

# Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of “Cultural Practices”

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*Nancy Ehrenreich\**

with *Mark Barr\*\**

Western feminism has represented African genital cutting as primitive, irrational, harmful, and deserving of condemnation. The Western medical community has represented its genital cutting as modern, scientific, healing, and above reproach. When will Western feminists realize that their failure to examine either of these claims “others” African women and allows the violent medical oppression of intersex people to continue unimpeded?<sup>1</sup>

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\* Professor of Law, University of Denver College of Law. I would like to thank the following individuals for their comments on previous drafts of this Article: Cheryl Chase, Emi Koyama, G. Kristian Miccio, Laura Rovner, Natsu Saito, Ann Scales, Rickie Solinger, Shelley Tremain, and Leti Volpp. I received helpful feedback as well from the audience and fellow panelists at each of several events where parts of this analysis were presented: Edward W. Clyde Distinguished Visiting Scholar Lecture, University of Utah College of Law, Sept. 2003; 2003-04 University of Denver College of Law Work in Progress Series; 2004 Law, Culture and Humanities Conference; 2004 LatCrit IX Conference. Thanks are also due to the staff of the *Harvard Civil Rights-Civil Liberties Law Review*, and in particular Rebecca Ingber, Allison Elgart, and Anne Fleming for valuable editing suggestions. For able research assistance, I thank librarian Diane Burkhardt and the following research assistants: Elizabeth Getches, Katherine Lovelace, Holly Panetta, Stacy Porto, Elizabeth Titus, Alyssa Yatsko, and Kari Zabel. This research was funded by a grant from the University of Denver College of Law. A directed research project by Keith Anderson, J.D., University of Denver, 2001, and conversations with him about the topic first piqued my interest in intersex issues. Finally, I owe a special debt to Mark Barr, who researched and wrote Part III.A and parts of Part IV, and whose sharp and subtle mind contributed in numerous ways to the information and analysis presented here.

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\*\* J.D., University of Denver College of Law, 2004.

<sup>1</sup> Cheryl Chase, “Cultural Practice” or “Reconstructive Surgery”? *U.S. Genital Cutting, the Intersex Movement, and Medical Double Standards*, in *GENITAL CUTTING & TRANSNATIONAL SISTERHOOD* 126, 145–46 (Stanlie M. James & Claire C. Robertson eds., 2002). Chase's insightful article inspired much of the analysis presented here.

I. INTRODUCTION: NORTH AMERICAN EXCEPTIONALISM, FEMALE GENITAL CUTTING, AND INTERSEX SURGERY

For the past twenty-five years, feminists in the United States and elsewhere have been attempting to eliminate the cutting of women's genitals that is practiced in a number of African (and some Asian) societies.<sup>2</sup> They have run public information campaigns, placed petitions in doctors' offices, lobbied members of Congress, and held protests. As a result of their efforts (as well as those of opponents in the countries where the practices occur),<sup>3</sup> the practice that has been variously called "female genital mutilation" ("FGM"), "female circumcision," "female genital cutting" ("FGC"), or "female genital surgery"<sup>4</sup> has been banned by federal statute<sup>5</sup> and is pro-

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<sup>2</sup> Such procedures are performed in various parts of Africa, as well as on the Arabian Peninsula and in Indonesia and Malaysia. Isabelle R. Gunning, *Arrogant Perception, World-Travelling and Multicultural Feminism: The Case of Female Genital Surgeries*, 23 COLUM. HUM. RTS. L. REV. 189, 195 (1992) (citing E. MEDITERRANEAN REG'L OFFICE, WORLD HEALTH ORG., TECHNICAL PUBLICATION NO. 2, TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN: FEMALE CIRCUMCISION, CHILDHOOD MARRIAGE, NUTRITIONAL TABOOS, ETC. 44 (1979) (Reprint of a Seminar that was held February 10–15, 1979, in Khartoum)). "[T]he vast majority of female genital operations occur on the African continent in countries as diverse as Sudan, Somalia, Ethiopia, Egypt, Kenya, Tanzania, Nigeria, Togo, Senegal, and Mali. Practitioners include Muslims, Christians, Falasha Jews, and followers of indigenous African religions." Christine J. Walley, *Searching for "Voices": Feminism, Anthropology, and the Global Debate over Female Genital Operations*, in GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD, *supra* note 1, at 17, 19. Estimates of rates of circumcision vary widely from country to country (e.g., Senegal: 20% of all women; Somalia: 98%). Amnesty International Human Rights Information Pack, at <http://www.amnesty.org/ailib/intcam/femgen/fgm9.htm> (last visited Oct. 14, 2004). On the history of international efforts to address this practice, see Elizabeth Heger Boyle & Sharon E. Preves, *National Politics as International Process: The Case of Anti-Female-Genital-Cutting Laws*, 34 LAW & SOC'Y REV. 703 (2000). Because the oppositional discourse that is the focus of this Article has primarily associated the practice with African societies, I will primarily refer to those practices in my discussion here.

<sup>3</sup> Although readers will likely be familiar with the decades-long fight against female genital cutting by mainstream United States feminists, they may be less aware that activists in the countries where the surgeries are practiced have also opposed female circumcision for many years. See generally Boyle & Preves, *supra* note 2, at 711, 713–14 (describing some of those efforts). Many activists now direct their efforts to the local level. Susan Kreimer, *Women-Health: Female Mutilations Slow, But Only Gradually*, INTER PRESS SERVICE, Jan. 14, 2004, available at LEXIS, News Library, Inpres File. Those efforts have met with some success. Stanlie M. James, *Listening to Other(ed) Voices: Reflections around Female Genital Cutting*, in GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD, *supra* note 1, at 87, 104–06.

<sup>4</sup> In this Article, I will use the terms "female genital cutting" ("FGC"), "female circumcision," and "female genital surgery," avoiding the more inflammatory "female genital mutilation" ("FGM"). For reasons that will become clear below, I think one should hesitate to call African genital cutting practices "mutilation" unless one is willing to apply the same term to genital cutting practiced in this country. Whether to call these procedures "surgeries" raises more complex issues. On the one hand, the term might suggest more sanitary or institutionalized practices than are often used in African societies. On the other hand, the term "surgery" commonly applied to North American medical procedures (including those on genitalia) evokes assumptions of "scientific" and culture-free expertise that are also not fully accurate. Thus, to use "surgery" only for North American practices would perpetuate exactly the false dichotomy (between "civilized" Western medicine and

hibited in a number of states.<sup>6</sup> It is also now condemned by the United Nations,<sup>7</sup> formally prohibited in several European countries and effectively banned in others, and illegal in the majority of countries where it is commonly practiced.<sup>8</sup>

Yet while attacking this African practice, mainstream feminists in the United States have turned a blind eye to similar, and equally problematic, types of genital cutting that occur in their own country. One of those procedures, male circumcision, is an important issue in itself but is not the focus of this Article.<sup>9</sup> My focus is on a much less well-known and usu-

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“barbaric” non-Western medicine) that this Article attempts to challenge. As a result, I will use “surgery” to apply to both North American and African practices of genital cutting. Similarly, I will apply the term “circumcision,” which seems to me to have a more medical connotation, to both types of procedures as well.

<sup>5</sup> The statute provides:

(a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both.

(b) A surgical operation is not a violation of this section if the operation is—

(1) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner; or

(2) performed on a person in labor or who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife, or person in training to become such a practitioner or midwife.

(c) In applying subsection (b)(1), no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual.

Criminalization of Female Genital Mutilation Act, 18 U.S.C. § 116 (2000).

<sup>6</sup> See, e.g., CAL. PENAL CODE § 273.4 (Deering 2004); DEL. CODE ANN. tit. 11, § 780 (2004); MINN. STAT. § 609.2245 (2003); OR. REV. STAT. § 163.207 (2003).

<sup>7</sup> The General Assembly condemned FGC in its “Girl Child” resolution, passed in 2003. G.A. Res. 57/189, U.N. GAOR, 7th Sess., at 2–3, U.N. Doc. A/RES.75/189 (2003). The World Health Organization of the U.N. has also been active in supporting efforts to end the practice since the 1980s. Boyle & Preves, *supra* note 2, at 713.

<sup>8</sup> Boyle & Preves, *supra* note 2, at 720–21. *But see* INS RESOURCE INFORMATION CENTER, REF. NO. AL/NGA/94.001, ALERT SERIES-WOMEN-FEMALE GENITAL MUTILATION 6 (1994) (“[F]ew African countries have officially condemned female genital mutilation and still fewer have enacted legislation against the practice.”). For a list of the European countries that have prohibited FGC, see *infra* note 22. There are anti-FGC groups in nearly every country where the cutting is practiced. EFUA DORKENOO, CUTTING THE ROSE: FEMALE GENITAL MUTILATION: THE PRACTICE AND ITS PREVENTION 83 (Minority Rights Group 1994).

<sup>9</sup> Male circumcision is still quite widely practiced in the United States. In 1999, 65.3% of all male infants born in U.S. hospitals were circumcised. NAT’L CTR. FOR HEALTH STATISTICS, TRENDS IN CIRCUMCISIONS AMONG NEWBORNS, at <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/circumcisions/circumcisions.htm> (last visited Oct. 17, 2004).

For a critique of this procedure as a violation of informed consent law, see J. Steven Svoboda et al., *Informed Consent for Neonatal Circumcision: An Ethical and Legal Conundrum*, 17 J. CONTEMP. HEALTH L. & POL’Y 61 (2000). I am sympathetic to such critiques but have decided that a thorough discussion of male circumcision is simply beyond

ally more extreme type of genital cutting known as “intersex” surgery. Every year in this country, thousands of intersex genital surgeries are performed on children and infants. These surgeries are medically unnecessary, are far more complicated than African genital cutting, and often have equally, if not more, serious physical and psychological consequences for their recipients.<sup>10</sup> The parents of these children are often poorly informed about the need for and effects of the surgery and are sometimes pressured by doctors to consent to it.<sup>11</sup>

The individuals upon whom these surgeries are performed have one of a variety of conditions involving anomalies of the genitalia that doctors consider to be abnormal. The surgeries are performed to conform these individuals’ genitalia to societal expectations and thereby save them and their parents from psychological trauma, embarrassment, and emotional discomfort. In the vast majority of cases, these conditions pose no physical threat.<sup>12</sup>

In recent years, intersex activists have begun to protest these surgeries, arguing that they are unnecessary and extremely harmful. Finding parallels between intersex surgery and the African practice (in that both are unnecessary genital cuttings that often result in pain, infection, sexual and physical dysfunction, and permanent disfigurement),<sup>13</sup> these activists have proposed that mainstream anti-FGC movement leaders include intersex cutting in their efforts to eliminate unnecessary and harmful genital cutting throughout the world. Leaders of the anti-FGC movement, however, have explicitly refused to embrace the intersex cause.<sup>14</sup>

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the scope of this Article. A number of factors distinguish male circumcision from intersex surgery, including: (1) religious reasons often stand behind the decision to circumcise an infant, raising First Amendment questions that are not raised by intersex surgery; (2) intersex surgery has a much more serious negative impact on physical well-being and sexual function than male circumcision usually does; (3) male circumcision does not permanently preclude alternative sex identities that may be more consonant with the felt identity of the individual; and (4) male circumcision does not seem to enforce patriarchal gender norms, as I argue FGC and intersex surgery do (it might enforce class or racial hierarchies, however). See *infra* Parts II.B.1.d, III.B.4. Despite noting these differences, I reiterate that by limiting my discussion to intersex operations I do not intend to justify the practice of male genital cutting. In fact, I am inclined to think that coalitions among intersex activists, anti-FGC activists and anti-male-circumcision activists could be both productive and elucidating. Cf. Isabelle R. Gunning, *Female Genital Surgeries: Eradication Measures at the Western Local Level—A Cautionary Tale*, in GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD, *supra* note 1, at 114, 117 (noting similarities between male circumcision and FGC, and criticizing the differential treatment of male circumcision (which has been approached as a problem of health care and education) as compared to FGC).

<sup>10</sup> See *infra* Part III.B.1 & 2.

<sup>11</sup> ANNE FAUSTO-STERLING, *SEXING THE BODY: GENDER POLITICS AND THE CONSTRUCTION OF SEXUALITY*, 64–65 (2000); Kate Haas, *Who Will Make Room for the Intersexed?*, 30 AM. J.L. & MED. 41, 62 (2004).

<sup>12</sup> Anne Fausto-Sterling, a leading scholar on intersex issues, has noted that intersex surgery “is cosmetic surgery performed to achieve a social result.” *Id.* at 80.

<sup>13</sup> See *infra* Part III.B.1.

<sup>14</sup> Interestingly, *African* opponents of FGC living in the United States have been more receptive to intersex concerns than the mainstream North American anti-FGC movement

In an attempt to understand (and challenge) that refusal, this Article applies the arguments usually marshaled against FGC to intersex cutting, concluding that those arguments have equal force in the intersex context. Analyzing the discourse of mainstream FGC opponents, the Article concludes that the dissimilar treatment those activists accord to such similar practices is based upon, among other things,<sup>15</sup> a racially privileged North American<sup>16</sup> exceptionalism underlying their thinking.<sup>17</sup> In short, the posture of white privilege subtly revealed in the arguments against female circumcision prevents FGC opponents from acknowledging that similar unnecessary and harmful genital cutting occurs in their own backyards. In turn, recognition of that similarity has policy implications: the condemnation directed at FGC practitioners is inappropriate unless we are equally willing to condemn physicians performing intersex operations. Consistent treatment of both types of cutting requires policies aimed not only at ending the practices but also at recognizing their cultural content and the benign motivations of those who engage in them.

As many have pointed out, the mainstream anti-FGC position is premised upon an orientalizing<sup>18</sup> construction of FGC societies as primitive, patriarchal, and barbaric, and of female circumcision as a harmful, un-

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leaders. See Chase, *supra* note 1, at 141.

<sup>15</sup> See *infra* text accompanying note 337, for a discussion of other possible reasons for the anti-FGC movement's resistance to the intersex issue.

