surgery helps parents feel more comfortable with their child).

339. *Pickup v. Brown*, 740 F.3d 1208, 1236 (9th Cir. 2014).

340. See *supra* note 68 (listing several studies regarding the harmful effects of surgery and the probability that surgery in infancy will be unsuccessful as the child enters puberty and adulthood).

341. See *Pickup*, 740 F.3d at 1236 (stating that the state can ban mental-health practices it has reasonably found to be harmful to minors).

342. See *id.*; *Doe v. Christie*, 33 F. Supp. 3d 518, 530 (D.N.J. 2014) (upholding on similar grounds the conversion therapy ban in New Jersey).

343. See *Griswold v. Connecticut*, 381 U.S. 479, 484-85 (1965).

344. See, e.g., *Lawrence v. Texas*, 539 U.S. 558, 562 (2003) (defining liberty to include freedom of thought and belief); *Planned Parenthood of Se. Pa. v. Casey*,

privacy cases is the focus on intimacy, forming a family, and procreating as among the parts of human life and identity that are so central to human identity as to be inviolate.³⁴⁵ As seen in *Carey v. Population Services International*³⁴⁶ and *Bellotti v. Baird*,³⁴⁷ these rights are extended to minors.

The Court's privacy jurisprudence, particularly as it pertains to minors through abortion and contraceptive rights, further emphasizes self-determination as central to the substantive due process right to privacy.³⁴⁸ In *Bellotti v. Baird*, the Court reasoned that the consequences of having a child, particularly at a young age, coupled with the time-sensitive nature of choosing to terminate a pregnancy, made it necessary for states to allow minors to go through a judicial bypass procedure to obtain an abortion without notifying a parent.³⁴⁹ The Court noted that a pregnant minor usually cannot avoid confrontation with her parents by waiting until she reached the age of majority before obtaining an abortion.³⁵⁰ The gravity of the decision could result in the minor not feeling ready or able to speak to a parent about the decision, and in those cases, the minor would often benefit more from terminating the pregnancy than from carrying the child to term.³⁵¹ The underage abortion cases illustrate the fundamental importance of self-determination when making medical decisions that will affect an individual's entire life,³⁵² even minors should be granted deference in making decisions that will impact the minor's life for decades to come.³⁵³

Supporters of the surgical model for intersex case management would argue, rightly, that there is a significant difference between a pregnant teenager and a newborn infant in terms of competence to

505 U.S. 833, 851 (1992) (plurality opinion) (defining liberty to include "personal dignity and autonomy").

345. See *supra* note 98 (discussing cases discussing the right to privacy as applied to sexual conduct, marriage, abortion, contraception, and reproduction).

346. 431 U.S. 678 (1977) (stating the right to privacy protects minors' access to contraception).

347. 443 U.S. 622 (1979) (mandating judicial bypass procedures so that minors are not required to notify their parents in all circumstances before obtaining an abortion).

348. See *Planned Parenthood*, 505 U.S. at 851; *Baird*, 443 U.S. at 643.

349. *Baird*, 443 U.S. at 642.

350. *Id.*

351. *Id.*

352. See *supra* Section II.B.

353. *Baird*, 443 U.S. at 642.

make complex medical decisions.³⁵⁴ While this is true, the distinction misses the mark. The Court emphasized in *Bellotti* that minors must have some avenue to bypass parental consent because if the child had legitimate concerns about her parents learning of the pregnancy, she did not have the option of waiting until adulthood to obtain the abortion.³⁵⁵ In this context, the self-determination concerns that undergird the privacy doctrine become relevant at a much faster pace.³⁵⁶ A pregnant minor only has a few months to decide whether to assume the identity of a mother, as well as the responsibilities that accompany that identity.³⁵⁷

Genital surgery for intersex children differs from the decision to terminate a pregnancy in that, in most cases, whether to undergo the surgery is not a time-sensitive issue.³⁵⁸ However, just as becoming a parent has “grave and indelible” consequences for a minor,³⁵⁹ so too does irreversible cosmetic surgery undergone before the child has had the opportunity to explore his or her gender identity.³⁶⁰ The decision in *Baird* evinces a larger principle that some minors are mature enough to make life-altering decisions about their sexuality and reproductive health.³⁶¹ Intersex case management, in most cases, is not under the same time pressure that the Court identified in *Baird*, which is all the more reason to cease infant genital surgeries until such time as the child can meaningfully participate in the decision.³⁶² Genital assignment surgeries implicate the same privacy rights and concerns as abortion, but the time aspect simply works in reverse: Rather than it being important to resolve the issue quickly, it is important to wait to undergo surgery until the child is old enough to give informed consent.³⁶³

Finally, setting aside the practicalities of postponing surgeries that are purely cosmetic, the effect of gender on identity and self-

354. See *id.* at 643-44 (discussing the “mature minor” doctrine in the context of judicial bypass, while emphasizing the emotional maturity and stability of the minor making the abortion decision).

