

FIXED AT BIRTH: MEDICAL AND LEGAL ERASURES OF INTERSEX VARIATIONS

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I INTRODUCTION

The term ‘intersex’¹ describes variations in sex development whereby a person’s biological sex traits are not exclusively male or female. Intersex variations occur in many species, including humans. Intersex variations are always congenital, but their aetiology varies greatly, as does the impact on an individual’s anatomy. There are a great number of different circumstances which may result in a person being born with intersex variations.² Many variations are apparent at birth – often because the genitals do not present as unambiguously male or female. When that occurs, the medical establishment marshals its forces to provide a range of medical interventions aimed at assigning the child to a particular sex and bolstering that assignment. How law and medicine respond to intersex provides insight into our cultural, political and social constructions of sex and the ‘natural’ body. The very existence of anomalous bodies challenges the security of the natural status of binary sex. Literature over the centuries

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- 1 In this article I have generally adopted the term ‘intersex’ or ‘variations of sex development’. Much of the medical literature endorses the term ‘Disorders of Sex Development’ (‘DSD’). Both DSD and intersex are controversial, as each is criticised as pathologising and derogatory, though there is little evidence to support that contention regarding the term ‘intersex’. In Australia, intersex activists have adopted the term ‘intersex’ and condemned ‘DSD’. See the discussion on terminology in Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia* (2013) 21–7 [2.2]–[2.19]. In the discussion on historical attitudes to intersex variations I have adopted the term ‘hermaphrodite’ as consistent with contemporary usage. See also Organisation Intersex International Australia, *Style Guide: On Intersex and Terminology* (11 June 2009) <<https://oii.org.au/style/>>.
- 2 A clear and informative outline of some of these variations is provided in Senate Community Affairs References Committee, above n 1, 1–13 [1.6]–[1.49].

reflects profound unease with the possibilities of gender fluidity, transformation and ambiguity that the intersex body poses. Epstein describes the tension inherent in the ‘vexed relation between scientific recognition of hermaphroditism as a natural biological possibility and cultural investments in sexual difference as an absolute and invariable binary opposition’.³

This article will interrogate the legal and medical regulation of intersex people, focusing on the legal status of intersex people and issues of consent to medical interventions performed on minors with intersex variations under Australian law. While American scholarship on both the medical and legal constructs of intersex is relatively well developed,⁴ very little has been written with a focus on Australian law. In relation to consent to medical intervention on intersex children, Australia is unique in having a special medical jurisdiction exercised by the Family Court which is responsible for monitoring and regulating non-therapeutic and contested medical and surgical interventions on minors. Thus there is immense scope for judicial oversight of medical and surgical interventions on intersex minors in the Australian legal context. This article argues that this role has not been utilised effectively in relation to intersex and that the issue is under-researched within legal scholarship. This article seeks to address that gap.

The legal response to gender diversity has attracted scholarship in Australia, as in other jurisdictions. However, this has largely emerged from issues around defining the gender of transgender and transsexual people, with little attention to the unique perspective of intersex. As noted by Organisation Intersex International Australia (‘OII Australia’): ‘Intersex, trans, and same sex attraction are distinct concepts and issues, and people with intersex variations face distinct health and human rights issues’.⁵ Currently the most important sources of information and critical scholarship around intersex variations in the Australian context have been generated by advocacy organisations such as OII Australia, Androgen Insensitivity Syndrome Support Group Australia and the National Lesbian Gay Bisexual Transsexual Intersex Health Alliance (‘National LGBTI Health Alliance’).

This article brings a unique perspective to issues of gender diversity in the law and to legal constructs of intersex by offering a critical analysis of the

3 Julia Epstein, ‘Either/Or – Neither/Both: Sexual Ambiguity and the Ideology of Gender’ (1990) 7 *Genders* 99, 101.

4 See, eg, Katrina Karkazis, *Fixing Sex: Intersex, Medical Authority, and Lived Experience* (Duke University Press, 2008); Julie A Greenberg, *Intersexuality and the Law: Why Sex Matters* (New York University Press, 2012); Symposium, ‘Intersex Education, Advocacy & the Law’ (2005) 12 *Cardozo Journal of Law & Gender* 1; Anne Fausto-Sterling, *Sex/Gender: Biology in a Social World* (Routledge, 2012); Hazel Glenn Beh and Milton Diamond, ‘An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?’ (2000) 7 *Michigan Journal of Gender & Law* 1; Samantha S Uslan, ‘What Parents Don’t Know: Informed Consent, Marriage, and Genital-Normalising Surgery on Intersex Children’ (2010) 85 *Indiana Law Journal* 301; Darra L Clark Hoffman, ‘Male, Female and Other: How Science, Medicine and Law Treat the Intersexed, and the Implications for Sex-Dependant Law’ (2012) 21 *Tulane Journal of Law & Sexuality* 1.

5 Admin, *Basic Differences between Intersex and Trans* (3 June 2011) Organisation Intersex International Australia <<https://oii.org.au/18194/differences-intersex-trans/>>.

interwoven medical and legal responses to intersex. The focus of medical and legal responses to intersex variations has been the erasure and eradication of ambiguity which threatens to undercut the reliability of established dichotomies of sex, gender and sexuality. Reviewing historical attitudes to intersex reminds us that cultural investment in the sexed body drives not only religious, social, legal and political understanding, but scientific and medical constructs too.

II MEDICAL CONSTRUCTIONS OF INTERSEX

A Historical Approaches

Writings from antiquity and the Middle Ages categorised hermaphrodites as supernatural beings, monstrous and existing outside the realms of civil society.⁶ However, perceptions of hermaphroditism have never been uniformly schematised. As Daston and Park comment, '[t]he early modern literature on hermaphrodites is veined with fault lines that run along many different axes'.⁷ Two primary conceptions of the nature of hermaphroditism were available from antiquity. One concept, associated with Hippocrates and Galen, viewed sex as a continuum or spectrum, with male and female at opposite poles and hermaphrodites falling in the middle, beings of intermediate sex. The other model of sex, associated with Aristotle, was dichotomous. Hermaphroditism was a condition localised in the genitals and was superficial and apparent rather than representing somatic ambiguity in the organism as a whole.⁸ Daston and Park write that: 'Hippocratic and Aristotelian interpretations wove their way through medieval and early modern medicine and natural philosophy, sometimes in counterpoint, more often in uneasy synthesis'.⁹

The implications of each model are far-reaching. The Aristotelian model retains the binary construction of sex as natural and inevitable, with hermaphroditic bodies requiring investigation to uncover the 'true sex' beneath the apparent ambiguity. The Hippocratic model is more morally and sexually charged, as hermaphrodites represent liminality, fostering uncertainty and corrosive doubt about the naturalised categories of sex. The ambiguous body generates social anxiety, particularly when the naturalised status of categories and classifications is under threat from other sources. For example, Reis' research shows that in the United States, the hermaphrodite not only threatened the sex binary, but also replicated and echoed anxieties about racial identity that were prevalent in the late 19th century.¹⁰ Early cosmetic surgery tropes focus on

6 Epstein, above n 3, 107–13; George Androustos, 'Hermaphroditism in Greek and Roman Antiquity' (2006) 5 *Hormones* 214.

7 Lorraine Daston and Katharine Park, 'The Hermaphrodite and the Orders of Nature: Sexual Ambiguity in Early Modern France' (1995) 1 *GLQ: A Journal of Lesbian and Gay Studies* 419, 420.

8 Ibid 421.

9 Ibid 422.

10 Elizabeth Reis, 'Impossible Hermaphrodites: Intersex in America, 1620–1960' (2005) 92 *The Journal of American History* 411, 429; Karkazis, above n 4, 34.

the capacity of cosmetic surgery to mask racialised facial features (Irish pug nose, Jewish hook nose, African flat nose etc). This was a selling point which simultaneously generated anxiety about the capacity of inferior races to pass as white.¹¹ Anxiety generated by hermaphroditism also echoed waves of concern about the rise of homosexuality and ‘deviant’ sexual behaviour.¹² If a person was truly female but they had ambiguous genitals, such as an enlarged clitoris that looked like a penis, then there was a real possibility that they might engage in homosexual activity if their status was not discovered and disclosed. In both models, the indeterminacy of a hermaphrodite’s sex raised the spectre of fraudulence, deceit and passing.

Although at a theoretical level the two models are incommensurate, in practice they manifested in similar ways. For example, the Hippocratic model tended to manifest in a search for ‘predominant’ sex. Hermaphrodites were beings whose combination of male and female lay so close to the centre that it could be difficult to assign them to one role or the other. The necessary response was to determine which sex predominated. This could be done by examining both anatomy and physiology, but also by assessing demeanour, behaviour, sexual attraction and so on. The factors that we would describe as cultural, social or individual were regarded as essential and fixed. It seems that the Hippocratic approach was in some ways more flexible. For example, if a predominant sex could not be identified, then very often the attitude was to allow the hermaphrodite to decide whether they were male or female.¹³

The Aristotelian model required a determination of the underlying truth of the sex of the body. In practice, though, investigations frequently ended in a compromise deriving from an assessment of the predominant sex, as organs or biological features identified as reliable markers of the true sex were either indeterminate or inscrutable. For example, an orthodoxy of Victorian medicine was that the gonads were the reliable guide to true sex, but until there were reliable and accessible anaesthetics, exploratory surgery was not possible, so that a proper determination could only be made post-mortem. The medical investigator sometimes had to make an educated guess.¹⁴ External examination could yield some indication. This could be supplemented by looking at secondary sex traits, such as hair growth, breast development, voice timbre, demeanour, personality (chaste and humble or outspoken and forthright), friendships (which

11 Sander L Gilman, *Making the Body Beautiful: A Cultural History of Aesthetic Surgery* (Princeton University Press, 1999) 85–118.

12 Christina Matta, ‘Ambiguous Bodies and Deviant Sexualities: Hermaphrodites, Homosexuality, and Surgery in the United States, 1850–1904’ (2005) 48 *Perspectives in Biology and Medicine* 74.