<sup>16</sup> In an effort to avoid using "American," an adjective that conflates the part (the United States) with the whole (the Western hemisphere—the "Americas"), I will use "North American" as an alternative, despite its imprecise reference to both the United States and Canada. Perhaps eventually an appropriate adjective will be developed to refer to the United States alone ("UnitedStatesian"?).

<sup>17</sup> By "exceptionalism," I mean the tendency to assume that the United States is both different from and better than other nations. In other words, my use of the word is disparaging, and is intended to indict the uncritical endorsement of U.S. economic, political, cultural, and legal structures and practices as self-evidently superior to those of other societies. As the discussion of intersex cutting below is intended to illustrate, such knee-jerk pro-U.S. attitudes often serve to obscure and legitimate U.S. military and cultural domination throughout the world, as well as hegemonic practices here at home.

<sup>18</sup> The late Edward Said

use[d] the term "Orientalism" to refer to the discourses that structure Westerners' understanding of the Orient. He emphasize[d] the extent to which the identity of the colonial and postcolonial West is a rhetorical achievement. In a series of imperial gestures, we have reduced "the Orient" to a passive object, to be known by a cognitively privileged subject—ourselves, "the West."

Teemu Ruskola, *Legal Orientalism*, 101 MICH. L. REV. 179, 192 (2002) (citation omitted). See also EDWARD W. SAID, *ORIENTALISM* (1978). Although Said wrote about the "Orient," his insights have been applied to other colonial and postcolonial contexts as well. See, e.g., Katherine M. Franke, *The Uses of History in Struggles for Racial Justice: Colonizing the Past and Managing Memory*, 47 UCLA L. REV. 1673, 1686 (2000). I use his term here to convey the ways in which Western understandings of Africans who practice FGC objectify those individuals as uncivilized and "other" and deploy those disparaging images to construct a contrasting and positive image of the West. For a useful discussion of Said's concept of orientalism and an insightful application of it to Western comparative law analyses of Chinese legal history, see Ruskola, *supra*.

necessary cultural practice based on patriarchal gender norms and ritualistic beliefs.<sup>19</sup> In their (understandable) anxiousness to eliminate procedures that clearly cause much harm and suffering to women, mainstream opponents of female circumcision frequently lapse into an extremely “othering” and disparaging discourse.<sup>20</sup> Lambasting African societies and practices (while failing to critique similar practices in the United States),<sup>21</sup> mainstream North American anti-FGC discourse simultaneously constructs the United States as civilized and sexually egalitarian, and North American genital cutting as safe, scientific, and defensible. It essentially implies that North American understandings of the body are “scientific” (i.e., rational, civilized, and based on universally acknowledged expertise), while African understandings are “cultural” (i.e., superstitious, uncivilized, and based on false, socially constructed beliefs).

Moreover, in emphasizing the “cultural,” socially contingent nature of female genital cutting, the mainstream critique conveys the message that societies where FGC is practiced are homogeneous and monolithic. It implies that the extreme patriarchal nature of those societies is what accounts for particular practices that take place there, such as genital cutting. In short, the cutting becomes a metonym for the entire society; cultures that allow such patriarchal and barbaric practices are patriarchal and barbaric cultures. This discourse thus implicitly elevates the nations from which the mainstream critique of FGC has emanated (primarily former colonial powers),<sup>22</sup> articulating a Western/North American excep-

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<sup>19</sup> Accord Stanlie M. James & Clare C. Robertson, *Introduction: Reimagining Transnational Sisterhood* to GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD 5, *supra* note 1; Clare C. Robertson, *Getting Beyond the Ew! Factor: Rethinking U.S. Approaches to African Female Genital Cutting*, in GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD, *supra* note 1, at 54. In describing the discourse of anti-FGC activism, I am drawing on statements by politicians, journalists, and academics. I refer to this discourse as “feminist” because I assume that the various individuals comprising the anti-FGC movement see themselves as taking a pro-woman position on the issue of genital cutting, and therefore as being feminists, at least for the purpose of that issue. Also, I believe that the anti-FGC position is widely identified in the society at large as “feminist.” I realize that FGC opponents, especially politicians, may not take “feminist” positions on other issues.

<sup>20</sup> See *infra* Part II.B.2.a.

<sup>21</sup> In addition to intersex surgery, which will be my focus here, other harmful gendered cutting practices in the United States that could be compared to FGC include breast augmentation surgery, liposuction, foot surgery (to facilitate the wearing of high heels), and cosmetic reconstruction of the genitals (known as “aesthetic vaginal labioplasty”). SUZANNE J. KESSLER, LESSONS FROM THE INTERSEXED 114 (1998). For further discussion of these practices, see *infra* note 99. I have at least anecdotal evidence that breast reduction surgery should also be included in this list. A student shared with me the story of a friend who had breast reduction surgery because her parents convinced her that she would not be “marriageable” without it. After the surgery, she retained little sensation in her breasts.

<sup>22</sup> Besides the United States, other nations that have expressly criminalized FGC include Great Britain, Switzerland, and Sweden. Canada, the Netherlands, France, and Belgium all prohibit the practice as a form of child abuse. Alexi Nicole Wood, *A Cultural Rite of Passage or a Form of Torture: Female Genital Mutilation from an International Law Perspective*, 12 HASTINGS WOMEN’S L.J. 347, 370–71 (2001). A bill criminalizing genital cutting was recently introduced in the Italian parliament as well. Frank Bruni, *Doctor in*

tionalism that presents those societies as superior to the societies where female circumcision is practiced.<sup>23</sup>

The central point of this Article is that neither of these depictions is accurate. North American medicine is not free of cultural influence, and FGC practices are not bound by culture—at least not in the uniform way imagined by opponents. Thus, a close examination of intersex treatment protocols reveals that they are based on the same types of culture-bound understandings as those that motivate African genital cutting. The Western medical science upon which the “need” for such surgeries is based is not objective, neutral, or universally true but rather reflects patriarchal and heteronormative cultural influences. Moreover, as recent critics have noted, societies where female circumcision is practiced are not monolithically misogynist, ignorant, or barbaric. The reductionist use of female genital cutting as shorthand for “African” “culture” is just as open to a number of challenges as the association of intersex surgery with “objective” science. First, the reductionism masks differences among and within African societies where FGC is practiced.<sup>24</sup> Second, it obscures the wide variety of functions and meanings that attach to distinct female genital cutting practices.<sup>25</sup> Third, it hides the internal political struggles about FGC within particular societies, erroneously relying upon a fixed notion of culture as the monolithic expression of a uniform set of societal values and rules, rather than a dynamic understanding of culture as a contested ground where political and social struggles are negotiated.<sup>26</sup>

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*Italy Tries to Ease Pain of African Tradition*, N.Y. TIMES, Feb. 1, 2004, at A3.

<sup>23</sup> Of course, the rhetoric surrounding the FGC issue is just one of a number of instances of Western discourse that evokes non-Western cultural practices that harm women as evidence of Western superiority, and even as justification for U.S. foreign policies. For a critique of the use of Afghan restrictions on women to justify the recent U.S. invasion of that country, see Nancy Ehrenreich, *Masculinity and American Militarism*, TIKKUN, Nov.–Dec. 2002, at 45. Similarly, France was willing to kill hundreds of thousands of Algerians to “free” Algerian women from the veil. See T. Denean Sharpley-Whiting, *Fanon’s Feminist Consciousness and Algerian Women’s Liberation: Colonialism, Nationalism, and Fundamentalism*, in *RETHINKING FANON: THE CONTINUING DIALOGUE* 329, 340 (Nigel C. Gibson ed., 1999). Of course, it should also be pointed out that, in condemning FGC, mainstream North American feminists were arguably *improving* on the mainstream women’s movement’s past record—a record of virtually complete inattention to reproductive wrongs perpetrated upon women of color. White feminism was woefully silent, for example, during the catastrophic epidemic of sterilization abuse wreaked on low-income women and women of color during the first two-thirds of the twentieth century. See ANGELA Y. DAVIS, *WOMEN, RACE AND CLASS* 215–21 (1981). Thus, anti-FGC activists should be lauded for the willingness to recognize harms suffered by women of color that their movement represents. Nevertheless, the irony persists: they have been willing to condemn genital cuttings perpetrated by *Africans* abroad but not those perpetrated by *European Americans* here.

<sup>24</sup> See *infra* Part II.B.3. See Robertson, *supra* note 19, at 75 (critiquing an author for talking about all Nigerians as a group, even though the country is composed of over 200 ethnic groups).

<sup>25</sup> See *infra* notes 118–121 and accompanying text.

<sup>26</sup> See Nancy Ehrenreich, *Confessions of a White Salsa Dancer: Appropriation, Identity, and the “Latin Music Craze,”* 78 DENV. U. L. REV. 795 (2001) (LatCrit V Symposium issue); James, *supra* note 3, at 90–93; Leti Volpp, *Blaming Culture for Bad Behavior*, 12

Thus, both the cultural, socially constructed aspects of intersex treatment (usually seen as culture-free) and the heterogeneity and fluidity of FGC cultures (usually seen as monolithically patriarchal) suggest that the distinction anti-FGC activists draw between female circumcision and intersex surgery is more illusory than real. Both are harmful cultural practices of genital cutting that are debated and challenged within their own societies. This deconstruction of the two sides of the culture/science binary reveals the flaws in the idea that the FGC issue pits cultural relativism against women's equality and health. Although the "cultural practice" rubric presents the genital cutting issue as posing a conflict between cultural relativism and feminism, a more nuanced understanding of the cultural influences on and social conflicts about both practices exposes that rubric as simplistic and orientalizing. Finally, the conclusion that intersex treatment is not neutral "science" but rather contingent cultural behavior—and that female circumcision is not cohesive cultural tradition but rather contested political practice—removes a central support for the Western/North American exceptionalism upon which anti-FGC discourse is grounded. The intersex issue reveals the influence of white privilege in the mainstream movement's discourse.

Deconstructing the rhetorical binary between the "science" of a "civilized" United States and the "culture" of "uncivilized" FGC societies, the critique of intersex surgery does more than raise questions about the moral purity of our own mainstream positions and practices. It also invites us to revisit the punitive approach to female circumcision taken by statutes such as the federal act criminalizing FGC.<sup>27</sup> If FGC and intersex cutting are sufficiently similar, then either both should be criminalized or both should instead be addressed only through education or other such awareness-raising reforms (as has so far been the approach used with intersex cutting).

While the United States has taken an essentially punitive approach to FGC, the United Nations and a number of African nations have used less coercive, education-focused policies.<sup>28</sup> In contrast, since there is still much debate about the appropriateness of intersex surgery, no institutional commitment to eliminating it exists, whether through education or more punitive means. However, as the discussion below will make clear, I am convinced that the surgeries do significantly more harm than good. That conclusion raises the question of what means should be used to attempt to stop them.

On the one hand, the similarities between FGC and intersex cutting suggest that it would be inappropriate to subject practitioners of female cir-

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YALE J.L. & HUMAN. 89, 90 (2000); Leti Volpp, *(Mis)Identifying Culture: Asian Women and the "Cultural Defense,"* 17 HARV. WOMEN'S L.J. 57 (1994). See also HOMI K. BHABA, *THE LOCATION OF CULTURE* (1994) (culture is performed, not possessed).

<sup>27</sup> 18 U.S.C. § 116.

<sup>28</sup> See Boyle & Preves, *supra* note 2, at 705.



cumcision to serious punishment<sup>29</sup> unless one were willing to treat the practitioners of harmful genital cutting from our *own* society equally harshly. On the other hand, the elevated position of doctors in this society, and the assumption that most physicians performing intersex surgery are benignly motivated,<sup>30</sup> make it difficult to imagine incarcerating such individuals. The intersex critique tempts one to ask, in other words, whether the same steps would have been taken to prevent FGC if it were an established medical practice in *this* society, rather than a rite associated with the most orientalized of continents, Africa.

Finally, the relationship between female circumcision and intersex cutting implicates broader theoretical and practical questions about the interconnections between systems of subordination and the possibility of meaningful collaboration between ant子subordination organizations and movements. Like so many other intersectional issues that appear to pit different subordinated groups against each other, the genital cutting issue (here, seeming to pit “women” against “intersexuals”) illustrates the pitfalls of narrow, group-focused activism. The “not our problem” stance taken by mainstream anti-FGC activists to the issue of intersex surgery is not an uncommon reaction by groups facing invitations to join forces with other social reform efforts. Many examples of similar refusals are well known, such as Betty Friedan’s infamous “lavender menace” dismissal of lesbian efforts to collaborate with heterosexual feminists<sup>31</sup> and the Human Rights Campaign’s refusal to see racial discrimination and sex equality as relevant to the gay community.<sup>32</sup> I have argued elsewhere that such narrow definitions of group interest often work to the disadvantage of identity groups. By ignoring the ways in which systems of subordination mutually reinforce each other, these “not our problem” arguments often unwittingly facilitate that reinforcement in a way that negatively affects their own efforts.<sup>33</sup> Applying that insight to this context suggests that the exclusion of intersex issues from anti-FGC activism may ultimately work *against* the interests of that very movement, rein-

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<sup>29</sup> The federal statute carries a maximum sentence of five years’ imprisonment. 18 U.S.C. § 116. In addition, under current immigration laws, conviction under the statute could result in deportation as well. An immigrant is deportable if convicted of a crime “involving moral turpitude” or a crime which carries a sentence of a year or more. 8 U.S.C. § 1227(2)(A)(i) (2000).

<sup>30</sup> See generally KESSLER, *supra* note 21 (reporting results of study of physician decision-making about intersex treatment).

<sup>31</sup> See LILLIAN FADERMAN, *ODD GIRLS AND TWILIGHT LOVERS* 212 (1991).

<sup>32</sup> See Darren Lenard Hutchinson, *Identity Crisis: “Intersectionality,” “Multidimensionality,” and the Development of an Adequate Theory of Subordination*, 6 MICH. J. RACE & L. 285, 285–88 (2001).