355. See *id.* at 642-44.

356. See *id.* at 642; Rubinfeld, *supra* note 94, at 752-54 (discussing self-determination and personhood as it relates to privacy law).

357. See *Baird*, 443 U.S. at 642.

358. Beh & Diamond, *supra* note 49, at 43-44.

359. *Baird*, 443 U.S. at 642.

360. See GERMON, *supra* note 28, at 36.

361. See Rubinfeld, *supra* note 94, at 753; *Baird*, 443 U.S. at 642-43, 650.

362. Cf. GERMON, *supra* note 28, at 36-37. But see KESSLER, *supra* note 9, at 31-32.

363. See GERMON, *supra* note 28, at 36-37; *Baird*, 443 U.S. at 642.

determination cannot be understated.³⁶⁴ Every person navigates through the world and interacts with others within a larger cultural milieu that places heavy emphasis on the gender binary and the behaviors associated with each pole.³⁶⁵ Gender is implicated to some degree in the “personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education” that Justice O’Connor identified as inherently protected under the constitutional right to privacy.³⁶⁶ It would be anomalous to argue that a personal characteristic underlying nearly every aspect of individual life does not deserve the same protections afforded to decisions such as whether to procreate.³⁶⁷ For this reason, the state would be well within its rights to intervene as *parens patriae* to protect children born with intersex conditions from having their gender decided for them, without their consent, and before they can even understand what they are losing. Mandated social workers and the possibility of referral to a neutral decisionmaker in cases of disagreement are very minor procedural protections and obstacles when compared to the interests at stake for the child born with an intersex condition.

CONCLUSION

As an area of law that has not been well addressed by American courts, intersex case management presents unique questions about privacy, self-definition, and the interplay of parental and state interests in protecting the health and safety of children.³⁶⁸ Intersex activists recognize the harm that could result from raising children with intersex conditions to view themselves as “outside” of societal norms.³⁶⁹ However, gender does not have to correspond with physical sex, particularly when an intersex individual can simply choose to undergo surgery later in life, rather than risk the complications of surgery in infancy.³⁷⁰ For this reason, the state, exercising its power as *parens patriae*, can prevent parents from

364. See Jackson & Warin, *supra* note 328 (discussing the influence of gender on children as they progress through school and develop life skills).

365. See *id.*; *supra* note 12 and accompanying text (discussing and defining the gender binary).

366. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) (plurality opinion).

367. See, e.g., *Baird*, 443 U.S. 622; *Roe v. Wade*, 410 U.S. 113 (1973).

368. White, *supra* note 16, at 788.

369. See *id.*

370. See *id.*; see also *supra* note 68 (discussing common complications associated with genital assignment surgery in infancy).

making the decision on behalf of their children because surgical assignment at birth is ultimately more harmful to the child than helpful.³⁷¹ By imposing two simple procedural requirements preceding all intersex genital reconstruction surgeries, consultation with a social worker and possible review by a neutral decisionmaker, the state would protect the rights of many children while imposing minimal burden on hospitals and parents.

While there are likely many legal avenues through which intersex activists could attempt to reform the current method of treating intersex conditions through genital surgery in infancy, allowing the state to invoke *parens patriae* to prevent medically unnecessary surgeries can, if used effectively, mediate the tensions between state and parental power.³⁷² The state has a particular interest in actively taking steps to protect intersex children from these surgeries, given the many implications gender carries for the substantive due process right to privacy.³⁷³ Ultimately, social workers or other state officials can combat the stigma associated with intersex conditions through educating medical professionals and parents about the conditions and the possible long-term consequences of early surgical intervention.³⁷⁴ Neutral decisionmakers would assure that the parents' concerns are heard and considered before any surgery is performed, while also ensuring that everyone involved in the process is informed about the consequences of intersex genital reconstruction surgeries.³⁷⁵ Until then, children born with intersex conditions will continue to suffer as a result of misinformation and fundamental misunderstanding of gender, sex, and the gender binary in the medical community and society at large.

371. See *supra* Section I.B.

372. See *supra* Part IV.

373. See *supra* Section IV.C.

374. See *supra* Part IV.

375. See *supra* Part IV.