13 Though this attitude was not uniform or without tensions and conflicts. See, eg, the contrasting discussions in Michel Foucault, ‘Introduction’ in Herculine Barbin, *Herculine Barbin: Being the Recently Discovered Memoirs of a Nineteenth-Century Hermaphrodite* (Richard McDougall trans, Harvester Press, 1980) vii–xvii [trans of: *Herculine Barbin, dite Alexina B* (first published 1978)]; Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Harvard University Press, 1990) 124, 135–42; Daston and Park, above n 7, 428.

14 Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* (Harvard University Press, 2000).

were assumed would be with people of the same sex) and sexual attractions (which were assumed to be heterosexual).

The perception of hermaphrodites as supernatural or miraculous/monstrous in the early modern period gradually yielded to a biomedical approach which 'normalised' intersex in the sense of identifying the biological processes which produced variations of sex development.¹⁵ This normalisation was simultaneously pathologising.¹⁶ As a variation of normal, these biological processes transgress 'correct' development and produce defective bodies. This perception of intersex as a biological defect rather than a naturally occurring biological variation persists within medical discourse.¹⁷ Intersex is conceived as a mutation which produces inherently defective bodies.¹⁸ Eckert argues that shifting attitudes to hermaphroditism/intersex describes a shift 'from the notion of the *right sex* to *true sex* to *best sex*'.¹⁹

In the late 19th century, when medical science began asserting jurisdiction over the body and the medical profession constituted its professional authority,²⁰ medical men²¹ in England, France and the United States were investigating, documenting and defining sex, searching for the incontrovertible markers of 'true sex'.²² There was no promise of a cure for anomalous anatomy. The role of the medical authority was to make the patient aware of their true sex and changes in dress, behaviour, relationships and social, legal, personal and political status would follow naturally and as a matter of course. In the later 19th century, a consensus emerged that the reliable marker of true sex was gonadal.²³ In keeping with the Aristotelian model, it was believed that, although people may present as sexually ambiguous, very few were 'true' hermaphrodites – with both male and female gonadal tissue.²⁴ This was considered to be vanishingly rare and most apparent hermaphrodites were, in fact, either truly male or truly female, despite some misleading anatomical evidence to the contrary. Hence, the terminology used was 'pseudo-hermaphrodite' which reflects something of the underlying attitudes of distrust and suspicion that often lurk beneath the surface of the

15 This shift in perception was both piecemeal and gradual, beginning in the 16th century and culminating during the process of medicalisation of intersex in the late 19th century: Epstein, above n 3, 101.

16 Elizabeth Grosz, 'Intolerable Ambiguity: Freaks as/at the Limit' in Rosemarie Garland Thomson (ed), *Freakery: Cultural Spectacles of the Extraordinary Body* (New York University Press, 1996) 55–66, cited in Dreger, *Hermaphrodites and the Medical Invention of Sex*, above n 14, 35.

17 See, eg, Leonard Sax, 'How Common Is Intersex? A Response to Anne Fausto-Sterling' (2002) 39 *The Journal of Sex Research* 174, 177.

18 Daston and Park, above n 7, 425.

19 Christina Annalena Eckert, *The Historicisation of the Hermaphroditic/Intersexed Body: From Medicalisation to De-medicalisation* (MA (Gender History) Thesis, University of Essex, 2003) 4 (emphasis in original).

20 Ivan Waddington, 'The Movement towards the Professionalisation of Medicine' (1990) 301 *British Medical Journal* 688.

21 The leading medical experts on hermaphroditism in this period were, with one exception, male: Dreger, *Hermaphrodites and the Medical Invention of Sex*, above n 14, 10.

22 Ibid; Reis, above n 10; Geertje Mak, 'Doubtful Sex in Civil Law: Nineteenth and Early Twentieth Century Proposals for Ruling Hermaphroditism' (2005) 12 *Cardozo Journal of Law & Gender* 197.

23 Dreger, *Hermaphrodites and the Medical Invention of Sex*, above n 14, 11; Karkazis, above 4, 36.

24 Dreger, *Hermaphrodites and the Medical Invention of Sex*, above n 14, 139.

medical men's reports and recordings of their encounters with the intersexed.²⁵ Some texts reveal anxiety that the hermaphrodite would be able to shift from one sex to another, to slip between the cracks of clear sexual identity and concomitant social role.²⁶

The medical paradigm for intersex underwent gradual change towards the end of the 19th century and into the 20th century as developments in medical science, particularly in the realm of endocrinology and genetics, revealed the underlying complexity of sex development and undermined reliance on a single or straightforward gonadal marker of true sex. According to Redick, during the first half of the 20th century, intersex was dealt with on a case-by-case basis:

during the period from 1916–1955, if a child was born intersexed – with a condition in which hormonal development as male or female is affected in utero, resulting in indeterminate genitalia – doctors would make an approximate sex assignment and then advise parents to wait and see whether contradictions indeed arose during puberty. If contradictions emerged – for example, if at puberty a person raised male grew breasts, or female failed to menstruate – *then* medical counsel would be sought.²⁷

From the mid-1930s, psychology became an increasingly important factor in the diagnosis of true sex.²⁸ Developments in biotechnology such as improved surgical techniques and anaesthesia contributed to a more interventionist approach to intersex variations.²⁹

It was in this context that the dominant medical paradigm for the management of intersex in the latter half of the 20th century emerged, spearheaded by sexologist John Money at the John Hopkins Hospital in the United States, which was the nexus for gender and intersex research in the 20th century.³⁰ This paradigm sought to bring unity and coherence to the 'anarchy of idiosyncrasy'³¹ that had prevailed in preceding decades as the gonadal theory waned in the face of emerging evidence and shifting emphasis.

Money developed a complex theory of gender acquisition which incorporated input and feedback loops involving seven variables including not only biological features, but also cultural, social and psychological factors.³² According to Money's 'optimal gender theory', gender identity is not fixed in human beings, but develops at around the age of two. Up to that age, humans are largely gender neutral. The development of gender identity depends on the complex interplay of variables, but a central determinate is how children are

25 Reiss, above n 10, 426.

26 Ibid.

27 Alison Redick 'What Happened at Hopkins: The Creation of the Intersex Management Protocols' (2005) 12 *Cardozo Journal of Law & Gender* 289, 289–90 (emphasis in original).

28 Ibid 291.

29 Ibid; Karkazis, above n 4, 41–5.

30 Redick, above n 27.

31 John Money's concluding remarks in his PhD: John William Money, *Hermaphroditism: An Inquiry into the Nature of Human Paradox with a Part Two: Ten Case Reports* (PhD thesis, Harvard University, 1952) quoted in *ibid* 290.

32 Redick, above n 27, 290.

reared, as long as the rearing does not clash with the visible anatomy.³³ However, Money did not eschew gender roles. What his theory did promise was a cure for intersex. The combination of relative gender fluidity and surgical innovation meant that intersex children could be literally reshaped into males and females.

Based on this theory, Money and his team constructed comprehensive treatment and management protocols that were not only swiftly implemented into the medical literature, but governed medicalisation of intersex variations for decades and continue to linger in current practices.³⁴ Although Money's early research into the psychosocial impact of intersex biology led him to conclude that non-surgical intersex people coped well,³⁵ the management protocol promised to alleviate the suffering caused by living with the defect of intersex variations. If the Victorian era was the 'Age of the Gonads',³⁶ then the second half of the 20th century could be called the 'Age of the Genitals' or, more specifically, the 'Age of the Penis'. Under Money's treatment protocol the most salient factor for gender assignment of children with intersex variations was whether there was an adequate penis. If there was, then the child could be raised as a boy, and the gender identity could develop normally. If there was no adequate penis, then the child was at risk of developing an unstable gender identity, no matter how unambiguously male their rearing.³⁷ Surgical innovations and technical developments become important, as surgeons could cosmetically fashion a convincing-looking vagina and cut down the clitoris to a 'correct' size for a clitoris. On the other hand, surgeons could not construct a penis that was either convincing-looking or functional. Limits to surgical techniques often dictated the decision on whether to assign a child male or female.³⁸ For this and a variety of other reasons, the majority of children born with ambiguous genitals (whether as a result of an intersex condition or otherwise) were assigned and raised as female under Money's treatment protocol.³⁹ For most of those children, the assignment included surgical 'normalisation' of the genitals involving clitoral reduction and/or vaginoplasty.⁴⁰

33 It should be noted that this summary glosses over many of the complexities and nuances of optimal gender theory: *ibid.*

34 Alice Domurat Dreger, "'Ambiguous Sex': Or Ambivalent Medicine?" (1998) 28(3) *The Hastings Center Report* 24; Karkazis, above n 4, 41–5; Suzanne J Kessler, 'The Medical Construction of Gender: Case Management of Intersexed Infants' (1990) 16 *Signs* 3.

35 Karkazis, above n 4, 49.

36 Dreger, *Hermaphrodites and the Medical Invention of Sex*, above n 14, 11.

37 Australasian Paediatric Endocrine Group, Submission No 88 to Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia*, 27 June 2013, 2.

38 John Money, Joan G Hampson and John L Hampson, 'Imprinting and the Establishment of Gender Role' (1957) 77 *Archives of Neurology and Psychiatry* 333.

39 Dreger, 'Ambiguous Sex', above n 34, 28.

40 Sarah Creighton and Catherine Minto, 'Managing Intersex: Most Vaginal Surgery in Childhood Should Be Deferred' (2001) 323 *British Medical Journal* 1264, 1264.