<sup>33</sup> Nancy Ehrenreich, *Subordination and Symbiosis: Mechanisms of Mutual Support Between Subordinating Systems*, 71 UMKC L. REV. 251 (2002) [hereinafter *Subordination and Symbiosis*] (featured article in symposium on “Theorizing the Connections Among Systems of Subordination”).

forcing patriarchal gender norms at home and eliciting defensive reactions to the critique of such norms abroad.

In Part II of the Article, I survey the arguments usually made against female circumcision, showing how those arguments construct such surgery as a harmful cultural (and therefore contingent) practice. In critically assessing the assumptions underlying anti-FGC discourse, I highlight the orientalist tone and exceptionalist assumptions that characterize that discourse, drawing on insights from an alternative, non-mainstream critique of FGC that has been articulated by a number of authors. I also describe the long history of the harmful cultural practice of female circumcision within the Western medical tradition. In Part III, I apply each of the anti-FGC arguments to intersex surgery and show that it, too, can be understood as a harmful cultural practice enforcing contingent, gendered (and heteronormative) cultural standards. In Part IV, I explore the policy implications of identifying both FGC and intersex surgery as harmful cultural practices. In particular, I suggest policies that address both types of surgery in a way that eliminates the harms they produce without demonizing the individuals who engage in them. Finally, in Part V, I return to the broader theoretical issues raised by the refusal of anti-FGC activists to embrace the fight against intersex surgery. I argue that this refusal both reinforces binary sex/gender norms that harm women and likely elicits defensive reactions from the very individuals whose behavior anti-FGC efforts are attempting to change.<sup>34</sup> As such, this resistance to intersex reform efforts illustrates the self-defeating effect of narrowly defined, “not our problem” definitions of group interests.

## II. FEMALE CIRCUMCISION AS HARMFUL CULTURAL PRACTICE: CULTURE, SCIENCE, AND NORTH AMERICAN EXCEPTIONALISM IN ANTI-FGC DISCOURSE

### A. Introduction

The practice usually referred to as “FGM” actually includes several different types of genital surgery. The mildest form, which consists of a slight nicking of the genitals with a sharp instrument, poses few if any health risks. The more serious forms include clitoridectomy (excising the clitoris) and infibulation (sewing the labia majora together, leaving just a small hole for urine and menstrual fluid to exit). These latter two procedures—of which there are a number of versions, each often entailing extreme pain and posing serious physical risks<sup>35</sup>—are the focus of much of

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<sup>34</sup> The analysis presented here is of course just that, an analysis. Proceeding from my own position as a white, upper-middle-class North American law professor committed to antiessentialist and antisubordination theory and practice, the insights conveyed in this Article are admittedly just as provisional, partial, and situated as any other set of insights.

<sup>35</sup> See *infra* Part II.B.1.

the anti-FGC activism.<sup>36</sup> These circumcisions are usually performed by female midwives,<sup>37</sup> on children ranging in age from four years old to adolescence.<sup>38</sup> When the cutting is performed on a young child, it is essentially the decision of the child's parent. When it is performed on an adolescent, the child may initially willingly submit to it, but sometimes secrecy norms will prevent her from being fully informed of the nature of the procedure to which she is consenting.<sup>39</sup> Reasons commonly cited for undergoing the surgeries include economic pressures (to make one marriageable), social traditions (to celebrate womanhood), and health-related concerns (to ensure cleanliness and avoid disease or infertility).<sup>40</sup>

## B. Anti-FGC Discourse

### 1. Common Anti-FGC Arguments

The discourse of anti-FGC activism, articulated by academics, politicians, journalists, and activists, includes several recurring arguments.<sup>41</sup> Opponents recount the painful and dangerous physiological complications that circumcised women often suffer, as well as the harmful psychological impact of the procedure. They emphasize the impairment of sexual functioning that can result from genital surgeries, and the violation of sexual autonomy represented by the trend towards performing the surgeries at young ages. Finally, and most importantly for the purposes of this Article, they characterize the practice as a culture-bound, medically unnecessary ritual designed to reinforce patriarchal power over women.

#### a. Harmful Physical and Psychological Consequences

Descriptions of the immediate and future physiological and psychological effects of FGC provide compelling evidence against it. Mainstream opponents argue further that such procedures are often performed by individuals with little or no modern medical training, under non-sterile

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<sup>36</sup> See Robertson, *supra* note 19, at 60.

<sup>37</sup> Gunning, *supra* note 2, at 219.

<sup>38</sup> Olayinka Koso-Thomas reported in the 1980s that the trend (in Sierra Leone) was to do the cutting at younger ages. OLAYINKA KOSO-THOMAS, *THE CIRCUMCISION OF WOMEN: A STRATEGY FOR ERADICATION* 23–24 (1987).

<sup>39</sup> Opponents of FGC strongly emphasize the role of secrecy in preventing information about the procedures from being widely known. See, e.g., FRAN HOSKEN, *THE HOSKEN REPORT: GENITAL AND SEXUAL MUTILATION OF FEMALES* 52 (4th ed. 1993).

<sup>40</sup> On the health impact of FGC, see *infra* text accompanying notes 46–48.

<sup>41</sup> The points I summarize here represent the mainstream argument in opposition to FGC. They dominate both the scholarship and the Congressional testimony on the subject, as well as journalistic coverage of the issue. An alternative argument against FGC, articulated by some scholars and activists, critiques this mainstream anti-FGC discourse while still opposing the practice. That argument will be discussed further below. See *infra* Part II.B.3.

conditions, and without the benefit of anesthesia.<sup>42</sup> The girl or woman is sometimes forcibly restrained during the cutting.<sup>43</sup> The pain and trauma that these surgeries produce lead opponents to analogize them to child abuse<sup>44</sup> and even rape.<sup>45</sup>

Medical complications of FGC can include shock, urinary infection, pelvic infection (of the uterus and/or vagina), cysts and abscesses, scarring, menstrual pain and blockage, infertility, and even death.<sup>46</sup> Women who have undergone FGC can experience difficulty in urinating, incontinence, painful intercourse, and difficulty in achieving penetration during sex. Their condition may make it difficult for them to obtain vaginal exams or cause them to experience prolonged and obstructed labor during childbirth.<sup>47</sup>

Long-term psychological effects of these procedures may include anxiety, feelings of inadequacy, and depression.<sup>48</sup> Opponents of the practice have characterized it as a humiliatingly public ritual mutilation. Senator Harry Reid, for example, introduced a “sense of the Senate” resolution condemning FGC after the government of Egypt arrested two of its citizens who had allowed a television crew from the United States to film a circumcision they performed.<sup>49</sup> In discussing his resolution, Reid empha-

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<sup>42</sup> See, e.g., HOSKEN, *supra* note 39, at 37.

<sup>43</sup> Joleen C. Lenihan, *A Physician's Dilemma: Legal Ramifications of an Unorthodox Surgery*, 35 SANTA CLARA L. REV. 953, 956 (1995).

<sup>44</sup> In Senate floor debate on criminalization of female genital cutting, Senator Paul Wellstone called the practice a “horrific form of child abuse” and Senator Moseley-Braun labeled it a “child abuse issue.” 140 CONG. REC. S14,244 (1994).

<sup>45</sup> For example, Senator Harry Reid, testifying in favor of the federal statute, made an impassioned plea to “protect innocent young girls.” *Id.* at S14,243 (testimony of Sen. Reid). The use of the word “innocent” is evocative here. It seems to be an allusion to sexual innocence, to the fact that most girls on whom circumcision is performed (at least in the societies which Reid was describing, where it is done between the ages of four and ten) have not had any sexual experience. In a sense, then, Reid suggests that forced surgery on the genitalia of such a child is analogous to the sexual assault of a virgin.

<sup>46</sup> KOSO-THOMAS, *supra* note 38, at 25–26. The incidence of these complications is debated, however. For instance, Richard Shweder argues that “medical complications are the exception, not the rule.” Richard A. Shweder, *What About “Female Genital Mutilation”? And Why Understanding Culture Matters in the First Place*, 129 DAEDALUS 209, 223. He also points out that war, disease, and malnutrition are much more important causes of African children’s deaths. *Id.* Despite those important qualifications however, it still seems likely that a not-insignificant proportion of the surgeries have harmful consequences. See, e.g., *id.* at 224 (reporting urinary infection in 4% to 16% of cases and excessive bleeding in 7% to 13%).

<sup>47</sup> KOSO-THOMAS, *supra* note 38, at 27.

<sup>48</sup> *Id.* at 27–28. *But see* Shweder, *supra* note 46, at 217 (reporting that many women feel happy with the results of their surgeries). While Shweder’s point does raise questions about the incidence of depression or other psychological harms as a result of FGC, widespread patient satisfaction with the procedure does not render it unproblematic. It may, however, raise questions about whether criminalization is the appropriate policy for addressing it.

<sup>49</sup> S. Res. 263, 103d Cong. (1993). The scene was aired on CNN. See Boyle & Preves, *supra* note 2, at 715. There is an irony here, of course, since the public nature of the procedure was apparently imported through the intervention of Western media.

sized that these “two men [had] performed this deed, this illegal act, on a 10-year-old girl in front of television cameras beamed across the world.”<sup>50</sup> This episode contributed greatly to the Western sense that FGC is a public and humiliating ritual. Some opponents have commented on the affront to dignity that the procedure represents,<sup>51</sup> and still others have stated that it treats women as less than human.<sup>52</sup> All of these criticisms demonstrate opponents’ conviction that the surgery often produces emotional as well as physical harm.

*b. Sexual Impairment; Violations of Sexual Autonomy and Bodily Integrity*

Many women who undergo female genital cutting lose sexual function.<sup>53</sup> Obviously, excision of the clitoris is likely to severely impair a woman’s ability to achieve orgasm.<sup>54</sup> Painful scarring and infections further limit the enjoyment that a woman who has undergone FGC can expect to attain from sexual interactions.<sup>55</sup> Penetration can be so difficult that some couples ultimately resort to anal intercourse.<sup>56</sup> All of these problems can diminish the sexual satisfaction that some circumcised women can achieve.<sup>57</sup>

Some opponents of FGC contend that such sexual impairment, which will affect the woman throughout her adult life, should not be forced on underage females without their consent. Emphasizing the fact that many girls lack adequate information about what is going to happen to them,<sup>58</sup> that some are physically restrained during the procedure,<sup>59</sup> and that the

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<sup>50</sup> 140 CONG. REC. S14,243 (testimony of Sen. Reid). Reid’s use of the words “deed” and “illegal act” here evokes the image of a criminal attack, and the nature of the surgery adds the sexual component. The rhetoric evokes rape.

<sup>51</sup> See quote by Senator Reid *infra* text accompanying note 61.

<sup>52</sup> See *infra* text accompanying note 70.

<sup>53</sup> See KOSO-THOMAS, *supra* note 38, at 37–39.

<sup>54</sup> Usually, penile penetration of the vagina is not enough for most women to achieve orgasm consistently; intercourse fails to produce orgasm in more than half the female population by some estimates. DONALD SYMONS, *EVOLUTION OF HUMAN SEXUALITY* 83 (1979). Moreover, some experts believe that, no matter how an orgasm is produced (masturbation, oral stimulation, vaginal stimulation, etc.), female orgasm always results from some form of clitoral stimulation. W.D. Petok, *A Practical Approach to Evaluating Female Sexual Dysfunction*, in ELIZABETH G. STEWART & PAULA SPENCER, *THE V BOOK: A DOCTOR’S GUIDE TO COMPLETE VULVOVAGINAL HEALTH* 117 (2002).

<sup>55</sup> KOSO-THOMAS, *supra* note 38, at 26–28.

<sup>56</sup> *Id.*

<sup>57</sup> *But see* Shweder, *supra* note 46, at 223 (reporting anecdotal evidence that “[c]ircumcised women did not lose their ability to enjoy sexual relations”); Susan Erikson, *Cutting Through the Body Politics: Genital Surgeries and Feminism* 48–51 (1994) (unpublished Master’s Thesis, University of Colorado-Boulder) (on file with the author) (arguing that sexuality in some African societies is not clitorocentric and that, therefore, the extent of the sexual impact of FGC has been overstated).

<sup>58</sup> See HOSKEN, *supra* note 39, at 53.

<sup>59</sup> See Lenihan, *supra* note 43, at 956, 971.

trend is toward performing circumcisions at very young ages<sup>60</sup> (making consent by the child impossible), these opponents of FGC characterize it as a forceful violation of the sexual autonomy and bodily integrity of girls and young women. For example, Senator Reid, testifying before Congress in favor of the federal anti-FGC statute, stated,

What troubles me most about this reality is that [the procedure] is most often performed on children, young girls under the age of 18, at an age at which a child cannot give consent. A child does not have the ability to consent or understand the significance and the consequence of this ritual, certainly what effect it will have on her life and health and certainly not on her dignity.<sup>61</sup>

Opponents of FGC emphasize that the surgery is not medically necessary, making these harmful physiological, psychological, and sexual consequences unjustified.<sup>62</sup>

*c. FGC as “Cultural” Practice*

Mainstream anti-FGC activists clearly see female genital cutting as a “cultural” practice.<sup>63</sup> They do not, however, believe that it should be tolerated in the name of pluralism. Emphasizing that medical knowledge and practices in FGC societies are socially constructed—that is, that they represent cultural traditions specific to the societies in which FGC is practiced<sup>64</sup>—many opponents reject a posture of relativist deference to such practices. Senator Carol Moseley-Braun, testifying in favor of the federal anti-FGC statute, noted that she did not see this issue as “just a matter of difference in cultural points of view. This really goes to a public health concern, a concern for human rights that I think as Americans we all share.”<sup>65</sup> Similarly, Representative Patricia Schroeder, the bill’s principal author, remarked, “FGM has long been excused as a cultural and religious difference. Such a designation ignores the pain, trauma, infections and serious long-term psychological and physical effects that women who have been mutilated cope with.”<sup>66</sup> For these individuals, the status of

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<sup>60</sup> See AMNESTY INT’L, FEMALE GENITAL MUTILATION: A HUMAN RIGHTS INFORMATION PACK, available at <http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm#a2> (last visited Nov. 24, 2004).