B Current Protocols and Practices

From around the mid-1990s cracks began to appear in the facade of successful treatment and management of intersex. People with variations of sex development began to challenge the legitimacy, efficacy and ethics of the treatment protocol. Activists who had been among the first generation to be treated under Money's protocol protested the damage and mutilation that had been inflicted on them in the name of medical therapy.⁴¹ A number of support groups for people with intersex variations were established, some adopting a more political agenda, some focusing on individualised support relating to particular intersex conditions. These support and advocacy groups forced the medical and scientific establishment to reconsider the hegemony of the treatment protocol.⁴² Critical voices also emerged within the academic⁴³ and medical establishments.⁴⁴ In particular, investigation into a case study that had been central to and extensively cited in Money's research revealed serious flaws in optimal gender theory.⁴⁵

The growing swell of criticism and concern eventually prompted an international symposium involving clinicians, researchers and advocacy groups revisiting the treatment protocol, which resulted in new guidelines being developed and published in a consensus statement in 2006 ('2006 Guidelines').⁴⁶ The consensus statement, which remains the benchmark for medical management of intersex today, represents a notable shift in the practices recommended, including a more cautious approach to early genital surgery. The extent to which the 2006 Guidelines represent a critical rethinking of the medicalised response to intersex is a complex and contested question. Certainly the 2006 Guidelines purport to displace the supremacy of optimal gender theory and many of the egregious practices of secrecy and immediate and urgent surgical normalisation that the treatment protocol endorsed. However, the 2006 Guidelines sanction relatively early genital surgeries on children to make genitals appear more 'normal', though with greater caution and less urgency. The 2006 Guidelines recommend that gender assignment decisions be based on the interplay of

41 See, eg, Cheryl Chase, 'Surgical Progress Is Not the Answer to Intersexuality' (1998) 9 *Journal of Clinical Ethics* 385.

42 The most prominent of these support groups particularly in terms of advocacy and political action was the Intersex Society of North America: Karkazis, above n 4, 236–62.

43 See, eg, Anne Fausto-Sterling, 'The Five Sexes: Why Male and Female Are Not Enough' (1993) 33(2) *The Sciences* 20; Dreger, 'Ambiguous Sex', above n 34; Kessler, 'The Medical Construction of Gender', above n 34; Suzanne J Kessler, *Lessons from the Intersexed* (Rutgers University Press, 1998).

44 See, eg, Justine M Schober, 'Quality-of-Life Studies in Patients with Ambiguous Genitalia' (1999) 17 *World Journal of Urology* 249; Jorge Daaboul and Joel Frader, 'Ethics and the Management of the Patient with Intersex: A Middle Way' (2001) 14 *Journal of Pediatric Endocrinology & Metabolism* 1575; Creighton and Minto, above n 40.

45 Milton Diamond and H Keith Sigmondson, 'Sex Reassignment at Birth: Long-Term Review and Clinical Implications' (1997) 151 *Archives of Pediatrics & Adolescent Medicine* 298. The case of David Reimer, known in the medical literature as the 'John/John case' was the subject of a best-selling book by John Colapinto: John Colapinto, *As Nature Made Him: The Boy Who Was Raised a Girl* (Harper Perennial, 2000).

46 I A Hughes et al, 'Consensus Statement on Management of Intersex Disorders' (2006) 91 *Pediatrics* 554.

nebulous and imprecise criteria. Exactly how these recommendations are implemented in practice, including the prevalence and extent of genital normalisation surgeries, is difficult to discern. Advocacy and support groups such as OII Australia argue that despite the shift in rhetoric, medical practice has not changed significantly since the publication of the 2006 Guidelines, and that genital normalising surgery remains the standard response to variations of sex development apparent at birth.⁴⁷

In 2013, the Victorian Department of Health published a report ('Victorian Report') on decision-making principles for intersex which endorses the approach of the 2006 Guidelines.⁴⁸ The report states that 'in 2011, Victorian hospitals reported seeing approximately 40 new cases of infants with identified intersex conditions per year, and involvement in follow up and monitoring for 240 patients into childhood and adolescence'.⁴⁹ The Victorian Report promotes even greater caution in decision-making around genital normalising surgery, and highlights the controversies that the practice has elicited.⁵⁰ However, like the 2006 Guidelines, the Victorian Report does not recommend against genital normalising surgeries. As discussed below, it seems that the Victorian Report, like the 2006 Guidelines, has not resulted in a uniform approach to medical treatment of intersex or consensus on whether or not genital normalising surgeries should be performed.

C Genital Normalising Surgery

There is evidence that the current practice in Australia is to surgically 'normalise' the genitals of some children with intersex variations at an early stage. An article in *The Age* in 2013 reported that the Royal Children's Hospital in Melbourne performs 10 to 15 genital reconstruction operations a year, often on children under the age of two.⁵¹ In the article the director of the department of gynaecology at the Royal Children's Hospital is cited as arguing that for some intersex cohorts there is little risk that early surgery will irreversibly implement an incorrect sex assignment because available research suggests that most people with Congenital Adrenal Hyperplasia (for example) are assigned female and end up identifying as female. Associate Professor Grover is quoted as saying:

While we have the data to say they are going to end up identifying as females ... and we have evidence that surgical outcomes are good, and sensory outcomes and sexual function are good, where's the pressure to change the practice?⁵²

47 Organisation Intersex International Australia, Submission No 23 to Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia*, 15 February 2013, 3–7; National LGBTI Health Alliance, Submission No 60.2 to Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia*, 9 July 2013, 2.

48 Department of Health (Victoria), 'Decision-Making Principles for the Care of Infants, Children and Adolescents with Intersex Conditions' (Report, February 2013).

49 Ibid 1.

50 Ibid 14–15, 21–2.

51 Andrew Bock, 'It Takes More than Two', *The Age* (Melbourne), 20 June 2013, 18.

52 Ibid.

In its submissions to the Senate Community Affairs References Committee Inquiry into the Involuntary or Coerced Sterilisation of Intersex People in Australia ('Senate Committee'), the Australian Paediatric Endocrine Group noted that there are no clear guidelines on the timing of cosmetic genital surgery and that some specialists 'argue that very early surgery in the first months of life is optimal, and that there is no need to wait for any natural regression in clitoral size'⁵³ suggesting that, in the absence of consensus, both early and later surgeries are being performed. As noted in the National LGBTI Health Alliance submission to the Senate Committee:

In an anonymous online survey of current practice in feminizing surgery for congenital adrenal hyperplasia (CAH) among 162 specialists (60% paediatric surgeons or paediatric urologists) attending the IVth World Congress of the International Society of Hypospadias and Disorders of the Sex Development (ISHID) (sic) in 2011, 78% of surgeons reported that they preferred conducting early surgery before the age of two years. Most conduct surgical alteration of the clitoris, vagina and labia. Most surgeons reported that their techniques include surgical removal of clitoral erectile tissue.⁵⁴

The evidence suggests that early genital normalising surgeries are performed on children with intersex variations in Australia today. This was the conclusion reached by the Senate Committee.⁵⁵

III INTERSEX IN THE LAW

There are two key legal issues which arise from the experiences and status of people with variations of sex development. One issue relates to the legal sex of people with intersex variation. This can arise in a number of contexts such as the law of marriage, the production of formal identity documents, and discrimination. This article will focus primarily on the law of marriage, particularly judicial considerations of the status of intersex people in that context. The article will then provide a brief oversight of recent judicial and legislative changes to the laws concerning production of identity documents for gender diverse and intersex people. Finally, the article will consider the issue of sex discrimination, noting that recent amendments to the *Sex Discrimination Act 1984* (Cth) specifically identify intersex as a category of potential discrimination.⁵⁶ The second issue is the legitimacy of parental consent to genital normalising surgeries performed on intersex children who are too young to consent. The final section of the article examines this issue, considering the few cases heard by the Family Court exercising special medical jurisdiction. What is notable is the paucity of cases and legislation which deal with the issue. This

53 Australasian Paediatric Endocrine Group, above n 37, 5.

54 Francisca Yankovic et al, 'Current Practice in Feminizing Surgery for Congenital Adrenal Hyperplasia: A Specialist Survey' (2013) 9 *Journal of Pediatric Urology* 1103, cited in National LGBTI Health Alliance, above n 47, 2.

55 Senate Community Affairs References Committee, above n 1, 49 [3.45], [3.48].

56 *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth).

arguably supports the contention that medical and legal regulation of intersex has been effective in erasing and eradicating the disruptive potential of variations of sex development. As noted in OII Australia's submission to the Senate Committee, 'intersex is erased from official documentation through the assignment of a binary sex of rearing'.⁵⁷

A Legal Status and Sex Determination

1 *The Law of Marriage*

Historically, most Anglo-Australian cases addressing the legal status of people with variations of sex development have arisen in the context of the law of marriage. *Corbett v Corbett (Otherwise Ashley) [No 1]* ('*Corbett*')⁵⁸ was an influential United Kingdom case determining the legal status of a woman for the purposes of marriage law. A fact rarely mentioned in texts and other discussions of the case is that one of the evidentiary issues was whether the wife of the marriage and respondent in the case, April Ashley, had been born with an intersex variation. The central legal issue in *Corbett* was whether a post-operative transsexual could be legally defined as a member of the sex to which she had been medically/surgically reassigned. The trial judge, Ormrod J, had both medical and legal training, and seemed well-placed to hear the matter, given the extensive medical evidence that was tendered in the course of the hearing. The question of gender and sex was explicitly constructed as a biomedical issue that must be articulated through the lens of science. As Ormrod J notes in his judgment,⁵⁹ no less than nine medical experts gave evidence, two of whom were appointed by the Court. A considerable portion of the judgment is devoted to a close dissection of the medical evidence.

One issue canvassed in the evidence was whether the respondent wife had an intersex condition. Although neither party had raised this point in the pleadings, it was raised by several of the experts. In particular the report and evidence of Professor Mills, specialist in sex anomalies relating to endocrinology, focused on the possible diagnosis of the wife as having an intersex condition:

In [Professor Mills'] opinion, patients in whom the balance between male and female hormones is abnormal should be regarded as cases of inter-sex, and he considers that there is sufficient evidence to justify the view that the respondent is an example of this condition ... He thinks that the respondent was probably a case of partial testicular failure, in the sense that though born a male, the process of androgenisation at and after puberty did not proceed in the normal way. It is suggested that she may be a case of what is called Klinefelter's syndrome, a disorder in which a degree of feminisation takes place at about the time of puberty in, hitherto apparently, normal males.⁶⁰

57 Organisation Intersex International Australia, above n 47,15.

58 [1971] P 83.