<sup>61</sup> 140 CONG. REC. S14,243 (testimony of Sen. Reid).

<sup>62</sup> “There are no medical justifications for these practices on healthy girls or women.” H.R. REP. NO. 103-501, at 502 (1994).

<sup>63</sup> For discussion of possible assumptions behind this notion of “cultural practice,” see *infra* Part II.B.2.c.

<sup>64</sup> 140 CONG. REC. S14,244 (statement of Sen. Wellstone) (“cultural tradition”); H.R. REP. NO. 103-501, at 2 (“cultural, traditional, and social pressures”).

<sup>65</sup> 140 CONG. REC. S14,244 (statement of Sen. Moseley-Braun).

<sup>66</sup> *Hearing on Human Rights Abuses Against Women Before the House Comm. on Foreign Affairs, Subcomm. on Int’l Security, Int’l Org.s & Human Rights*, 103d Cong. 133

FGC as a cultural practice is outweighed by its violation of universal human rights.

*d. FGC as Gender Subordination*

Many opponents have pointed out that female genital cutting is a practice with a particular political valence. Emphasizing its purpose of enforcing virginity and fidelity, its status as a prerequisite to marriageability, its stigmatization of female sexual organs as dangerous and dirty, and its reduction of women's capacity for sexual pleasure, they argue that FGC is a central mechanism for enforcing patriarchal power.<sup>67</sup> As author Olayinko Koso-Thomas has noted, female circumcision is "a symbol of feminine maturity and subservience. Women have been successfully persuaded to attach special importance to female circumcision, motherhood, and housekeeping, in order to maintain male domination in patriarchal societies."<sup>68</sup> Alexi Nicole Wood notes that the societies where FGC is practiced are "highly patriarchal" and emphasizes that genital cutting should be understood as "part of a larger system of discrimination, domination and control of women" in such countries.<sup>69</sup> Similarly, Senator Moseley-Braun has described the practice as "a passport into the only role that women can play," concluding, "[f]emale circumcision is, in the final analysis, about treating women as something less than people."<sup>70</sup> Thus, opponents view FGC as a tool of hegemony—a mechanism by which male superiority is created, male control over women's sexuality is effectuated, and consignment of females to the traditional roles of wife and mother is enforced.<sup>71</sup>

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(1993) (testimony of Rep. Patricia Schroeder) [hereinafter "*Hearing*"]. See also Wood, *supra* note 22, at 385–86 (noting that, "[i]t is important . . . for Western women's rights groups not to impose their own sets of values on African women," but nevertheless concluding that, "FGM must be seen not as a cultural rite of passage into adulthood, but as a form of torture and sexual subordination of women.").

<sup>67</sup> See, e.g., Amanda Cardenas, Note, *Female Circumcision: The Road to Change*, 26 SYRACUSE J. INT'L. L. & COM. 291, 311 (1999). Of course, some of these critics' conclusions have themselves been challenged—such as the apparent assumption that the mechanisms and details of sexual pleasure are universal. See, e.g., Erikson, *supra* note 57.

<sup>68</sup> KOSO-THOMAS, *supra* note 38, at 97. Unlike some of the other critics mentioned in this paragraph, Koso-Thomas by and large avoids orientalizing the societies or individuals who engage in FGC and emphasizes that "[t]he first step in this revolution must be taken by the women themselves, using their own organizations." *Id.* at 98.

<sup>69</sup> Wood, *supra* note 22, at 371–72.

<sup>70</sup> 140 CONG. REC. S14,245 (statement of Sen. Moseley-Braun).

<sup>71</sup> I should emphasize that I do not disagree with this conclusion; I merely object to the impression, created by many mainstream critics of FGC, that our own society is comparatively free of patriarchal practices. See *infra* Part III. In contrast, Shweder argues that the frequency of male circumcision in FGC societies suggests gender equality rather than inequality. Shweder, *supra* note 46, at 221. I find this argument unconvincing, however, at least without having more information about the actual cultural *meaning* and *effect* of the surgery in each instance.

Although they are sometimes overstated, each of these arguments against FGC makes a compelling point. However, as discussed further below, characterizing FGC as a cultural practice of gender subordination without addressing similar subordinating practices in the United States creates misimpressions about practices, practitioners, and peoples in societies where FGC occurs. In so doing, this characterization relies upon and reinforces orientalizing images of African societies.

## 2. *Culture Versus Science: The Hidden Messages Conveyed by Mainstream Anti-FGC Discourse*

In labeling female circumcision as a harmful cultural practice that should be eliminated while simultaneously failing to criticize intersex cutting,<sup>72</sup> mainstream anti-FGC discourse constructs the former as inaccurate and “unscientific” and the latter as a rational response to objective medical truths.<sup>73</sup> This orientalizing effect is, in turn, exacerbated by the inflammatory and disparaging tone that frequently characterizes the statements made by mainstream opponents of FGC. I turn first to the issue of tone.

### a. *Disparaging and Orientalizing Tone*

While some opponents are nuanced and thoughtful in their critiques,<sup>74</sup> mainstream anti-FGC discourse constructs societies where FGC is performed as barbaric, primitive, and uncivilized.<sup>75</sup> This discourse implies

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<sup>72</sup> This silence on the intersex question (as well as on male circumcision) is strikingly consistent in the mainstream anti-FGC literature and is precisely what makes the tone of that literature so problematic. In contrast, the authors I am calling “alternative” critics of FGC do sometimes mention intersex surgery. *See, e.g.*, GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD, *supra* note 1 (including a piece by intersex activist Cheryl Chase). If mainstream anti-FGC critics had also condemned intersex surgery as “barbaric” and those consenting to it as “ignorant,” or if they had acknowledged the numerous patriarchal aspects of their own society, that literature would be much less susceptible to my orientalization critique. *Cf.* bell hooks, *Sexism and Misogyny: Who Takes the Rap?*, Z MAG., Feb. 1994, at 26–29 (critiquing feminists who indicted the misogyny in African American rap music without indicting similar misogynist practices by European Americans).

<sup>73</sup> In a recent French case against a practitioner and some parents of excised girls, one of whom had died from the operation, the prosecutor’s summation to the jury characterized the case as involving “law versus custom, the unacceptable versus the tolerable, the universality of certain values versus cultural relativism.” *See* Robertson, *supra* note 19, at 72.

<sup>74</sup> *See infra* Part II.B.3.

<sup>75</sup> Sometimes that association of FGC with barbarism is explicit. *See, e.g.*, 142 CONG. REC. S8,972-01, S8,973 (1996) (testimony of Sen. Reid); Jaimee K. Wellerstein, *In the Name of Tradition: Eradicating the Harmful Practice of Female Genital Mutilation*, 22 LOY. L.A. INT’L. & COMP. L. REV. 99, 101 (1999) (labeling the practice “torture” and calling for its criminalization). Senator Reid used the word “barbaric” four times in his testimony. Cynthia Fernandez-Roman, *The Banning of Female Circumcision: Cultural Imperialism or a Triumph for Women’s Rights?*, 13 TEMPLE INT’L & COMP. L.J. 137, 152 n.145 (1999). Feminist theorist Mary Daly included FGC in her list of “Unspeakable Atrocities.” Robertson, *supra* note 19, at 62–63. Other times, however, the primitive nature



that these societies need the enlightened, civilizing influence of North American culture—and of critics of FGC in particular—in order to abandon their harmful traditional practices.<sup>76</sup> Through analogies to torture, child abuse, and woman battering,<sup>77</sup> and labels such as “ritualistic” and “barbaric,” mainstream anti-FGC discourse thus “others” African societies as uncivilized places engaging in irrational and misogynistic behavior, and elevates the United States as a site of enlightened, scientific practices that are consistent with feminism.

For example, when testifying before Congress in favor of the federal anti-FGC statute, Representative Schroeder called female circumcision an “[a]buse[ ] against women,” comparing it with domestic violence and torture.<sup>78</sup> Columnist Abe Rosenthal, author of many newspaper articles opposing the practice, has contended that it is “rooted in superstitious contempt of women.”<sup>79</sup> Feminist columnist Ellen Goodman says that FGC “happens only in places where ancient ritual still overwhelms reason,” places where “women are taught that mutilation is the price of belonging.”<sup>80</sup> Similarly, novelist Alice Walker, in her anti-FGC book, *Warrior Marks*, calls practitioners of FGC “prisoners of ritual.”<sup>81</sup> Academic arti-

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of African genital cutting is just subtly implied by referring to FGC as a “traditional” or “ignorant” practice.

<sup>76</sup> For a review and critique of mainstream academic, media, and legal representations of female genital cutting, see Robertson, *supra* note 19, at 54–86. In her survey, Robertson identifies “three R’s” that characterize representations of female genital cutting in those discourses: reducing all of Africa to one uncivilized place; reducing African women to the status of their genitals, presumed to be infibulated, and Africans to being sadistic torturers or victims; and reducing all FGC to its worst form, infibulation. James & Robertson, *supra* note 19, at 5. She notes as well that legal discourse about asylum cases constructs “African women as helpless victims of infamous practices, while the United States [is] being presented as a liberated paradise for Africans.” Robertson, *supra* note 19, at 75. These images are consistent, Robertson says, with racist stereotypes of Africans as needing “the help of more advanced civilizations, a.k.a. European-Americans, to raise them out of their ignorance and poverty, which ancient rituals perpetuate by promoting ‘tradition.’” *Id.* at 59. Tellingly, the discussions of the federal FGC prohibition in Congress repeatedly identified FGC as a “traditional” practice. See, e.g., H.R. REP. NO. 103-501 (1994).

<sup>77</sup> See *infra* notes 78–81 and accompanying text.

<sup>78</sup> *Hearing, supra* note 66, at 133 (statement of Rep. Patricia Schroeder).

<sup>79</sup> The full quotation is: “rooted in superstitious contempt of women so deep that its victims, their mothers and daughters pay homage to the knife that mutilates them.” A. M. Rosenthal, *World’s Females Not Protected from Mutilation*, OREGONIAN, July 28, 1993, at C7.

<sup>80</sup> Ellen Goodman, *A Grotesque Tradition*, BOSTON GLOBE, Oct. 19, 1995, at 19.

<sup>81</sup> ALICE WALKER & PRATIBHA PARMAR, *WARRIOR MARKS* 25 (1993). See also HANNY LIGHTFOOT-KLEIN, *PRISONERS OF RITUAL: AN ODYSSEY INTO FEMALE GENITAL MUTILATION AND THE SEXUAL BLINDING OF WOMEN*, at x (1993) (referring to “men and women entrapped in an antiquated ritual, dating from heaven knows how far back into history, unable to free themselves from its centuries-old enmeshment, all of them its prisoners”). For a discussion of the implicit messages in this “prisoner of ritual” theme, see *infra* note 85. It is perhaps worth emphasizing here that I believe the dedication of Walker, Schroeder, and others to eliminating female circumcision should be applauded, and that the end they sought is a laudable one. My objection is only to the tone with which they undertook to accomplish their ends, and the assumptions that seem to have informed their efforts. For a more detailed critique of Walker and Parmar’s *Warrior Marks*, see James, *supra* note 3, at

cles use equally strong language.<sup>82</sup> According to Alexi Nicole Wood, “FGM should be seen as torture, cruel, inhuman and degrading treatment and child abuse.”<sup>83</sup> Examples of such extreme language abound.<sup>84</sup>

*b. Western Medical Practice as Culture-Free*

By labeling African genital cutting a “cultural practice” but not applying the same label to North American intersex surgery, FGC opponents imply that medical treatment around intersex cutting is culture-free.<sup>85</sup> In so doing, they also imply that procedures deemed necessary by

89, 103.

<sup>82</sup> Academicians convey similar messages in their classes as well. Claire C. Robertson recounts, for example, how

some of my colleagues in women’s studies were teaching students in introductory or women’s health courses about female genital cutting, usually in a section about violence against women, without providing any cultural context whatsoever. All of Africa was reduced to one place and all of the practices reduced to infibulation, called FGM, giving the impression that all African women are genitally mutilated.

Robertson, *supra* note 19, at 55.

<sup>83</sup> Wood, *supra* note 22, at 352 (citations omitted). Similarly, the columnist A. M. Rosenthal has referred to the practice as “torture,” a “crime,” and “sexual and social insanity.” A. M. Rosenthal, *On My Mind: Female Genital Torture*, N.Y. TIMES, Dec. 29, 1992, at 15; A. M. Rosenthal, *The Torture Continues*, N.Y. TIMES, July 27, 1993, at 13.

<sup>84</sup> Robertson cites several others, including: “African women . . . are yoked to a traditional culture that keeps them pregnant and powerless.” Robertson, *supra* note 19, at 67. For other examples, see *infra* Parts II.B.2.b & c.

<sup>85</sup> In Western discourse, culture is often contrasted with “nature,” which tends to be equated with biological imperatives. The term “culture” evokes associations with human consciousness (as opposed to unthinking plants and animals), with artifice and human creation (as opposed to instinct), and with contingency and agency (as opposed to biological destiny). In nature/nurture debates, for example, lines are drawn between traits that are innate and unchangeable, on the one hand, and those that are socialized and malleable on the other. See Janet E. Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability*, 46 STAN. L. REV. 503 (1994) (discussing biological versus social understandings of sexual orientation). In such discourse, emphasis on the contingency of culture rhetorically invokes as its opposite the notion of universal scientific knowledge—and, in this context, of universal medical knowledge about human biology. If a practice is necessitated by culture, then it is not biologically driven, and vice versa. See generally Michelle Z. Rosaldo, *Moral/Analytic Dilemmas Posed by the Intersection of Feminism and Social Science*, in SOCIAL SCIENCE AS MORAL INQUIRY 76 (N. Haan et al. eds., 1983) (discussing the tension for feminist anthropologists between believing in some sort of universal female “nature” and extolling the virtues of cultural relativism).