59 Ibid 89.

60 Ibid 102.

Professor Mills' views were supported to some extent by two of the other medical experts. Dr Armstrong, who was an expert on intersex conditions, concluded that April was transsexual, but noted that she:

was not a physically normal male. He said that the respondent was an example of the condition called 'inter-sex', a medical concept meaning something between intermediate and indeterminate sex, and should be 'assigned' to the female sex, mainly on account of the psychological abnormality of transsexualism.⁶¹

A similar view was expressed by Professor Roth, a Professor of Psychiatry who had experience in sex identity and transsexualism and who diagnosed transsexualism 'with some physical contributory factor'⁶² and conceded that April might be classed as intersex. Two of the medical experts called by the husband⁶³ classified April as 'a male homosexual transsexualist' and 'a castrated male'.⁶⁴

The attitude of the wife, whose sex, gender and identity were under such detailed scrutiny, was markedly disinterested in this process of biomedical dissection. In a later interview, she reported 'that swine Ormrod would not even look at me. He decided that he wanted me X-rayed and examined from head to toe'.⁶⁵ When pressed to provide details about the size of her testicles or other details of her genital anatomy prior to her sex-change surgery, she refused to answer.⁶⁶ While Ormrod J explicitly stated that the wife's refusal to answer these questions does not reflect adversely on her credit, he expressed exasperation and disapprobation throughout the judgment, referring repeatedly to 'such unhelpful evidence'⁶⁷ and to the problem that there is no evidence to assist in the diagnosis and classification where pre-surgical anatomical features are an ingredient in the diagnostic process. In keeping with the medicalised approach to defining sex and gender, and classifying 'anomalies' using various typologies, much of the judgment was devoted to teasing out the science of sex and gender, and evaluating the available evidence about the wife's embodiment against the different classifications. The medical evidence was both complex and contested and identified a number of criteria relevant to sex determination, with particular emphasis on chromosomes, gonads, genitals, psychology, hormones and secondary sexual characteristics.⁶⁸

All but the first three criteria are excluded from Justice Ormrod's legal test of sex determination:

61 Ibid 99.

62 Ibid.

63 Ibid.

64 These comments reflect broader contemporary typologies and classification systems relating to medicalisation of transsexualism by prominent sexologists such as Harry Benjamin and Ray Blanchard: see, eg, Harry Benjamin, *The Transsexual Phenomenon* (Julian Press, 1966).

65 Nigel Fardale, 'Sex and the Single Grande Dame', *The Sydney Morning Herald* (online), 4 June 2005 <<http://www.smh.com.au/news/People/Sex-and-the-single-grande-dame/2005/06/03/1117568360972.html>>.

66 *Corbett* [1971] P 83, 91 (Ormrod J).

67 Ibid.

68 Ibid 100.

the law should adopt in the first place, the first three of the doctors' criteria, ie, the chromosomal, gonadal and genital tests, and if all three are congruent, determine the sex for the purpose of marriage accordingly, and ignore any operative intervention. The real difficulties, of course, will occur if these three criteria are not congruent.⁶⁹

The exclusion is explained on the following basis:

Having regard to the essentially heterosexual character of the relationship which is called marriage, the criteria must, in my judgment, be biological, for even the most extreme degree of transsexualism in a male or the most severe hormonal imbalance which can exist in a person with male chromosomes, male gonads and male genitalia cannot reproduce a person who is naturally capable of performing the essential role of a woman in marriage.⁷⁰

Justice Ormrod decided that there was insufficient evidence to support the diagnosis of intersex, and concluded that April was chromosomally male, and, prior to surgery, had male gonads and testicles and was therefore a male transsexual.⁷¹ He then cited the medical experts as authority for the proposition that:

the biological sexual constitution of an individual is fixed at birth (at the latest), and cannot be changed, either by the natural development of organs of the opposite sex, or by medical or surgical means. The respondent's operation, therefore, cannot affect her true sex.⁷²

In *Corbett*, Ormrod J made it clear that legal sex is determined by the features of the unsullied natural body. Any 'artificial' alterations to the body through medical or surgical processes do not alter the individual's true sex. Surgical modifications to the body should be understood as mere cosmetic inscriptions on the natural body rather than genuinely transformative. Justice Ormrod attached a qualification to his decision that the law should adopt chromosomal, genital and gonadal tests to determine sex in the context of marriage. The qualification is that all three must be congruent. He raised the issue of determining sex where a person is intersex and suggests in obiter 'that it would seem to me to follow from what I have said that the greater weight would probably be given to the genital criteria than to the other two'.⁷³ He left open the question of how law should deal with any surgical intervention in these circumstances. This seems to anticipate that any genital normalising surgery would be construed as irrelevant to legally determining sex. Quite how the law would then rely on the appearance of ambiguous genitalia is unclear and perhaps Ormrod J was unfamiliar with the possibility that infant genitals may not be clearly male or female at birth in many intersex conditions.

This attitude to the artificiality of surgical and medical constructs re-emerges later in the judgment where Ormrod J considers in obiter the issue of whether, if there was a marriage, it had been consummated. He stated that:

69 Ibid 106.

70 Ibid.

71 Ibid.

72 Ibid 104.

73 Ibid 106.

I do not think that sexual intercourse, using the completely artificial cavity constructed by Dr Burou, can possibly be described in the words of Dr Lushington in *D v A (falsely calling herself D)* as ‘ordinary and complete intercourse’ or as ‘vera copula – of the natural sort of coitus’. In my judgment, it is the reverse of ordinary, and in no sense natural. When such a cavity has been constructed in a male, the difference between sexual intercourse using it and anal or intra-crural intercourse is, in my judgment, to be measured in centimetres.⁷⁴

Having cited one of the medical specialists stating ‘we do not determine sex – in medicine we determine the sex in which it is best for the individual to live’,⁷⁵ Ormrod J responded that criteria used by medical professionals are relevant but ‘do not necessarily decide, the legal basis of sex determination’⁷⁶ and later in the judgment noted that ‘doctors decide the gender rather than the sex’.⁷⁷ Despite these words, the judgment assumes that sex and gender are primarily biomedical matters to be dissected forensically on the basis of medical diagnosis and evidence before they are filtered through a normative legal lens. The result is a pseudo-scientific amalgam of descriptive and normative gender assumption combined with a naturalised construct of the biological basis of sex binaries.

The *Corbett* test was adopted across many common law jurisdictions, and the relevant cases reflect the same attitude rejecting surgical and medical interventions as surface manipulations that do not impact on the true sex of the individual.⁷⁸ The test was adopted in the only reported Australian case determining the legal status of an intersex person for the purposes of marriage. In 1979, Bell J of the Family Court of Australia heard an application for nullity of marriage.⁷⁹ The applicant in *In the Marriage of C and D (falsely called C)* was the wife of the marriage. Her original application was for dissolution of marriage, but Bell J suggested to the wife’s counsel that her application should be amended to seek a declaration of nullity. The husband did not appear or contest the application.

Proceeding on an ex parte basis, Bell J outlined the husband’s birth and medical history, beginning with the statement that ‘[t]he parents of the husband appear to have been related’.⁸⁰ Bell J then turns to a description of the husband’s siblings, who suffered from various physical and mental ailments, aside from one brother who is referred to as ‘one normal brother’.⁸¹ No further mention of these facts is raised, but the implications are clear: the husband’s family is genetically defective in various ways, and his intersex condition was a manifestation of that. Justice Bell recounted the husband’s medical history, relying apparently on an academic article published by the husband’s medical professionals, who treated

74 Ibid 107 (citations omitted).

75 Ibid 100.

76 Ibid.

77 Ibid 104.

78 See, eg, *Bellinger v Bellinger* [2003] 2 AC 467; *Re T* [1975] 2 NZLR 449; *W v W* [1976] 2 SA 308 (Nestadt J) (Local Division). See also discussion in Terry S Kogan, ‘Transsexuals, Intersexuals and Same-Sex Marriage’ (2004) 18 *Brigham Young University Journal of Public Law* 371.

79 *In the Marriage of C and D (falsely called C)* (1979) 28 ALR 524.

80 Ibid 525.

81 Ibid.

him when he was in his early teens.⁸² The treatment outlined was removal of an ovary and uterus, four surgical procedures to ‘correct his external sex organ’⁸³ and a mastectomy. The husband was diagnosed as a ‘hermaphrodite verus’.⁸⁴ Justice Bell explicitly noted that the surgeries were ‘to confirm the recognition that he was born a male and had been reared a male’.⁸⁵ The application for nullity was on the grounds that the wife’s consent was not real because she was mistaken as to the identity of the husband under *Matrimonial Causes Act 1959* (Cth) section 18(1)(d)(ii). Justice Bell found that this ground was made out, as the wife had contemplated marriage to a man, but had married a person who was a ‘combination of both male and female’.⁸⁶

Justice Bell then raised a more profound question – whether a ‘hermaphrodite’ can marry at all. In purported reliance on the *Corbett* criteria for sex determination, Bell J concluded that, although the husband ‘exhibited as male in two of the three criteria’,⁸⁷ his chromosomes were female. This led him to conclude that the husband was neither man nor woman but was a combination of both, and therefore the marriage was void. On Justice Bell’s analysis intersex people were neither male nor female and therefore could not marry at all. In reaching this conclusion, Bell J ignores Justice Ormrod’s explicit caveat regarding intersex persons – ‘[t]he real difficulties, of course, will occur if these three criteria are not congruent’.⁸⁸

*Corbett*⁸⁹ and *In the Marriage of C and D (falsely called C)*⁹⁰ are interesting for their supposed reliance on a strict biomedical understanding of sex while simultaneously ignoring or rejecting much of the medical evidence presented as well as the dominant medical paradigm for treatment of intersex in the 1970s, which was based on optimal gender theory. As outlined above, optimal gender theory and the treatment protocols that were developed out of it were premised on the belief that sex and gender are fluid, and can be determined by a strict regimen of medical, surgical, social and psychological interventions directed to curing the defect of intersex ambiguity.

The *Corbett* test of sex determination purports to identify the biological markers of true sex – fixed, immutable, natural and reliable. We see here direct tension between the Hippocratic and Aristotelian style understandings of intersex. While the medical response has moved from a search for true sex to a search for best sex, the juridical approach rejects gender fluidity as unreliable, untrustworthy and unnatural. Even biological markers such as hormonal balance and secondary sex characteristics are rejected on the basis that they cannot turn a man into a woman. Such markers are elastic and malleable. According to Ormrod

82 Ibid 525–6.

83 Ibid.

84 Ibid 526.

85 Ibid.

86 Ibid 527.

87 Ibid.

88 *Corbett* [1971] P 83, 106.