In addition to the contrast that anti-FGC discourse thus draws between contingent culture and universal science, its “prisoners of ritual” motif also draws upon certain associations with “culture.” See *supra* note 81 and accompanying text. When behavior is associated with culture, the message conveyed is that the individuals engaging in it lack agency and the capacity for rational thought. Leti Volpp, *Feminism Versus Multiculturalism*, 101 COLUM. L. REV. 1181, 1211 (2001). Thus, calling circumcised women prisoners of ritual supports a view of them as helpless victims of a patriarchal society. This imagery dehumanizes and disparages both the practitioners of FGC and the individuals upon whom the surgeries are performed, as well as rendering invisible indigenous efforts to reform the practice. Such a passive image of African women in turn facilitates the construction of North American reformers as educators and saviors.

doctors in the United States cannot possibly constitute “cultural practices” or “rituals” of the sort that exist in Africa.<sup>86</sup> This conclusion is consistent with common, hegemonic understandings of Western medicine as providing objective, apolitical, and accurate descriptions of physical processes and conditions.<sup>87</sup> To the extent that scientific (in this case, medical) assessments of, and treatment protocols for, various human conditions are seen as merely descriptive of a biological reality, they are *not* seen as cultural, socially constructed, or contingent.<sup>88</sup>

This rhetorical association of Western medical knowledge with objective science as opposed to contingent culture ignores not only the cultural understandings behind intersex treatment protocols (to be discussed further below),<sup>89</sup> but also the history of female circumcision in the West—as well as modern feminist critiques of medicine and of science more generally.<sup>90</sup> As critics of mainstream anti-FGC discourse have pointed out, female circumcision was long used in Western societies, and its use was justified on grounds of medical necessity premised upon patriarchal as-

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<sup>86</sup> This implicit endorsement of North American obstetrics is particularly problematic in light of feminist critiques of U.S. birthing practices, which overuse Cesarean sections and episiotomies and pathologize women’s bodies and the process of labor. *See generally* OUR BODIES OURSELVES FOR THE NEW CENTURY 468–70 (Boston Women’s Health Collective 1998) (critiquing mainstream Western childbirth practices); BARBARA KATZ ROTHMAN, *IN LABOR: WOMEN AND POWER IN THE BIRTHPLACE* (1982) (favorably comparing midwife-assisted birthing practices in the United States with physician-assisted delivery); Nancy Ehrenreich, *The Colonization of the Womb*, 43 *DUKE L.J.* 492, 530–38 (1993) (documenting overuse of consented C-sections and racially disproportionate use of mandatory Cesareans).

<sup>87</sup> *Cf.* Ehrenreich, *supra* note 86, at 541–42 (arguing that medical “knowledge” about human reproduction is socially constructed); Shelley Tremain, *On the Government of Disability*, 27 *SOC. THEORY & PRAC.* 617 (2001) (criticizing disability studies theorists for assuming that scientific descriptions of bodily “impairment” are unmediated by culture).

<sup>88</sup> Of course, the culture/science binary is racialized as well. Thus, socially unacceptable individual behavior by members of minority groups is often understood as reflecting the “culture” of the entire group (e.g., the “culture of poverty”) while privileged, white actors who engage in similar behavior are seen as individuals. However, the positive behavior of members of racialized groups is often *not* seen as representing their cultures. For example, the successes of athletes of color are often attributed to their innate physical abilities, while the successes of white athletes are attributed to their discipline and hard work.

<sup>89</sup> *See infra* Part III.

<sup>90</sup> *See generally* BARBARA EHRENREICH & DEIDRE ENGLISH, *FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS’ ADVICE TO WOMEN* (1978) (describing and critiquing the history of inaccurate medical “verities” about women’s bodies); ANNE FAUSTO-STERLING, *MYTHS OF GENDER: BIOLOGICAL THEORIES ABOUT WOMEN AND MEN* (1985) (critiquing sociobiological research on gender); DONNA HARAWAY, *PRIMATE VISIONS: GENDER, RACE & NATURE IN THE WORLD OF MODERN SCIENCE* (1989) (critiquing primatology); *THE “RACIAL” ECONOMY OF SCIENCE: TOWARD A DEMOCRATIC FUTURE* (Sandra Harding ed., 1993) (race- and gender-based critiques of science); KATZ ROTHMAN, *supra* note 86 (critiquing medical management of birthing); SUZANNE J. KESSLER & WENDY MCKENNA, *GENDER: AN ETHNOMETHODOLOGICAL APPROACH* (1978) (critiquing medical theories of gender); EMILY MARTIN, *THE WOMAN IN THE BODY* (1987) (medical anthropological analysis of Western medical understandings of women’s bodies). *See also* Ehrenreich, *supra* note 86 (critiquing court-ordered Cesarean sections as disciplinary gender practice).

sumptions about women.<sup>91</sup> Clitoridectomy was performed in Great Britain until the 1860s, as well as in France and Germany. In this country, female circumcision began in the late 1860s and, despite the fact that the British medical establishment repudiated it in 1867, continued well into the twentieth century.<sup>92</sup> The surgery was usually performed to address female “hysteria,” a diagnosis that was frequently applied to women who violated gender norms of the era. Behaviors “treated” with the surgery included masturbation, hypersexuality, melancholy, and nervousness, as well as “[I]esbianism and aversion to men.”<sup>93</sup> Middle-class white women, the same demographic group agitating for women’s rights during this period, were the main recipients of clitoridectomies.<sup>94</sup> Like current recipients of FGC on other continents, they often consented to these treatments, convinced that the surgeries were necessary to alleviate their depression or “cure” their “deviant” impulses.<sup>95</sup> Other recipients of genital surgeries did not have that luxury, however. No option to refuse was given, for example, to the slave women and poor white immigrant women who were subjected to shocking “practice” surgeries—as many as thirty per woman—performed by the now-infamous Dr. Marion Sims to perfect the clitoridectomies and other gynecological techniques he would later use on privileged white women.<sup>96</sup>

Isabelle Gunning, discussing the important research of Ben Barker-Benfield, places these surgeries in historical context. Following the Civil War, white men in the United States were concerned not only about “disorderly” women who posed a threat to the established patriarchal order by seeking to wear bloomers and speak in public, but also about immigrants who posed a threat to the “racial purity” of the United States. Thus, female circumcision practices arguably expressed social concerns of the dominant male elite about threats posed by both middle class

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<sup>91</sup> Wood is one mainstream anti-FGC author who does mention the historical use of genital cutting in Europe and the United States during the nineteenth century. Wood, *supra* note 22, at 361. She says nothing, however, about intersex surgeries today, giving the distinct impression that harmful genital mutilation no longer occurs in the West.

<sup>92</sup> Ehrenreich and English, in their groundbreaking exploration of the historical effect of gender-based assumptions on medical practice, report that the last known clitoridectomy in the United States was performed on a five-year-old girl in 1948 to cure masturbation. EHRENREICH & ENGLISH, *supra* note 90, at 111. Other procedures performed on women during the nineteenth century included ovariectomies (removal of the ovaries) and the application of leeches or hot steel to the cervix. *Id.* at 111–12.

<sup>93</sup> Gunning, *supra* note 2, at 207–08.

<sup>94</sup> EHRENREICH & ENGLISH, *supra* note 90, at 112.

<sup>95</sup> Gunning, *supra* note 2, at 208 (noting that this compliance is the same sort of attitude that “contemporary European feminists might describe as ‘false consciousness’ in African or Middle Eastern women today”).

<sup>96</sup> See Diana E. Axelson, *Victims of Medical Experimentation: J. Marion Sims’ Surgery on Slave Women, 1845–1850*, 2 SAGE 10 (1985); Ben Barker-Benfield, *Sexual Surgery in Late Nineteenth Century America*, 5 INT’L J. HEALTH SERVICES 279, 288–89 (1975). Of course, in many cases, even privileged women lacked a meaningful opportunity to withhold consent. See, e.g., CHARLOTTE PERKINS GILLMAN, *THE YELLOW WALLPAPER* (1899).

women and lower class immigrant populations. Those concerns were addressed by controlling the sexual and reproductive behavior of both groups of women. Moreover, these surgeries also might have helped to elevate the status of the field of gynecology, which arose as a specialty during this period.<sup>97</sup> Barker-Benfield describes gynecological practice of the era as “characterized by flamboyant, drastic, risky and instant use of the knife.”<sup>98</sup> These dramatic surgeries arguably enhanced the image of gynecological practitioners, presenting them as god-like transformers of the bodies—indeed, the very nature—of North American women.

Thus, Western nations are not immune from patriarchal cultural practices that involve female genital cutting. Moreover, these historical accounts cannot be dismissed by arguing that the United States is simply more advanced than non-Western nations, having abandoned practices that those nations still employ. Other more modern practices of harmful bodily disfigurement to which women consent in order to conform their bodies to patriarchal gender norms include breast augmentation surgery, liposuction, and even genital reconstruction.<sup>99</sup> Moreover, as Part III will

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<sup>97</sup> Gunning, *supra* note 2, at 205–10.

<sup>98</sup> Barker-Benfield, *supra* note 96, at 284. For a striking contrast, compare this description to Fausto-Sterling’s discussion of the competitive and ostentatious development and deployment of intersex surgical techniques designed to correct hypospadias (“misplaced” urethra). See FAUSTO-STERLING, *supra* note 11, at 61–63 (“[A] review of the literature . . . suggests that surgeons take particular pleasure in pioneering new approaches to penile repair. Even medical professionals have remarked on this obsession with penis-building.”).

<sup>99</sup> In 2002, nearly 237,000 women underwent breast augmentation and more than 230,000 had liposuction. AMERICAN SOCIETY OF PLASTIC SURGEONS, 2002 GENDER DISTRIBUTION STATISTICS, at [http://www.plasticsurgery.org/public\\_education/2002statistics.cfm](http://www.plasticsurgery.org/public_education/2002statistics.cfm) [hereinafter *Statistics*]. Cosmetic genital reconstruction surgery, including reduction in the size of the clitoris and/or labia, is also increasingly available. See KESSLER, *supra* note 21, at 112–19. Of course, each of these procedures poses the usual dangers associated with major surgery. Other serious complications may result from some of the surgeries as well. For example, 33% of women with breast implants experience rupture and removal or replacement of the implants. S. Lori Brown & Gene Pennello, *Replacement Surgery and Silicone Gel Breast Implant Rupture: Self Report by Women After Mammoplasty*, 11 J. WOMEN’S HEALTH & GENDER-BASED MED. 255, 255 (2002). Some strongly suspect that breast augmentation surgery can lead to cancer, although these claims have been hotly disputed. See, e.g., Louise Brinton & S. Lori Brown, *Breast Implants and Cancer*, 89 J. NAT’L CANCER INST. 1341 (1997); Joseph K. McLaughlin et al., *Cancer Risk Among Women With Cosmetic Breast Implants: A Population Based Cohort Study in Sweden*, 90 J. NAT’L CANCER INST. 156 (1998). Patients undergoing liposuction may experience a range of complications, from minor (small hematomas, seromas, and minor contour irregularities) to more severe (lidocaine toxicity, fluid overload, infection, skin perforations, major contour defects, skin necrosis, thermal injury, pulmonary embolus, and fat embolus). The more severe complications may require additional surgery or hospitalization and, in rare cases, result in death. COMM. ON PUB. SAFETY, AM. SOC’Y OF PLASTIC SURGEONS, PRACTICE ADVISORY ON LIPOSUCTION, EXECUTIVE SUMMARY (2003), at [http://www.plasticsurgery.org/medical\\_professionals/Policy\\_Statements/Policy-Statements.cfm](http://www.plasticsurgery.org/medical_professionals/Policy_Statements/Policy-Statements.cfm).

It is worth noting as well that the recent television and radio fad of offering plastic surgery “makeovers” to selected men and women suggests that men are also increasingly subject to pressures to conform to unrealistic gender norms. The ASPS statistics also demonstrate this trend: in 2002, 52,797 men underwent liposuction. *Statistics, supra*. According to Kessler, men are beginning to obtain cosmetic penis surgery as well. KESSLER, *supra*

reveal, intersex surgery is striking evidence that the harmful cultural practice of *nonconsensual*<sup>100</sup> genital- (and gender-) normalizing cutting continues in this country.

*c. African Medical Practice as Contingent and Culture-Bound*

In condemning African genital cutting but not intersex surgery, anti-FGC discourse conveys the message that, unlike “scientific” North American doctors, medical practitioners (often midwives) who perform African female circumcisions are backward, ignorant, and superstitious.<sup>101</sup> Constructing African procedures as *not* a medical or biological imperative, this discourse implies instead that they are the product of a particular, contingent, and dispensable set of cultural categories. That is, the surgeries are performed because they serve to create or reinforce certain roles, beliefs, or behaviors that characterize the culture of which they are a part.<sup>102</sup> As intersex activist Cheryl Chase puts it: “[A]nti-FGM activists seemingly consider Africans to have ‘harmful cultural or traditional practices,’ whereas we in the modern industrialized West presumably have something better. We have science . . . .”<sup>103</sup>

Characterizing female genital cutting as a contingent cultural practice presents it as open to legitimate criticism, thereby justifying challenges to the practice. Thus, as noted above, while opponents perceive FGC as raising concerns about cultural relativism, they nevertheless dismiss those concerns. In fact, the disparaging tone of their discourse makes it clear that they see little in these “cultural” practices that deserves protection. For some, cultural deference does not seem to be a concern at all. Thus, Alice Walker, when rhetorically addressing the mother of a friend who had been ostracized from her community for refusing FGC, had this to say: “I want to shout across the miles separating us: *Stand up and be a mother, damn it!* Don’t make this child suffer when, after all, *she* is right, not the society that enslaves both of you!”<sup>104</sup>

This emphasis on FGC as a primitive, ignorant, and misogynist cultural practice unique to Third World, especially African, societies is created by rhetorically contrasting it with an image of the United States as

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note 21, at 116.

<sup>100</sup> Many intersex surgeries are not consented to in the sense that they are performed upon infants who lack the capacity to consent.

<sup>101</sup> On the association of medicine with whiteness and maleness, see Ehrenreich, *supra* note 86, at 530–38.

<sup>102</sup> I do *not* mean to deny that FGC is all of these things. I do see it as a socially constructed cultural practice. My point here is simply to contrast the labeling of FGC as a cultural practice with the labeling of intersex cutting as scientific medical treatment, and to highlight the differential rhetorical strategies made possible by that labeling.

<sup>103</sup> Chase, *supra* note 1, at 142.

<sup>104</sup> WALKER & PARMAR, *supra* note 81, at 32–33.

the source of enlightened, pro-woman policies.<sup>105</sup> Opponents of FGC often present the problem as one of education and the United States as the educator. In his testimony supporting the federal statute, Senator Harry Reid advised that we need to “educate individuals that [FGC] is wrong.”<sup>106</sup> Even Senator Paul Wellstone, the recently deceased scion of the progressive movement in this country, fell prey to such rhetoric. Testifying before Congress in favor of the anti-FGM statute, Wellstone revealed his North American exceptionalism by arguing that such legislation would “set . . . an example for the world.”<sup>107</sup> Emphasizing that immigrants from Africa and elsewhere were importing female circumcision into the United States,<sup>108</sup> he remarked, “[I]t is difficult to . . . acknowledge that this form of child abuse could take place in our communities—in a nation which considers itself civilized.”<sup>109</sup>

Alice Walker emphasizes African ignorance as well, commenting that “those who practice [female genital cutting] are, generally speaking, kept ignorant of its real dangers—the breakdown of the spirit and the body and

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<sup>105</sup> It is useful to compare the rhetoric quoted above with that used in more culturally sensitive discussions of female genital cutting. For example, Hamid M. Khan also alludes to African genital cutting as a cultural practice, and likewise dismisses a “cultural” defense of the practice, but does so in a more thoughtful and less polemical way:

[W]e should unashamedly defend universality, defend a really universal universalism, defend what is positive, . . . humanist about the Western tradition, the Muslim tradition, and about other traditions as well. And at the same time, we must mercilessly challenge what is anti-humanist, anti-human rights, in all of the above traditions, regardless of what justification is offered thereto, be it cultural, religious, social, or one we don’t sometimes think about in this category, free market oriented.

Hamid M. Khan, *Dueling Fates: Should the International Legal Regime Accept a Collective or Individual Paradigm To Protect Women’s Rights?*, 24 MICH. J. INT’L L. 347, 469 (2002). See also Erika Sussman, *Contending with Culture: An Analysis of the Female Mutilation Act of 1996*, CORNELL INTL. L.J. 193, 212 (1998) (“The campaign against female circumcision will fail if it is perceived as an imperialist attempt to save non-Westerners from their ‘peculiar customs.’”). For a strong yet thought-provoking critique of the tone and content of anti-FGC discourse, see Shweder, *supra* note 46, at 209.

<sup>106</sup> 140 CONG. REC. S14,243 (testimony of Sen. Reid); Wellerstein, *supra* note 75, at 128 (“The international community . . . must . . . fulfill its responsibility by intervening and educating those who are ignorant about the reality of a woman’s body and the dangers inherent in female genital mutilation.”). However, the U.S. statute pays only lip service to an educational approach. Funds for the educational materials for which it calls have never been appropriated. Gunning, *supra* note 9, at 121. It employs instead the punitive (and relatively costless) approach of criminalization.

<sup>107</sup> 140 CONG. REC. S14,244 (testimony of Sen. Wellstone).

<sup>108</sup> See also *id.* (testimony of Sen. Reid) (“As immigrants from countries in which female genital mutilation is performed as a rite of passage have traveled to other nations, this practice, sadly, has traveled with them”); Goodman, *supra* note 80 (discussing the importation of FGC into this country by immigrants, but calling the analogy between that and male circumcision “bizarre” and not mentioning intersex surgery at all). But see Christopher T. Paresi, *Symbolic Rites: Examining the Adequacy of Federal Legislation Addressing the Problem of Female Excision in the United States*, 8 BUFF. HUM. RTS. L. REV. 163, 166 (2002) (noting the lack of a problem with FGC in the United States).

<sup>109</sup> 140 CONG. REC. S14,244 (testimony of Sen. Wellstone).

the spread of disease . . . .”<sup>110</sup> Walker recounts an interview she conducted of a circumcised mother about to circumcise her four-year-old daughter:

You know, I said, that the removal of sexual organs lessens sexual response and destroys or severely diminishes a woman’s enjoyment. Well, she replied, my sex life is perfectly satisfactory, thank you very much! (How would you know, though, I thought.) I said a heartfelt Good for you!, slapped her palm, and let it go. At least this group doesn’t infibulate.<sup>111</sup>

In Walker’s world, North American feminists have much more insight into the nature and effect of these indigenous practices than do those who practice them.

In summary, mainstream anti-FGC rhetoric constructs African practitioners of female circumcision as blind followers of barbaric cultural tradition and North American critics as enlightened, rational decision-makers who base their views on objective science. The central point of this Article is that neither of those depictions is accurate. A close examination of intersex treatment protocols provides further support for the contention that North American medicine is *not* culture-free.<sup>112</sup> And consideration of the work of alternative (non-mainstream) critics of FGC, to which I turn now, shows that African genital cutting practices are *not* culture-bound. Although female circumcision is clearly a harmful cultural practice, it is not “cultural” in the unidimensional way that opponents imagine it to be. In the next Part, I challenge the “culture” side of the culture/science binary, relying upon the alternative critique of female circumcision to suggest that the association of FGC with patriarchal cultural practices is overdrawn. This insight implies that the very notion of cultural practices needs to be more carefully interrogated, and the politics of its deployment explored.

### 3. *Complicating Culture: Alternative Understandings of Female Genital Cutting*

The assumption that FGC expresses a monolithic, patriarchal culture that irrationally and universally harms women ignores the variety of types of genital cutting, some much more harmful than others;<sup>113</sup> the complex role

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<sup>110</sup> WALKER & PARMAR, *supra* note 81, at 25.

<sup>111</sup> *Id.* at 44.

<sup>112</sup> See discussion *infra* Part III.

<sup>113</sup> Of the various types of FGC described *supra* in Part II.A, the superficial cut sometimes called “nicking” is quite rare, while clitoridectomy is the most common type of circumcision in West Africa. Only fifteen to twenty percent of women are infibulated. ELIZABETH HEGER BOYLE, FEMALE GENITAL CUTTING 25–26 (2002).



such cutting plays in African societies;<sup>114</sup> and the active indigenous resistance to FGC within many of the countries where it is practiced.<sup>115</sup> Some critics of the practice, many of them Africans,<sup>116</sup> emphasize these points, presenting a much more nuanced and culturally sensitive critique than the mainstream one on which I have focused thus far.<sup>117</sup> While not denying the patriarchal dimension of FGC or its harmful health effects, they nevertheless explicitly reject the way that mainstream anti-FGC discourse reductively associates African societies with ignorance, barbarism, and misogyny.

While acknowledging that female circumcision is “part of a complex system of male domination of women,”<sup>118</sup> those who articulate this alternative critique note that FGC has not traditionally served solely as a way for women to get husbands or for men to control women’s sexuality.<sup>119</sup> Instead, they emphasize its role in creating bonds among women, in forging a sense of identification with one’s group, and in serving as an age-group ritual of camaraderie and bravery.<sup>120</sup> Through this lens, practitioners of female genital cutting are seen as individuals who are trying to help parents improve the chances of life success and happiness of their children,<sup>121</sup> not just as misogynists trying to control women. The practices themselves are exposed as entailing a whole range of behaviors, from

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<sup>114</sup> See *infra* notes 118–121 and accompanying text.

<sup>115</sup> On African resistance to FGC, see *infra* text accompanying notes 124–128. See also sources cited in Gunning, *supra* note 9, at 123 nn.3–4.

<sup>116</sup> Africans have actively opposed FGC since as early as the 1970s. Boyle & Preves, *supra* note 2, at 711, 713. For lists of authors articulating the alternative critique and African activists opposing female circumcision, see James, *supra* note 3, at 93, 107–08.

<sup>117</sup> See, e.g., GENITAL CUTTING & TRANSNATIONAL SISTERHOOD, *supra* note 1; Gunning, *supra* note 2, at 223–27; Sussman, *supra* note 105, at 212. Cf. Shweder, *supra* note 46, at 228 (advocating some tolerance of the practice).

<sup>118</sup> Gunning, *supra* note 2, at 215.

<sup>119</sup> In a survey of women in Sierra Leone conducted by Koso-Thomas, 85% cited “tradition” as their reason for undergoing FGC (using, it would appear, a different meaning of “tradition” than that employed by anti-FGC activists) and 35% cited “social identity” (belonging to the group). Religion was cited by 17%, and all other reasons were cited by less than 4%. KOSO-THOMAS, *supra* note 38, at 46. But ethnic groups vary widely, so this finding may not be generalizable. See James & Robertson, *supra* note 19, at 7–12.

<sup>120</sup> James & Robertson, *supra* note 19, at 7–12. See also Gunning, *supra* note 2, at 216–18. Gunning notes the tendency to equate uncircumcised women with prostitutes, to associate genital surgeries with higher social status, and even to associate large genitals with slavery (as a result of the enslavement of an ethnic group that had stretched their female sexual organs as a sign of beauty). *Id.* at 217. The surgeries are also “believed to have health benefits similar to the benefits doctors in Nineteenth Century America claimed for such surgeries.” *Id.* at 217–18 (citation omitted). Shweder notes that circumcision is seen as making the body “smooth” by removing unsightly genital protuberances, raising (in my mind at least) images of leg-shaving and bikini waxes here in the United States. Shweder, *supra* note 46, at 218.

<sup>121</sup> Not surprisingly, physicians performing intersex surgeries have a very similar understanding of their own roles. See *infra* Parts III.A, III.B.3.a.

“nicking”<sup>122</sup> to infibulation (the procedure on which some mainstream critics tend to focus<sup>123</sup>).

Alternative critics of FGC urge North American opponents to take their lead from African activists<sup>124</sup> and emphasize the need for non-Africans to educate *themselves* about the “historical and cultural contexts surrounding the surgeries.”<sup>125</sup> These critics avoid the tone of moral and cultural superiority that characterizes so much of the anti-FGC rhetoric by acknowledging the valuable insight of those intimately familiar with these practices and the societies in which they occur. They also acknowledge the internal diversity of viewpoints within societies where FGC is practiced, emphasizing the role of indigenous anti-FGC activism. Implicitly challenging the monolithic and orientaling image of FGC societies produced by mainstream rhetoric, they treat female circumcision as a subject of social struggle and contention within those societies, rather than as an unchanging, primitive “cultural practice.”

Alternative critics of FGC also point out the North American exceptionalism behind many anti-FGC reform efforts. As Claire C. Robertson notes, some of these efforts convey the message that “Africans . . . need the help of more advanced civilizations, a.k.a. European Americans, to raise them out of their ignorance and poverty, which ancient rituals perpetuate by promoting ‘tradition.’”<sup>126</sup> As a consequence, Françoise Kaudjhis-Offoumou comments, “Controversies over the question of female genital mutilation have aroused impulsive and emotional reactions among Western women; African and other victims of excision have the impression that some of these women are trying to give us lessons, to accomplish a civilizing mission and are therefore shocked, even revolted.”<sup>127</sup> These alternative critics are also skeptical about the motivation behind some legislators’ support of anti-circumcision legislation. One activist noted:

The bills are of cynical and symbolic value. A vote for such a bill was a way for conservatives who had little interest in women or people of color, as shown by voting records, to claim concern for racial and gender issues. Moreover, the vote often provided an opportunity to make a comfortable speech, safely denouncing

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<sup>122</sup> See *supra* note 113.

<sup>123</sup> Robertson, *supra* note 19, at 64 (discussing Pratibha Parmar’s section of *Warrior Marks*).

<sup>124</sup> See also Boyle and Preves, *supra* note 2, at 711–13; Gunning, *supra* note 9, at 123 nn.3–4 (providing examples of indigenous African resistance to FGC).

<sup>125</sup> Gunning, *supra* note 9, at 114. Studying the history of efforts to eradicate FGC, for example, would have revealed to anti-FGC North Americans that colonial authorities’ efforts to use punitive approaches were less effective than programs developed by local activists. *Id.* at 122.

<sup>126</sup> Robertson, *supra* note 19, at 59.

<sup>127</sup> FRANÇOISE KAUDJHIS-OFFOUMOU, MARRIAGE EN CÔTE D’IVOIRE 159 (Éditions KOF 1994), *quoted and translated in* Robertson, *supra* note 19, at 56.

African culture and people. At the California and federal level that meant an opportunity to label Africans as the most egregious of child abusers.<sup>128</sup>

In sum, while maintaining opposition to the practice of FGC, these opponents avoid the orientalizing tone of the mainstream opposition. Their descriptions of female circumcision humanize those performing the ritual cutting and complicate the cultural role(s) of the practice. They thus paint a complex picture of both FGC cultures and African genital cutting, eschewing the unidimensional, pejorative image conveyed by mainstream anti-FGC discourse.