89 Ibid.

90 (1979) 28 ALR 524.

J, the sex binary is both too rigid and too fragile to permit the potential for manipulation.

The *Corbett* test has been overturned in all Australian jurisdictions and most common law countries.⁹¹ The *Corbett* test was distinguished but not overturned in the United Kingdom in a case concerning the validity of a marriage of a woman with a variation of sex development.⁹² In the context of marriage, Australian law now recognises post-operative transsexuals as belonging to their sex of assignment.⁹³ The decision in *In the Marriage of C and D*⁹⁴ has not been directly overturned. However, the decision in *Re Kevin*⁹⁵ which legalised the marriage of a post-operative transsexual in his post-transition sex would apply equally to a marriage of a person with a variation of sex development. In *Re Kevin* the list of criteria for defining sex is expanded beyond the congenital biological factors to include psychological factors such as gender identity, child and adult behaviour, social presentation and interaction, appearance and gender performance.⁹⁶ The test for sex determination in both marriage and other legal contexts in Australia has been extended to include medical and surgical interventions, as well as identity, ‘psychological sex identification’, behaviour, social presentation, appearance and gender performance as salient factors.⁹⁷

2 Legal Sex and Identity Documents

Australian judicial attitudes to sex and gender determination as reflected in judicial decisions have gradually expanded the criteria impacting on how we categorise individuals within the gender binary.⁹⁸ Similarly, every state and territory in Australia has enacted legislative schemes to permit amendment of identity documents to change legal gender.⁹⁹ However, the project of determining how to slot individuals into the binary – often appealing to stereotypical performance of gender and medical and surgical construction of anatomy to validate the classification – remained the central question until 2013, when the

91 *A-G (Cth) v “Kevin and Jennifer”* [2003] 172 FLR 300, 309 (The Court) (*‘Re Kevin’*); *MT v JT*, 355 A 2d 204, 85–6 [28] (Handler J) (NJ, 1976); *R v Harris* (1988) 17 NSWLR 158, 193 (Mathews J); *A-G v Otahuhu Family Court* [1995] 1 NZLR 603, 607 (Ellis J); *AB v Western Australia* (2011) 244 CLR 390, 396 (The Court).

92 *W v W (Physical Inter-sex)* [2001] 2 WLR 674.

93 *Re Kevin* [2003] 172 FLR 300.

94 (1979) 28 ALR 524.

95 [2003] 172 FLR 300.

96 *Ibid* 364 [376] (The Court).

97 *R v Harris* (1988) 17 NSWLR 158, 179 (Mathews J); *Re Kevin* [2003] 172 FLR 300; 355–7 [327]–[338] (The Court); *AB v Western Australia* (2011) 244 CLR 390, 405 [34] (The Court).

98 For analysis of different legislative and judicial approaches to gender determination see Theodore Bennett, “‘No Man’s Land’: Non-Binary Sex Identification in Australian Law and Policy” (2014) 37 *University of New South Wales Law Journal* 847; Laura Grenfell and Anne Hewitt, ‘Gender Regulation: Restrictive, Facilitative or Transformative Laws?’ (2012) 34 *Sydney Law Review* 761.

99 *Births, Deaths and Marriage Registration Act 1997* (ACT) s 24; *Births, Deaths and Marriages Registration Act 1995* (NSW) s 32B; *Births, Deaths and Marriages Registration Act 1996* (NT) s 28B; *Births, Deaths and Marriages Registration Act 2003* (Qld) s 23; *Sex Reassignment Act 1988* (SA) s 7; *Births, Deaths and Marriages Registration Act 1999* (Tas) s 28A; *Births, Deaths and Marriages Registration Act 1996* (Vic) s 30A; *Gender Reassignment Act 2000* (WA) s 14.

New South Wales Court of Appeal in *Norrie v Registrar of Births, Deaths and Marriages* ('*Norrie*')¹⁰⁰ directly challenged the underlying assumption that sex is a binary system of categorisation. In *Norrie*, the Court determined that a fundamental identity document could denote an identity which is neither male nor female. This is the first explicit judicial recognition in Australia of a non-binary concept of sex. The Court of Appeal decision was affirmed by the High Court in 2014. In its concluding comments, the High Court stated '[t]he [*Births, Deaths and Marriages Registration Act 1995* (NSW)] itself recognises that a person may be other than male or female and therefore may be taken to permit the registration sought, as "non-specific"'.¹⁰¹

This decision reinforces recent legislative and administrative measures of the Australian government directed to broader and more open recognition of the existence of sex and gender diversity. In 2013, the Australian government published guidelines¹⁰² on gender and sex recognition that provide for sex and gender information to include three data recording options, being male, female and indeterminate/intersex/unspecified.¹⁰³ Furthermore, changes to recorded sex or gender information can be amended more easily.¹⁰⁴ The Guidelines include specific recognition and definition of intersex variations.¹⁰⁵ These developments extend the much-publicised 2011 revision of Department of Foreign Affairs and Trade policy to include 'x' as a gender category on passports.¹⁰⁶

3 Discrimination Protections

Fears of discrimination, such as bullying and ridicule, were for many years cited as a reason and justification for surgical interventions on intersex children.¹⁰⁷ One concern for non-surgical intersex children was the prospect of psychological harm that might ensue where a child has genitals that do not conform to the 'norm' for the assigned sex. Accordingly, the trope of discrimination has historically provided moral weight to the paradigm of early surgical normalisation. As the medical paradigm moves away from surgical intervention to bolster sex assignment, and as legal reform opens up spaces for greater gender diversity, it is likely that intersex will become more socially and legally visible. People with variations of sex development who develop non-

100 [2013] 84 NSWLR 697.

101 *NSW Registrar of Births, Deaths and Marriages v Norrie* (2014) 250 CLR 490, 501 [46] (The Court).

102 Attorney-General's Department, 'The Australian Government Guidelines on the Recognition of Sex and Gender' (Guidelines, Government of Australia, July 2013).

103 *Ibid* 4–5 [19]–[21].

104 *Ibid* 5 [24].

105 *Ibid* 4 [12].

106 Although Australian passports designating 'x' as gender had been issued prior to this policy revision, the impact of the revisions was to improve and extend accessibility. The first such passport was issued in 2003 to a person with variation of sex development: Admin, *On Australian Passports and 'X' for Sex* (9 October 2011) Organisation Intersex International Australia <<https://oii.org.au/14763/on-x-passports/>>; Ingrid Holme, 'Hearing People's Own Stories' (2008) 17 *Science as Culture* 341, 341.

107 See, eg. American Academy of Pediatrics, 'Timing of Elective Surgery on the Genitalia of Male Children with Particular Reference to the Risks, Benefits, and Psychological Effects of Surgery and Anesthesia' (1996) 97 *Pediatrics* 590, 590.

binary gender identities may be more exposed to discrimination on the basis of intersex status, particularly if they seek to assert their right to a non-binary gender identity. A recent example of potential discrimination against intersex people is the recent ‘bathroom laws’ introduced by social conservatives in the United States in jurisdictions such as Arizona, Maryland, Kentucky and Florida, which seek to exclude people from using public toilets that do not accord with the gender recorded on their birth certificates.¹⁰⁸ These laws of course could impact directly on transgender people, but could also affect people with intersex variations. As part of a wider amendment to extend protection from discrimination, the *Sex Discrimination Act 1984* (Cth) was amended in 2013 to include protection against discrimination on the basis of sexual orientation, gender identity and intersex status.¹⁰⁹ These amendments would be effective in addressing discrimination such as the bathroom laws proposals.

Perhaps the most egregious arena of discrimination on the basis of intersex status is sports. Both professional and amateur sports organisations have uncritically adopted a rigid and often arbitrary construct of sex binary. The International Olympic Committee (‘IOC’) and other international sporting organisations have generated controversy on numerous occasions for their treatment of intersex athletes.¹¹⁰ South African runner Caster Semenya’s treatment by the International Association of Athletics Federation exemplifies this discrimination.¹¹¹ The IOC recently disseminated guidelines on both transgender and intersex athletes.¹¹² As noted by OII Australia, the IOC statement ‘contains two statements, one entitled “Transgender guidelines” and one entitled “Hyperandrogenism in female athletes”. One is still medicalised; the other makes an attempt to acknowledge human rights concerns’.¹¹³ However, such discrimination is exempted from the operations of the *Sex Discrimination Act 1984* (Cth).¹¹⁴ The impact of anti-discrimination laws may be significant in addressing many instances of discrimination but will have little impact on discrimination in sports.

108 Transgender Law Center, ‘Transgender Law Center Outraged by Discriminatory Arizona Bill’ (Press Release, 28 March 2013) <<http://transgenderlawcenter.org/archives/3800>>.

109 *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth).

110 See, eg, Rebecca M Jordan-Young, Peter H Sonksen and Katrina Karkazis, ‘Sex, Health and Athletes’ (2014) 348 *British Medical Journal* 20; Morgan Carpenter, ‘Intersex Rights and Freedoms’ (2015) 9 *Court of Conscience* 27, 29.

111 Associated Press, ‘Caster Semenya Announces Return to Athletics and Blasts IAAF’, *The Guardian* (online), 31 March 2010 <<http://www.theguardian.com/sport/2010/mar/30/caster-semenya-return-athletics-iaaf>>.

112 Medical and Scientific Commission, *Consensus Meeting on Sex Reassignment and Hyperandrogenism November 2015* (November 2015) IOC <<http://www.olympic.org/medical-and-scientific-commission?tab=statements>>.

113 Morgan Carpenter, *IOC Policy: No Change for Athletes with Intersex Traits* (2 February 2016) Organisation Intersex International Australia <<https://oii.org.au/30303/ioc-no-change-athletes-intersex/>>.

114 *Sex Discrimination Act 1984* (Cth) s 42.