### III. INTERSEX SURGERY AS HARMFUL CULTURAL PRACTICE: GENDER, SCIENCE, AND INTERSEX TREATMENT PROTOCOLS

#### A. *A Brief Introduction to Intersexuality and Genital-Normalizing Surgeries*

The term “intersex” covers a wide variety of congenital conditions in which an individual has anomalous sexual characteristics.<sup>129</sup> While the mixture of sexual anatomy can be completely internal,<sup>130</sup> an intersexed newborn often displays “ambiguous” genitalia.<sup>131</sup> For example, a child may be born with the external genitalia of a male, but also have ovaries in place of testes.<sup>132</sup> In other scenarios, an infant girl may be born with an “abnormally large” clitoris or an infant boy may be born with an “abnormally small” penis.<sup>133</sup>

The existence of intersexed people is not a new phenomenon. Many references are found in ancient literature to hermaphrodites,<sup>134</sup> and the no-

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<sup>128</sup> Gunning, *supra* note 9, at 121. Supporting the critics’ skepticism is the fact that, as of the end of the 1990s, no money had been appropriated for educational programs established under the federal and California laws. *Id.*

<sup>129</sup> Julia S. Barthold & Richard Gonzalez, *Intersex States*, in PEDIATRIC UROLOGY PRACTICE 547 (E. Gonzalez ed., 1999). One medical dictionary defines “intersexuality” as “[t]he condition of having both male and female characteristics; being intermediate between the sexes.” *Intersexuality*, in THE ON-LINE MEDICAL DICTIONARY, at <http://cancerweb.ncl.ac.uk/cgi-bin/omd?intersexuality> (last visited Nov. 1, 2004). Psychologist Alice Dreger, in a chart posted on the website for the Intersex Society of North America, advocates a “patient-centered model” of intersexuality that would define it as “a relatively common anatomical variation from the ‘standard’ male and female types . . . [that] is neither a medical nor a social pathology.” ALICE DREGER, *SHIFTING THE PARADIGM OF INTERSEX TREATMENT*, at <http://www.isna.org/pdf/dreger-compare.pdf> (last visited Nov. 1, 2004).

<sup>130</sup> Alice Dreger, *Intersex*, FATHERING MAG. (2002), at <http://www.fathermag.com/206/intersex> (last visited Nov. 6, 2004).

<sup>131</sup> Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics & the Law*, 11 ANNALES HEALTH L. 195, 196 (2002).

<sup>132</sup> *Id.*

<sup>133</sup> Kishka Ford, “First, Do No Harm”—*The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants*, 19 YALE L. & POL’Y REV. 469, 470 (2001).

<sup>134</sup> FAUSTO-STERLING, *supra* note 11, at 33.

tion of a “continuum” of sex and gender has long been recognized within the biological sciences.<sup>135</sup> However, only recently, with advances in molecular biology and surgical techniques, has it been possible both to articulate a more precise explanation of these anomalies and also to try to “fix” the appearances of non-conforming children.<sup>136</sup> This increased ability to surgically alter the appearance of genitalia may also have spurred a concomitant rigidity in notions of what counts as “standard” male or female appearance.<sup>137</sup>

While the medical terminology used to describe intersexuality suggests that it is an uncommon occurrence, the birth of an intersexed child is actually quite common.<sup>138</sup> The Intersex Society of North America (ISNA), a national organization representing the interests of intersex children and adults,<sup>139</sup> reports that at least one or two of every 1000 births in the United States leads to surgical alteration of the genitalia.<sup>140</sup> While the actual number of intersex individuals may be elusive, due in no small part to the subjectivity inherent in the physician’s determination of whether a child’s genitalia are ambiguous, it is clear that there are many thousands, if not hundreds of thousands, of intersexed people living in the U.S. today.<sup>141</sup>

The very definition of intersexuality—that it is a condition characterized by a mixture of “key masculine anatomy with key feminine anat-

<sup>135</sup> *Id.*

<sup>136</sup> *Id.* at 44.

<sup>137</sup> Alice Dreger, *A History of Intersexuality: From the Age of Gonads to the Age of Consent*, 9 J. CLIN. ETHICS 345, 345 (1988).

<sup>138</sup> Estimates of prevalence of both intersex conditions and intersex surgery vary widely, and depend in part on how one defines “intersex.” One leading scholar has determined that the number of individuals born with a body that deviates at all from what is defined as “normal” male and female (chromosomally, phenotypically, etc.) represents 1.7% of births in the United States. FAUSTO-STERLING, *supra* note 90, at 51. (In comparison, Fausto-Sterling notes, albinos are born at a rate of 1 in 20,000. *Id.* at 53.) Many of the individuals in Fausto-Sterling’s 1.7% figure do not actually develop *visible* intersex conditions, however, and most do not undergo surgery. Thus, the figure is relatively meaningless—the equivalent of saying that X percent of people are albino because they have a small number of pigment anomalies not present in most people. The number of surgeries, however, is not inconsequential. *See infra* text accompanying note 140. Moreover, even if they do not undergo surgery, the anomalous physical conditions of individuals identified as intersex can subject them to humiliating medical examinations (and their parents to anxiety and concern) that are harmful in their own right. Shame and humiliation are arguably the most painful negative consequences of an intersex diagnosis. *See, e.g., infra* note 217 and accompanying text.

<sup>139</sup> The organization was founded in 1993 and has grown progressively since that time. At ten years of age, it had a mailing list of 2600 individuals and 650 donors. SHARON E. PREVES, *INTERSEX AND IDENTITY: THE CONTESTED SELF* 93 (2003).

<sup>140</sup> INTERSEX SOC’Y OF N. AM., *FREQUENCY: HOW COMMON ARE INTERSEX CONDITIONS?*, at <http://www.isna.org/drupal/node/view/91> (last visited Oct. 16, 2004) (citing statistics drawn from the work of Anne Fausto-Sterling). Activist Cheryl Chase has estimated that intersex operations in the United States occur at a rate of five per day. Cheryl Chase, Presentation at Integrating Intersex Health Into the LGBT Movement Panel at the LGBTI Health Summit 2002 (Aug. 21, 2002).

<sup>141</sup> Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265, 267 (1999).

omy”<sup>142</sup>—recognizes that a variety of criteria are used to classify people within the binary sexual classifications of male and female. Today, there are eight commonly accepted criteria used to classify gender. They are: chromosomes, gonads, external morphology (the form or structure of external sexual organs), internal morphology, hormonal patterns, secondary sex characteristics, assigned sex, and personal sexual identity.<sup>143</sup> Among the criteria, the first six, and some would argue the last (personal sexual identity), develop in utero.<sup>144</sup> An intersex condition arises when genetic and/or hormonal patterns cause an embryo to exhibit a pattern of sexual differentiation that combines elements of both male and female developmental pathways.<sup>145</sup> The following examples are illustrative of the many ways in which an altered biochemical pathway can lead to an intersex condition.

In a condition known as Androgen Insensitivity Syndrome (AIS), chromosomally male individuals are completely or partially unable to process the androgens made by their own testes.<sup>146</sup> As a result, the developing fetus proceeds along a female pathway, leading to the development of feminized genitalia.<sup>147</sup> Internally, the normally functioning testes still produce an inhibiting factor that prevents the development of the uterus and fallopian tubes. Thus, an individual with AIS has male (XY) chromosomes but lacks “normal” male genitalia. A child born with Complete AIS (CAIS) will have a normal set of female external genitalia, including labia, a clitoris, and a vaginal opening.<sup>148</sup> Children with Partial AIS (PAIS) will have a range of appearances, from masculinized female external genitalia (e.g., clitorimegaly, or enlarged clitoris) to mildly under-masculinized male external genitalia (e.g., micropenis).<sup>149</sup> Internally, an individual with AIS will have normal testes and will not have fallopian tubes, a uterus, or an upper vagina.<sup>150</sup> A child with AIS is typically considered a girl at birth.<sup>151</sup>

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<sup>142</sup> INTERSEX SOC’Y OF N. AM., *supra* note 140.

<sup>143</sup> Patricia L. Martin, *Moving Toward an International Standard in Informed Consent: The Impact of Intersexuality and the Internet on the Standard of Care*, 9 DUKE J. GENDER L. & POL’Y 135, 141 (2002).

<sup>144</sup> Hermer, *supra* note 131, at 204.

<sup>145</sup> Human fetuses start out sexually undifferentiated in the womb. Eventually, the same body parts develop either into a clitoris and labia or into a penis and testes. FAUSTO-STERLING, *supra* note 7, at 49. According to traditional medical understandings, the fetus is originally female, and the release of androgens by the testes cause it to develop masculine traits. Fausto-Sterling criticizes this account, however, alleging that it reproduces familiar Western tropes that associate femaleness with passivity and lack. *Id.* at 202–03.

<sup>146</sup> *Id.* at 52.

<sup>147</sup> *Id.*

<sup>148</sup> Bruce E. Wilson, *Androgen Insensitivity Syndrome*, at <http://www.emedicine.com/ped/topic2222.htm> (last visited Oct. 16, 2004).

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

<sup>151</sup> Hermer, *supra* note 131, at 206.

A proper diagnosis is usually not made until the affected individual reaches puberty and fails to menstruate.<sup>152</sup>

An individual with 5-Alpha-Reductase Deficiency (5-ARD) also has male (XY) chromosomes but is unable to convert testosterone into dihydrotestosterone, the hormone responsible for the development of male genitalia.<sup>153</sup> As a result, chromosomal males with 5-ARD are born with ambiguous genitalia. Internally, individuals with 5-ARD have intact testes and lack a uterus or fallopian tubes.<sup>154</sup> As with AIS, a child born with 5-ARD is commonly considered a girl, due to the presence of female external genitalia.<sup>155</sup> Diagnosis of the condition commonly occurs at puberty, when the body of a 5-ARD individual begins to masculinize.<sup>156</sup>

Congenital adrenal hyperplasia (CAH) is also commonly labeled as an intersex condition when it occurs in chromosomal females.<sup>157</sup> In these individuals, the adrenal gland produces large amounts of androgens, hormones responsible for growth and development,<sup>158</sup> leading to the development of “masculinized” external genitalia.<sup>159</sup> Internally, these individuals typically have a normal uterus and ovaries.<sup>160</sup> In addition, at puberty, they often exhibit irregular menstrual periods and more body hair than typical for girls of their ethnic and family background.<sup>161</sup>

In other instances, chromosomal males have a variety of conditions that lead to the development of a smaller than typical penis (micropenis) and to hypospadias (incomplete fusion of the underside of the penis, resulting in a urethra of atypical appearance), as well as to undescended testes and incomplete development of the scrotum. For example, males with Klinefelter Syndrome have two or more X chromosomes and a Y chromosome.<sup>162</sup> While modern techniques, such as amniocentesis or chorionic

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<sup>152</sup> *Id.*

<sup>153</sup> Bruce E. Wilson, *5-Alpha-Reductase Deficiency*, at <http://www.emedicine.com/ped/topic1980.htm> (last visited Oct. 16, 2004).

<sup>154</sup> *Id.*

<sup>155</sup> Hermer, *supra* note 131, at 207.

<sup>156</sup> *Id.*

<sup>157</sup> Hermer, *supra* note 131, at 205–06. CAH can occur in chromosomal males as well, but it is usually not identified as an intersex condition in that circumstance because it causes no anomalous physical appearance. E-mail communications from Emi Koyama, intersex activist, to the author (Dec. 23, 2003 & Sept. 12, 2004) (on file with author). Nor do physicians generally consider “late-onset” CAH—CAH which becomes apparent later on in a girl’s life—to be intersex. *Id.* However, girls with undetected (and therefore untreated) late-onset CAH can still experience virulization. *Id.* A CAH diagnosis, even when it occurs at a later age, can result in the same invasive medical attention as is paid to individuals with conditions that are generally labeled intersex. *Id.*

<sup>158</sup> The Hormone Foundation, *Patient Fact Sheet: Endocrinology and Congenital Adrenal Hyperplasia (CAH)* (Deborah P. Merke, M.D. ed., 2004), at [http://www.hormone.org/resources/fact\\_sheets/cah.htm](http://www.hormone.org/resources/fact_sheets/cah.htm) (last visited Nov. 22, 2004).

<sup>159</sup> *Id.*

<sup>160</sup> Hermer, *supra* note 131, at 206.

<sup>161</sup> See The Hormone Foundation, *Patient Fact Sheet*, *supra* note 158.

<sup>162</sup> ROBERT BOCK, NAT’L INST. OF CHILD HEALTH & HUMAN DEV., NIH PUB. NO. 93-3203, UNDERSTANDING KLINEFELTER SYNDROME: A GUIDE FOR XXY MALES AND THEIR

villus sampling, can lead to a prenatal diagnosis,<sup>163</sup> males with Klinefelter Syndrome are more typically diagnosed at puberty, when atypical breast development occurs.<sup>164</sup> In addition, at puberty these individuals may exhibit sparse facial and body hair, a relative lack of strength compared to other boys, atypically small testes, and a rounded body type.<sup>165</sup> All individuals with Klinefelter Syndrome are raised as boys but may take hormones in order to experience masculine pubertal development more similar to that of their peers.<sup>166</sup>

The current standard of care for those intersexed infants born with ambiguous genitalia was initially developed in the late 1950s and 1960s.<sup>167</sup> Standard medical practice in such cases typically involves an assignment of sex followed by surgical modification of the child's genitalia soon after birth to make them conform to the anatomical standards of the chosen sex.<sup>168</sup> For example, in chromosomal females with CAH, where the adrenal production of androgens leads to the development of "abnormally large" clitorises, surgeons commonly perform a clitoroplasty<sup>169</sup> to remove or alter the clitoris to conform to the accepted standard. In most genital-normalizing surgeries, doctors construct or alter the newborn's genitalia to conform to that of a standard female, defined by the capacity to be penetrated by a penis, since, as one physician rather crassly put it, "you can make a hole but you can't build a pole."<sup>170</sup> The initial surgical intervention is commonly followed by one or more surgeries.<sup>171</sup> Originally, and

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FAMILIES (Aug. 1993), available at <http://www.nichd.nih.gov/publications/pubs/klinefelter.htm> (last visited Oct. 16, 2004).

<sup>163</sup> *Id.*

<sup>164</sup> Greenberg, *supra* note 141, at 283.

<sup>165</sup> BOCK, *supra* note 162.

<sup>166</sup> See Greenberg, *supra* note 141, at 283. Fausto-Sterling and colleagues reviewed nearly a half-century (1955–1998) of medical literature on intersex individuals and came up with the following estimates on the frequencies of various underlying medical conditions: Androgen Insensitivity Syndrome (one in 13,000 births); Partial Androgen Insensitivity Syndrome (one in 130,000); Classical Congenital Adrenal Hyperplasia (one in 13,000); 5 Alpha-Reductase-Deficiency (no current estimate); Klinefelter Syndrome (one in 1000); Complete Gonadal Dysgenesis (lack of an X chromosome in females) (one in 150,000); Sex Chromosome Anomalies (neither XX nor XY) (one in 1666); severe Hyposadias (urethral opening in perineum or along penile shaft) (one in 2000); mild Hyposadias (urethral opening between corona and tip of glans penis) (one in 770). INTERSEX SOC'Y OF N. AM., *supra* note 140.