4 *Making Intersex Visible in Law*

Since 1971, there have been significant developments in the legal and juridical understanding of variations of sex development. Recent legislative and administrative initiatives are directed to making intersex variations more visible, and to begin to undo the erasure of sex and gender diversity. A significant element of this reform has been the Report of the Senate Committee tabled in November 2013.¹¹⁵ The Report grew out of the Senate Committee's Inquiry into Involuntary or Coerced Sterilisation of Disabled People in Australia. The Senate Committee received so many submissions regarding sterilisation of intersex people that the terms of the Inquiry were expanded and a separate report was produced. The Report makes 15 recommendations addressing a range of important issues including funding for, monitoring of, and the production of guidelines for, medical management and intervention; as well as funding for intersex support groups; a registry of intersex patients; and research into long-term clinical outcomes of medical intervention.¹¹⁶ If these recommendations are implemented, this will be an important step towards making intersex visible in law and administration.

5 *Consent to Genital Normalising Surgery*

The second legal issue relevant to the current medical approach to variations of sex development is whether genital normalisation surgeries are lawful on the basis of parental consent. Surgical procedures on young children who lack 'Gillick-competence'¹¹⁷ can generally be consented to by parents.¹¹⁸ However, parental authority is not absolute. There are two significant limitations on parental authority in this context. One is that any medical procedure must be in the child's best interests.¹¹⁹ The other is that some procedures such as non-therapeutic sterilisation, identified in broad terms by the High Court in 1992, cannot be consented to by parents and must be authorised by a court operating within its *parens patriae* jurisdiction.¹²⁰ In exercising that jurisdiction and considering whether to authorise a particular medical procedure, the court itself is bound to act in the child's best interests.¹²¹

The best interests limitation merits greater critical analysis and attention in the context of genital normalising surgery. An argument challenging the orthodox position that genital normalising surgery is in the best interests of a child born with atypical genitalia would confront the hurdle that such surgeries

115 Senate Community Affairs References Committee, above n 1.

116 Ibid xiii–xiv.

117 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

118 *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case)* (1992) 175 CLR 218 ('*Marion's Case*'); *Family Law Act 1975* (Cth) s 65DAC(4).

119 *Marion's Case* (1992) 175 CLR 218, 259 (Mason CJ, Dawson, Toohey and Gaudron JJ), 289 (Deane J), 317 (McHugh J).

120 Ibid 257 (Mason CJ, Dawson, Toohey, and Gaudron JJ). This jurisdiction was legislatively entrenched in 1995 by insertion of *Family Law Act 1975* (Cth) s 67ZC: *Family Law Reform Act 1995* (Cth) s 31.

121 *Marion's Case* (1992) 175 CLR 218.

have been (and arguably continue to be) a central plank in the psychosexual treatment regimen adopted and endorsed in the international medical literature and by authoritative medical experts in the field. This is particularly the case given the dearth of research investigating the psychosocial outcomes for intersex children whose genitals were ‘reconstructed’ in infancy – a dearth that can be attributed to the institutional legal erasure of intersex as alluded to above. There is, however, a large and growing literature critiquing surgical normalisation (see discussion below on therapeutic value).

6 Consent for Special Medical Treatment

In 1992, the High Court considered whether a parent could consent to the ‘non-therapeutic’ sterilisation of an intellectually disabled child in *Marion’s Case*.¹²² The High Court held that parental authority could not extend to sterilisation. Moreover, the limitations on parental authority are not confined to sterilisation procedures. The factors which the Court considered significant in *Marion’s Case* were that the procedure was non-therapeutic; invasive and irreversible; that there was a significant risk of making the wrong decision; and that the consequences of a wrong decision would be grave and serious.¹²³ Family Court-issued guidelines also state that ethically sensitive or disputed procedures should be authorised by a court.¹²⁴

In *Marion’s Case*, the High Court established a special category of medical treatment for which special consent and authorisation processes were considered necessary where the proposed patient is a child. The majority judgment’s reasoning highlights a need for judicial oversight of special medical procedures:

The medical profession very often plays a central role in the decision to sterilize as well as in the procedure itself. Indeed, the question has been ‘medicalized’ to a great degree. Two concerns emerge from this. It is hard to share the view of Cook J in *Re a Teenager*, that absolute faith in the integrity of all medical practitioners is warranted. We agree with Nicholson CJ in *Re Jane* that, as with all professions, there are those who act with impropriety as well as those who act bona fide but within a limited frame of reference. And the situation with which they are concerned is one in which incorrect assessments may be made. The second concern is that the decision to sterilize, at least where it is to be carried out for contraceptive purposes, and especially now when technology and expertise make the procedure relatively safe, is not merely a *medical* issue. This is also reflected in the concern raised in several of the cases reviewed, that the consequences of sterilization are not merely biological but also social and psychological. The requirement of a court authorization ensures a hearing from those experienced in different ways in the care of those with intellectual disability and from those with experience of the long term social and psychological effects of sterilization.¹²⁵

122 Ibid.

123 Ibid 250 (Mason CJ, Dawson, Toohey, and Gaudron JJ).

124 Victoria Legal Aid, Office of the Public Advocate (Victoria) and Family Court of Australia, ‘A Question of Right Treatment: The Family Court and Special Medical Procedures for Children – An Introductory Guide for Use in Victoria’ (Guidelines, Family Court of Australia, 1998) 8–9.

125 *Marion’s Case* (1992) 175 CLR 218, 251 (Mason CJ, Dawson, Toohey, and Gaudron JJ) (emphasis in original) (citations omitted).

Genital normalising surgery shares many of the salient features identified in *Marion's Case*. The phenomena of variations of sex development have been medicalised to a great degree. As noted in the report of the Senate Committee, '[t]he concern expressed by the intersex community that sex differences are pathologised sits at the heart of the inquiry'.¹²⁶ Given the extensive criticisms and concerns raised about the treatment protocols over the last 60 years, absolute faith in the medicalised framework is unreasonable. The issues around surgical normalisation are not merely medical or biological issues, but have profound social and psychological implications. Therefore, a formalised hearing and review of decision-making by 'those experienced in different ways' is needed. A report commissioned by the Australian Human Rights Commission reinforces this reading of the justification for establishing a special category of medical procedures:

doctors play a central role in what is not just a medical decision, but absolute faith in the integrity of all medical practitioners is not warranted; it is possible that parents, other family members, and carers may have conflicting interests which would influence their decision.¹²⁷

The report further notes that the decision in *Marion's Case* 'highlights the public interest in scrutinising differential and ethically contentious medical procedures for children and clearly articulated the need for heightened accountability in this type of decision making'.¹²⁸ The process established in *Marion's Case* to provide heightened accountability is the requirement for authorisation by the Family Court.

To date there have been six reported cases before the Family Court involving applications for court authorisation for special medical treatment of intersex children.¹²⁹ While each of these cases concerns proposed medical treatments of a range of intersex variations, the focus of the applications and judgments is not on genital normalising surgery. Although possible future clitoral reduction and vaginal surgeries were identified as part of the proposed future treatment regime in *Re Sally*,¹³⁰ the judgment does not consider the implications of genital normalising surgeries in specific terms. Rather, the discussion is focused on a proposed gonadectomy and the sterilising effect. In each of these cases aside from *Re Dylan*,¹³¹ the focus of the application and the reasoning in the judgment is primarily on sterilisation as a by-product of the proposed treatment regime. Another focus of concern in some of the cases is the issue of gender identity development, particularly where the child-subject of the proceedings is old enough to express gender identity (though not *Gillick*-competent).

126 Senate Community Affairs References Committee, above n 1, 108 [5.63].

127 Susan Brady, John Britton and Sonia Grover, 'The Sterilisation of Girls and Young Women in Australia: Issues and Progress' (Report, Australian Human Rights Commission, 2001) 6 (citations omitted).

128 *Ibid* 8.

129 *Re A (a Child)* (1993) 16 Fam LR 715; *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226; *Re Sally (Special Medical Procedure)* [2010] FamCA 237; *Re Sean and Russell (Special Medical Procedures)* (2010) 258 FLR 192; *Re Dylan* [2014] FamCA 969; *Re Sarah* [2014] FamCA 208.

130 [2010] FamCA 237.

131 [2014] FamCA 969.

The first of these cases, *Re A (a Child)*¹³² heard in 1993, concerned a 14 year-old who had been born with a variation of sex development called congenital adrenal hyperplasia, which meant that although A had female chromosomes and gonads, an over-production of fetal androgens had caused masculinisation in utero, resulting in genitals that were masculine at birth. A had been medically and surgically assigned to female in infancy. The application was for consent to medical and surgical intervention to re-assign A as a boy.

Justice Mushin quoted extensively from medical reports and uncritically endorses the medical paradigm of optimal gender theory which clearly underpins the expert evidence. The social and political implications of the decision have been considered in other commentary.¹³³ Early in his judgment his Honour stated: ‘Despite the advice that A was in fact a female affected by the condition of congenital adrenal hyperplasia, both A’s parents had the initial perception that A was in fact a male’.

It is odd in this context that Mushin J claimed that A was ‘in fact’ a girl. If we were to adopt the legal criteria of *Corbett* A was ‘in fact’ not a girl, because the key factors of genitals, gonads and chromosomes were not congruently female. If we apply the dicta in *Re the Marriage of C and D*, A was neither a girl nor a boy. In 1993, neither of these cases had been overturned, but the legal framework established within them is not considered. Furthermore, the possibility that A was not ‘in fact’ clearly either male or female is never considered.

While Mushin J explicitly blames A’s parents for failing to force A to conform to the medical regime dictated by compliance with optimal gender theory (thereby failing to avoid the ‘appalling situation’¹³⁴ before him), there is no consideration of the legitimacy or accuracy of the treatment protocol that had been imperfectly imposed on A since infancy. Mushin J refers in passing to the surgeon’s report that in the postnatal period ‘she had genital reconstruction to give her a feminine appearance’.¹³⁵ In other words, Mushin J uncritically accepts and endorses the medical paradigm that had informed the treatment of A. There is complicity between the medical and the legal construction of variations of sex development as pathological disorders in urgent need of correction. The tension between the medical and judicial responses to variations of sex development has disappeared.

*Re Sean and Russell*¹³⁶ concerned two children with Denys-Dash Syndrome aged 18 months, and three and a half years. The application was for authorisation of gonadectomies. Although there is reference to ambiguous genitalia, there was no proposal to perform genital normalising surgery on either child.¹³⁷

132 (1993) 16 Fam LR 715.

133 See J Millbank, ‘When Is a Girl a Boy? *Re A (a Child)*’ (1995) 9 *Australian Journal of Family Law* 8.

134 *Re A (a Child)* (1993) 16 Fam LR 715, 719.

135 *Ibid* 717.

136 *Re Sean and Russell (Special Medical Procedures)* (2010) 258 FLR 192.

137 *Ibid* 195 [16] (Murphy J). The judgment identifies a proposal for surgical repair of hypospadias, but this procedure is not considered cosmetic or normalising.

*Re Lesley*¹³⁸ concerned a child diagnosed with 17- β /HSD with male chromosomes and gonads but who had been raised as a girl. The proposed medical procedure was also a gonadectomy to prevent masculinisation at puberty. There is reference in the judgment to ambiguous genitalia¹³⁹ but no proposal to surgically ‘normalise’ the genitals.

*Re Sally*¹⁴⁰ concerned a proposed gonadectomy to be performed on a 14 year-old girl who was born with 5-alpha-reductase deficiency and consequently had male genotype and gonadal material but female genitals and had been reared as a girl. The judgment refers to an affidavit of a paediatric endocrinologist who outlined the treatment required to allow Sally ‘to live more normally as a female’:

The treatment involves:

- (a) removal of her testes to prevent any further testosterone production and to remove the obvious swellings in her labia and inguinal region;
- (b) the potential need for surgery to reduce the size of her clitoris;
- (c) treatment (which may also involve surgery) to enlarge the size of her vagina prior to sexual activity; and
- (d) ongoing oestrogen supplements for the remainder of her life.¹⁴¹

The judgment goes on to consider the reasons for removing testicular tissue, but no further reference or explanation is provided to justify the clitoral reduction or vaginal enlargement. The emphasis throughout the judgment, and apparently in the medical evidence, was on the sterilising effect of gonadectomy. Although the Queensland Department of Communities appeared as a friend of the Court in the proceedings, it did not advocate for any position.¹⁴²

The minor in *Re Dylan*¹⁴³ was a 15 year-old boy who had been diagnosed at 18 months with congenital adrenal hyperplasia and was genetically female but had been raised as a boy. The proposed treatment was to commence a regime of hormonal treatment.¹⁴⁴ There was no proposal for genital normalising surgery. *Re Sarah*¹⁴⁵ concerned a proposed gonadectomy to be performed on a girl with Turner Syndrome. Neither case involved a proposal to surgically ‘normalise’ the genitals.

These cases raise important issues about the gender assumptions that underpin the medical and legal construction of gender. What is significant for this analysis is that genital normalising surgery, even where it has been done or is proposed as a possible treatment, receives no judicial attention. The need to surgically shape the genitals to give them a more feminine appearance is

138 *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226.

139 *Ibid* [21] (Barry J).

140 *Re Sally (Special Medical Procedure)* [2010] FamCA 237.

141 *Ibid* [33] (Murphy J).

142 *Ibid* [7] (Murphy J).

143 [2014] FamCA 969.

144 The proposed regime is commonly the subject of applications for court authorisation in cases involving childhood gender dysphoria and is referred to in the case as ‘stage 2 treatment’: *ibid* [4] (Kent J).

145 [2014] FamCA 208.

constructed as so natural and normal as to need no explanation. This attitude also permeates much of the medical discourse. The unquestioned assumption is that there is a consensus about what genitals should and must look like in order to express gender authentically. This assumption is profoundly misplaced, as there is no ‘standard objective measure for cosmetic perceptions of “normal” female genitals’¹⁴⁶ or male genitals. The enculturated nature of these supposedly empirical judgments about normality is nicely captured in a quote from a pediatric endocrinologist: ‘If we’re saying genital surgery is for normalization purposes, I would ask the surgeons how many penises they’ve reduced to make them more normal in size’.¹⁴⁷ Research regarding ‘normal’ genitals reveals ‘enormous natural variation in the anatomy of sex’¹⁴⁸ even without taking into account the natural variations represented by the medicalised category of intersex.

Of equal significance is the implication that most genital normalising surgeries are performed without any court authorisation. Apparently genital normalising surgeries are performed on the basis of parental consent because they are seen as falling outside the parameters of ‘special medical treatment’.

The lack of judicial consideration has led OII Australia, a leading intersex advocacy group, to argue that requiring authority for surgery from the Family Court will do little to protect intersex children from unnecessary surgeries.¹⁴⁹ Despite the rationale outlined in *Marion’s Case*¹⁵⁰ for establishing a procedure to ensure independent scrutiny and oversight of medical procedures such as genital normalising surgery, the Court has consistently failed to play that role. Instead, the cases reveal extensive uncritical reliance on the medical evidence. Scrutiny tends to be reserved for considerations relating to the potential to sterilise children. Whilst this is clearly an important issue, it is not the only focus of concern in the medical treatment of children with variations of sex development. Current medical protocols do not exclude genital normalising surgery and there is strong evidence to suggest that such surgeries have been and continue to be performed.

7 *Prohibition of Female Genital Mutilation (‘FGM’)*

In New South Wales there is a specific legislative provision which prohibits female genital mutilation.¹⁵¹ An exception is provided where the procedure ‘is

146 Admin, *Medical Research: No (Wo)man is an Island and Subjective Perceptions of Genital Normality* (28 January 2012) Organisation Intersex International Australia <<https://oii.org.au/16517/no-woman-is-an-island/>>.

147 Karkazis, above n 4, 140.

148 Jillian Lloyd et al, ‘Female Genital Appearance: “Normality” Unfolds’ (2005) 112 *BJOG: An International Journal of Obstetrics and Gynaecology* 643. See also discussion in Senate Community Affairs References Committee, above n 1, 64–6 [3.98]–[3.102].

149 Organisation Intersex International Australia, Submission No 23.1 to Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia*, 8 March 2013, 15.

150 (1992) 175 CLR 218.

151 *Crimes Act 1900* (NSW) s 45.

necessary for the health of the person on whom it is performed and is performed by a medical practitioner'.¹⁵² The prohibition applies to consenting adult women, and specifically excludes from consideration any issues other than medical welfare when assessing 'health'. Neither 'medical welfare' nor 'health' is defined within the Act. The second reading speech makes it clear that 'mental health' is defined to bring Western genital surgeries within the exception provided by subsection (3)(a):

the bill is clear in prohibiting the practice of FGM, but is also clear not to interfere with legitimate forms of surgery. Thus this bill prohibits various acts of FGM unless they are necessary for the health of the person. *The health of the person can be defined as either physical or mental health. ... The bill also allows for operations that are necessary for the mental health of the person. This will allow for procedures such as the ones that have been raised: to remedy a physical malformation or to allow for forms of cosmetic surgery.* Again, to define precisely the operations which are permissible would risk a legitimate operation being excluded. Moreover, such a course may implicitly create a loophole for the performance of certain forms of FGM.¹⁵³

The illegality of specified forms of surgical incision, infibulation or mutilation of female genitals expresses a powerful antipathy in Australia towards current traditional practices within a number of developing countries, particularly in Africa. It is clear that section 45 is directed towards these 'cultural' practices within non-Western cultural and religious traditions. However, the distinction rests on some dubious assumptions about cultural norms of embodiment.

In seeking to understand why the practice of FGM persists despite strident opposition at international and national levels, it is helpful to consider the justifications and explanations which have been propounded. These provide an interesting comparison with our uncritical acceptance of genital normalising surgery on intersex children as necessary for them to function at a sociocultural and psychosexual level.

Comments that have been reported by anthropologists speaking to women who practice FGM include: 'We don't want the girl to be dirty, open, with smelly underwear'.¹⁵⁴ '[w]hoosh! The lumps are gone. It is smooth and clean. The stitching is like the zig zag stitch, so beautiful';¹⁵⁵ '[s]ince we've got a small one and sewn, when I saw this, I thought, they've got a lot of cow pussy ... I know myself we smell better and are less dirty than women who are uncircumcised'.¹⁵⁶ In some cultures clitoridectomy is interpreted as removing the hard, male parts

152 *Crimes Act 1900* (NSW) s 45(3)(a).

153 New South Wales, *Parliamentary Debates*, Legislative Council, 10 May 1994, 2151 (John Hannaford) (emphasis added).

154 Ellen Gruenbaum, 'Honourable Mutilation? Changing Responses to Female Genital Cutting in Sudan' in Robert A Hahn and Marcia Claire Inhorn (eds), *Anthropology and Public Health: Bridging Differences in Culture and Society* (Oxford University Press, 2nd ed, 2009) 397, 415.

155 Rita Morris, 'The Culture of Female Circumcision' (1996) 19(2) *Advances in Nursing Science* 43, 51.

156 Chantal Zabus, *Between Rites and Rights: Excision in Women's Experiential Texts and Human Contexts* (Stanford University Press, 2007) 170.

and making the woman forever soft and feminine.¹⁵⁷ This association between infibulated female genitals and femininity translates into a perception that normal female genitals must have a particular appearance to express and embody essential femaleness. Similarly, marriageability is often cited as an important factor which fuels FGM practices. Uncircumcised women are, in some contexts, regarded as unmarriageable because their genitals mark them as unfeminine and malformed.

Within Western cultures, such perceptions are regarded as deluded, unnatural and culturally pathological. Any such defence of FGM on these grounds as an issue of mental health would be dismissed as utterly illegitimate. A common thread in this discussion is the extent to which our cultural, sexual, social and legal identities are tied to a gendered embodiment that is acceptable.¹⁵⁸ The second reading speech referred to above does explicitly exempt surgeries to 'remedy a physical malformation' from prohibition under section 45 and this is how genital normalising surgery is characterised. This construction relies on normative concepts of pathology and embodiment. Clearly, genital normalising surgery is not intended to be prohibited under section 45. Our ability to distinguish between this surgery and FGM relies on unquestioned assumptions about what we mean by 'health' and 'medical', as opposed to 'cultural' or 'ritual', considerations.

8 *Assessing Therapeutic Value*

Genital normalising surgeries escape legal scrutiny under both the FGM prohibition and the special medical authorisation requirements because the surgeries are defined and constructed as therapeutic. The Victorian Report identifies the issue of whether medical treatment is therapeutic as 'a medical decision that is the responsibility of the patient's treating clinician, in collaboration with the multidisciplinary medical, ethical and legal experts assisting with the development of the management plan'.¹⁵⁹

The therapeutic value of genital normalising surgery is strongly contested, both within the medical establishment and within the intersex community. There were proposals for a moratorium on early surgical normalisation as early as 1998.¹⁶⁰ The orthodox explanations of the therapeutic value of surgery have been summarised as follows:

Proponents of feminizing genitoplasty in infancy cite the following as reasons to operate:

- a more stable development of gender identity;
- a better psychosexual and psychosocial outcome;

157 Christine J Walley, 'Searching for "Voices": Feminism, Anthropology, and the Global Debate over Female Genital Operations' (1997) 12 *Cultural Anthropology* 405.

158 Aileen Kennedy, 'Mutilation and Beautification: Legal Responses to Genital Surgeries' (2009) 24 *Australian Feminist Studies* 211.

159 Department of Health (Vic), above n 48, 21.

160 Kenneth Kipnis and Milton Diamond, 'Pediatric Ethics and the Surgical Assignment of Sex' (1998) 9 *Journal of Clinical Ethics* 398.

- a relief of parental anxiety;
- provision of a vaginal introitus for psychological relief;
- menstruation and intercourse in adolescence and adulthood.¹⁶¹

In its submission to the Senate Committee Inquiry into Involuntary and Coerced Sterilisation, OII Australia argues that “[g]ender-identity confusion”, and social and family concern, justify cosmetic and gonadal interventions that impact on intersex people from infancy and throughout our lives’.¹⁶² Parallels can be drawn between the justifications for FGM and surgical genital normalisation. The range of arguments – fear of bullying and ostracisation; consonance between bodies and social identities; the ability to engage in ‘normal’ sexual activity and form sexual relationships; unambiguous embodiment of a gendered identity – echo many of the attitudes that are identified to explain the prevalence of FGM, and which are treated in that context as irrational.

The Report of the Senate Committee canvasses the evidence relating to surgical normalisation and concludes that there is little evidence to support the practice, noting that this has been conceded by expert specialists in the field.¹⁶³ The Report concludes that ‘there are very limited studies of the long-term outcomes of surgery, and some of the results should be of serious concern’.¹⁶⁴ The Report sets out a number of conclusions and recommends that proposals put forward by OII Australia should be included in guidelines regarding early cosmetic surgery interventions.¹⁶⁵ OII Australia’s proposals given strongest support are:

4. Medical interventions should not be based on psychosocial adjustment or genital appearance.
5. Medical intervention should be deferred wherever possible until the patient is able to freely give full and informed consent; this is known as ‘Gillick competence’.
6. Necessary medical intervention on minors should preserve the potential for different life paths and identities until the patient is old enough to consent.¹⁶⁶

The claim that genital normalising surgeries are therapeutic is so strongly contested that this characterisation should not be relied on to justify surgery without judicial or administrative oversight via independent hearing. The blurry distinction between therapeutic and non-therapeutic medical procedures was acknowledged by the High Court in *Marion’s Case* when they reluctantly adopted it as a criteria to identify the parameters of parental consent.¹⁶⁷ Its role as lynchpin determining legitimacy of consent, particularly where an assessment about therapeutic value is made by the treating physician, has become untenable.

161 S M Creighton, ‘Long-Term Outcome of Feminization Surgery: The London Experience’ (2004) 93 *British Journal of Urology International* 44, 44.

162 Organisation Intersex International Australia, above n 47, 5.

163 Senate Community Affairs References Committee, above n 1, 51 [3.55].

164 *Ibid* 57 [3.73].

165 *Ibid* 74–5 [3.129].

166 Organisation Intersex International Australia, above n 47, 21.

167 *Marion’s Case* (1992) 175 CLR 218, 251 (Mason CJ, Dawson, Toohey and Gaudron JJ).

There has long been a countervailing voice in the intersex community¹⁶⁸ and among some clinicians and academics concerning the medical approach to intersex. The recommendation of the Senate Committee echoes those of various human rights and international law organisations that have been published domestically and internationally in the last two decades. For example, the United Nations Special Rapporteur on Torture tabled a report in February 2013 dealing with abuse in health care settings which includes a strongly-worded criticism of genital normalising surgeries performed on intersex children in infancy.¹⁶⁹ In the United States, the adoptive parents of an intersex child have commenced proceedings on his behalf, suing South Carolina Department of Social Services, Greenville Hospital System, and the Medical University of South Carolina for surgery performed when the child was in foster care to assign him as female.¹⁷⁰ Thus the medical treatment of intersex children, and particularly early genital normalising surgery, is gaining purchase as a matter of serious bioethical and legal concern. The practice in Australia of performing genital normalising surgery on the basis of parental consent is arguably unlawful and unethical.

IV CONCLUSION

An overview of medical and legal attitudes to intersex reveals significant shifts in both approach and emphasis across time. The alternate constructions of sex development identified with Hippocratic and Aristotelian traditions provide a framework around which these shifting and sometimes contradictory, inconsistent or unpredictable attitudes can be analysed. Medical interpretations since the Victorian era have moved from an Aristotelian search for true sex (both conceptually and in medical encounters with intersex patients) to a Hippocratic emphasis on best sex rather than true sex. In the period when optimal gender theory reigned more or less unchallenged, determining best sex meant not only to observe, assess and assign sex, but also to medically and surgically intervene in the body to eradicate intersex by shaping the body to conform to the assignment.

The same shift in legal responses to intersex can be read as occurring in a later time frame. In the 1970s, when optimal gender theory was at its height,

168 See, eg, Organisation Intersex International Australia, <<http://oii.org.au/>>.

169 Juan E Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 22nd sess, Agenda Item 3, UN Doc A/HRC/22/53 (1 February 2013) 18–19 [76]–[79]. See also *Corte constitucional* [Colombian Constitutional Court], SU377-99, 12 May 1999, which established limitations on the scope of parental consent; Australian Human Rights Commission, *Surgery on Intersex Infants and Human Rights*, Discussion Paper (2009); Susanne Brauer (ed), ‘On the Management of Differences of Sex Development: Ethical Issues Relating to “Intersexuality”’ (Opinion No 20/2012, Swiss National Advisory Commission on Biomedical Ethics, November 2012); the prohibition of sex assignment treatment or surgical intervention on the sex characteristics of minors until the child is able to consent: *Gender Identity, Gender Expression and Sex Characteristics Act 2015* (Malta) s 14.

170 Southern Poverty Law Center, ‘Federal Court Says Sex-Assignment Surgery on Child Could Violate US Constitution, Refuses To Dismiss Case’ (News Release, 22 August 2013) <<https://www.splcenter.org/news/2013/08/23/federal-court-says-sex-assignment-surgery-child-could-violate-us-constitution-refuses>>.

judicial decisions on defining sex were clinging to the concept of true sex, immutably inscribed in biology and anatomy. Medical, surgical, psychological, sexual, social, political, cultural and even biological processes could not impinge on true sex, they could only provide a ‘pastiche of femininity’¹⁷¹ or masculinity to mask its unalterable nature. Later judicial decisions in the context of consent to medical procedures on intersex children reveal consistency between the medical and legal approaches. Arguably, the legal perspective has been captured by the medical paradigm that prevailed. This was echoed in legislative and administrative measures to allow legal identity to be altered to reflect best sex rather than true sex.

The current medical management of intersex is far more heterogenous than in the late 20th century. The Senate Committee notes that research into current practices in Australia ‘highlights a great diversity of opinions amongst doctors, and some extreme geographic variation in medical practice’¹⁷² on the issue of genital normalising surgery, concluding that there is ‘no medical consensus’.¹⁷³ While the 2006 Guidelines are considered authoritative, they are couched in terms which countenance a broad range of practices. If Australian practice is any guide, the development of guidelines such as the 2006 Guidelines or the Victorian guidelines have not imposed a consensus of approach and practice. This could be read either as a return to the ‘anarchy of idiosyncrasy’ or as a loosening of the grip of medicalisation. The fact that these changes are occurring coincident with legal and administrative measures to revisit the criteria of legal sex identity and determination and move cautiously away from a strictly dyadic construct of sex provides some grounds for optimism.

Writing on Herculine Barbin,¹⁷⁴ Judith Butler asserts that ‘[h]er plight reveals in graphic terms the societal urge and strategy to discover and define anatomy within binary terms’.¹⁷⁵ This plight has been enacted over and over in the lives of intersex people. Biomedical modes of constructing identity and normality are configured as neutral scientific endeavours. Pathologising intersex variations also individualises and atomises the broader political and cultural issues. It casts intersex bodies as sites for intervention. Biomedicine and law construct sex-binaries as natural and pre-cultural, and discursively invest that construct with cultural and political significance. These constructs are challenged by the incursion of intersex bodies across the boundaries of male and female. Perhaps even more urgently than biomedicine, law has demanded clarity in its partition of categories. As Karpin notes in relation to genetic identities, ‘legal responses to bodily transgression are generally boundary policing and a singular individual is

171 *Corbett* [1971] P 83, 104 (Ormrod J).

172 Senate Community Affairs References Committee, above n 1, 67–8 [3.106].

173 *Ibid* 68 [3.107].

174 Who had intersex variations and whose anatomical ‘ambiguities’ brought her to the attention of the medical and legal establishments in France in the 19th century. Barbin’s memoirs were published after her death: Barbin, above n 13.

175 Judith Butler, ‘Variations on Sex and Gender: Beauvoir, Wittig and Foucault’ in Seyla Benhabib and Drucilla Cornell (eds), *Feminism as Critique: Essays on the Politics of Gender in Late-Capitalist Societies* (Polity Press, 1987) 128, 140.

artificially carved out through juridical force. This sometimes occurs literally on living bodies'.¹⁷⁶ The continuing practice of genital normalising surgeries is a stark example of medical and juridical carving out of tissues that threaten to disrupt our investment in bounded categories of sex.

176 Isabel Karpin, 'Genetics and the Legal Conception of Self' in Margrit Shildrick and Roxanne Mykitiuk (eds), *Ethics of the Body: Postconventional Challenges* (MIT Press, 2005) 195, 205.