<sup>167</sup> Hazel Glenn Beh & Milton Diamond, *An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?*, 7 MICH. J. GENDER & L. 1, 2–3 (2000).

<sup>168</sup> Martin, *supra* note 143, at 152.

<sup>169</sup> Clitoroplasty is a general term for plastic surgery on the clitoris. *Clitoroplasty*, in MEDICAL DICTIONARY, available at <http://medical-dictionary.com> (last visited Oct. 16, 2004).

<sup>170</sup> See FAUSTO-STERLING, *supra* note 11, at 59; Julie Greenberg & Cheryl Chase, *Colombia High Court Limits Surgery on Intersexed Infants*, at <http://www.isna.org/drupal/node/view/58> (last visited Oct. 16, 2004); PREVES, *supra* note 139, at 56.

<sup>171</sup> Sarah M. Creighton et al., *Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood*, 358 LANCET 124, 125 (2001), available at <http://www.thelancet.com/journal> (last visited Nov. 1, 2004) ("It is important that clinicians and parents understand that genital ambiguity cannot be

often still today, the surgery was accompanied by admonitions to the parents to raise their child strictly within the assigned sex/gender role (understood to reflect the “true” identity of the child) and/or to keep the initial ambiguous physiognomy a secret. Moreover, according to Anne Fausto-Sterling, “[m]edical manuals and original research articles almost unanimously recommend that parents and children not receive a full explanation of an infant’s sexual status.”<sup>172</sup>

The theoretical underpinnings of this treatment model were first articulated by Johns Hopkins researcher John Money.<sup>173</sup> Money believed that an infant retained a psychosexual plasticity in early life, allowing any child to be transformed into either gender as long as the external genitalia conformed to the chosen gender.<sup>174</sup> Implicit in this assertion was an underlying assumption that the psychosexual development of a child critically depended on normal-looking genitalia.<sup>175</sup> Therefore, the birth of a child with ambiguous genitalia posed an immediate threat to healthy psychosexual development and called for an emergency medical response.<sup>176</sup>

The case that most dramatically illustrated Money’s theories, and provided much of the medical justification for the treatment standards that are still used today, was the famous “John/Joan case.”<sup>177</sup> During circumcision, “John’s” penis was accidentally burned. Upon the advice of Dr. Money, John’s parents decided to have their son surgically changed to a female. Their decision was driven by a fear that their son would be “incomplete” and “physically defective” without a penis.<sup>178</sup> Doctors recon-

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corrected in infancy by a single procedure. For most individuals further treatment will be necessary in adolescence and the long-term impact of such treatment on adult sexual function is still unknown.”).

<sup>172</sup> FAUSTO-STERLING, *supra* note 11, at 64. That practice might be changing a bit, however, as currently (perhaps because of intersex activism) there seems to be somewhat more involvement of the parents and less “crisis mode” thinking than in the past. *See, e.g.*, Robert M. Blizzard, *Intersex Issues: A Series of Continuing Conundrums*, 110 PEDIATRICS 616, 617 (2002) (“[T]he decision of sex assignment must be made by the parents, and not the doctor, after being fully informed . . . .”); José F. Cara, Presentation at American Academy of Pediatrics 2002 Annual Meeting (Oct. 19–23, 2002) entitled *Approach to the Management of Intersex: Past and Present Concepts* (copy on file with the author) (noting that, in the past “parents were provided with only the most basic information . . .,” but arguing that current reassessments suggest they should be more fully informed). *But see* Robert Marion, *The Curse of the Garcias*, 21 DISCOVER 42 (2000), available at [http://www.findarticles.com/p/articles/mi\\_m1511/is\\_12\\_21/ai\\_67185294](http://www.findarticles.com/p/articles/mi_m1511/is_12_21/ai_67185294) (last visited Oct. 16, 2004) (describing one doctor’s impulse to withhold diagnosis information from an intersex patient).

<sup>173</sup> Robert A. Crouch, *Betwixt and Between: The Past and Future of Intersexuality*, 9 J. CLINICAL ETHICS 372, 373 (1998).

<sup>174</sup> *Id.*

<sup>175</sup> *Id.*

<sup>176</sup> KESSLER, *supra* note 21, at 34, 127. *See also* PATRICK C. WALSH ET AL., CAMPBELL’S UROLOGY 2155 (7th ed. 1998) (“The neonate with sexual ambiguity represents one of the true emergencies in pediatric urology.”).

<sup>177</sup> *See generally* Kenneth Kipnis & Milton Diamond, *Pediatric Ethics and the Surgical Assignment of Sex*, 9 J. CLINICAL ETHICS 398 (1998) (discussing the John/Joan case).

<sup>178</sup> *Id.* at 399.



structed John, turning him into “Joan” by removing his penis and sculpting a vagina out of his scrotum.<sup>179</sup> Dr. Money concluded, years later, that the re-assignment had been successful and that a child’s sexual identity could be surgically determined through early medical intervention.<sup>180</sup> Recently, however, the textbook success of the John/Joan case has been called into serious doubt by the revelation that Joan had rejected his assigned gender from a very early age and had been living for years as a man.<sup>181</sup> Moreover, recent empirical studies and anecdotal evidence indicate that individuals who have undergone genital-normalizing surgeries as infants often experience severe pain and psychological trauma.<sup>182</sup>

Despite these revelations, Money’s theory continues to have an impact on modern medical practice. For example, the American Academy of Pediatrics (AAP) Action Committee on Surgery stated in 1996:

[C]hildren whose genetic sexes are not clearly reflected in external genitalia (i.e., hermaphroditism) can be raised successfully as members of either sex if the process begins before the age of two and one-half years. Therefore, a person’s sexual body image is largely a function of socialization.<sup>183</sup>

In support of this conclusion, the AAP committee cited only one study, Money’s.<sup>184</sup>

More recently, the AAP has revised its assessment. In 2000, the AAP’s Committee on Genetics, Section on Endocrinology, and Section on Urology concluded that the long-term physiological and physical consequences of intersex treatment are uncertain, and that on-going counseling should be provided to the parents of intersex children.<sup>185</sup> Nevertheless, the group did not call for a moratorium on intersex surgeries until those uncertain-

<sup>179</sup> *Id.*

<sup>180</sup> Alice Domurat Dreger, *Ambiguous Sex—or Ambiguous Medicine? Ethical Issues in the Treatment of Intersexuality*, 28 HASTINGS CTR. REP. 24, 25 (1998).

<sup>181</sup> Milton Diamond & Keith Sigmundson, *Sex Reassignment at Birth: Long-Term Review and Clinical Implications*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 298 (1997). In a tragic end to this story, John (whose real name was David Reimer) recently committed suicide. See John Colapinto, *Gender Gap: What Were the Real Reasons Behind David Reimer’s Suicide?*, SLATE MAG., June 3, 2004, at <http://slate.msn.com/id/2101678> (last visited Oct. 16, 2004).

<sup>182</sup> Martin, *supra* note 143, at 154. For more details regarding the harms suffered by intersex patients, see *infra* Part III.B.1 & 2.

<sup>183</sup> Evan Kass et al., *Timing of Elective Surgery on the Genitalia of Male Children with Particular Reference to the Risks, Benefits and Psychological Effects of Surgery and Anesthesia*, 97 PEDIATRICS 590, 590 (1996).

<sup>184</sup> Hermer, *supra* note 131, at 204.

<sup>185</sup> Committee on Genetics, Section on Endocrinology and Section on Urology, *Evaluation of the Newborn with Developmental Anomalies of the External Genitalia*, 106 PEDIATRICS 138, 141 (2000). Ironically, in its statement condemning FGC, the AAP has called on its members to “decline performing all medically unnecessary procedures to alter female genitalia.” American Academy of Pediatrics Committee on Bioethics, *Female Genital Mutilation*, 102 PEDIATRICS 153, 153 (1998).

ties are resolved, and it still recommended the surgical treatment of infants. The AAP is currently in the process of reconsidering its opinion on intersex treatment protocols.<sup>186</sup> Nevertheless, despite increasing debate within the relevant medical communities about appropriate intersex treatment, the basic elements of the traditional approach—psychosocial emergency label, early surgery, limited information given to parents, and permanent gender assignment at a young age—remain central to the treatment approach used by most physicians.<sup>187</sup>

### B. Applying Anti-FGC Arguments to Intersex Treatment

As noted above, mainstream opponents of female circumcision have ignored the intersex issue, focusing only on practices found in African nations or brought here by immigrants. Moreover, although ISNA has tried to form alliances with opponents of African genital cutting, anti-FGC activists have repeatedly rebuffed those overtures, refusing to condemn intersex surgery or to work for its elimination.<sup>188</sup>

For instance, one anti-FGC activist responded to inquiries from ISNA founder Cheryl Chase by saying “we are not concerned with biological exceptions.”<sup>189</sup> Another asserted that the intersex issue was irrelevant to her work because that work focused on genital surgery “that is performed as a harmful cultural or traditional practice on young girls.”<sup>190</sup> In short, these anti-FGC feminists see intersex surgeries as fundamentally different from the procedures they are attacking.

Yet close analysis of intersex surgeries shows that each of the arguments central to anti-FGC discourse—including the argument that FGC is a patriarchal cultural ritual—applies with equal force to intersex surgeries. Like FGC, intersex cutting can produce severe physiological complications and have a devastating psychological impact. It frequently results in sexual impairment and can permanently deprive an individual of the right to make decisions affecting his or her own sexuality and gender identity. Finally, despite their good intentions,<sup>191</sup> medical practitioners performing intersex surgeries, like their counterparts who perform female circumcisions, do not provide medically necessary treatment but rather enforce

<sup>186</sup> Christine Gorman & Wendy Cole, *Between the Sexes*, TIME, Mar. 1, 2004, at 54, 56.

<sup>187</sup> See, e.g., Blizzard, *supra* note 172, at 616; Cara, *supra* note 172.

<sup>188</sup> Chase, *supra* note 1, at 140–42.

<sup>189</sup> *Id.* at 141. See also FAUSTO-STERLING, *supra* note 11, at 79 n.9 (“Chase has repeatedly tried to get the attention of mainstream American feminists through venues like *Ms. Magazine* and the academic journal *Signs*, but has been unable to stir their interest in the question of genital surgery on American newborns.”).

<sup>190</sup> Chase, *supra* note 1, at 142.

<sup>191</sup> I am more than willing to assume that the vast majority of physicians performing intersex surgery are convinced that they are acting in the best interests of the child. See generally Suzanne J. Kessler, *The Medical Construction of Gender: Case Management of Intersexed Infants*, 16 SIGNS 3 (1990) [hereinafter Kessler, *Medical Construction*] (describing attitudes of physicians managing intersex cases).

(perhaps unwittingly) a system of culturally specific gender norms—norms that, ironically, harm men as well as women.<sup>192</sup>

### 1. Harmful Physical and Psychological Consequences

Genital normalization is not a simple matter and often requires several surgeries.<sup>193</sup> The average number of operations an intersex individual undergoes over the course of his or her childhood is probably between three and five.<sup>194</sup> But sometimes there are many more, with at least one person having undergone twenty-two operations.<sup>195</sup> The procedures usually begin within the first six months of life<sup>196</sup> and often continue into puberty.<sup>197</sup> While surgeons today always anaesthetize patients, a study pub-

<sup>192</sup> See *infra* Part III.B.4.

<sup>193</sup> Medical literature indicates that between thirty and eighty percent of individuals receiving intersex surgery undergo more than one operation. FAUSTO-STERLING, *supra* note 11, at 86. See also Creighton et al., *supra* note 171.

<sup>194</sup> FAUSTO-STERLING, *supra* note 11, at 86 (noting that three to five surgeries is not uncommon). A recent study at Johns Hopkins University analyzed adults (twenty-one years or older) who had a 46,XY karyotype and who showed genital ambiguity, including a small phallus and perineoscrotal hypospadias. Some of the study patients were raised male and others female. Men had a mean of 5.8 surgeries, while women had an average of 2.1. Claude J. Migeon et al., *Ambiguous Genitalia With Perineoscrotal Hypospadias in 46,XY Individuals: Long-Term Medical, Surgical, and Psychosexual Outcome*, 110 PEDIATRICS 31 (2002), at <http://www.pediatrics.org/cgi/content/full/110/3/e31> (last visited Oct. 16, 2004).

Despite these figures, the University website, designed to inform parents of the pros and cons of infant genital surgery, still reassuringly maintains that “in favorable cases, [the] maximum number of operations” for males “can be two or three,” and females usually only have one surgery, followed by a “‘touch up’ operation in adolescence.” JOHNS HOPKINS CHILDREN’S CTR.: SYNDROMES OF ABNORMAL SEX DIFFERENTIATION—SURGICAL TREATMENT § 6 (2001), available at <http://www.hopkinsmedicine.org/pediatricendocrinology/intersex/sd7.html> (last visited Sept. 13, 2004). Note also that, although the focus here has been on early childhood surgical interventions, many intersex conditions are not discovered until puberty. Greenberg, *supra* note 141, at 283–85.

<sup>195</sup> Chase, *supra* note 1, at 131. The data here are really quite shocking. Fausto-Sterling reports:

One review of vaginoplasties [vaginal reconstruction surgeries] done at Johns Hopkins University Hospital between 1970 and 1990 found that twenty-two out of twenty-eight (78.5 percent) of girls with early vaginoplasties required further surgery. Of these, seventeen had already had two surgeries, and five had already had three. Another study reported that achieving successful clitoral recessions “required a second procedure in a number of children, a third in several patients and a glansplasty in others.” (Glansplasty involves cutting and reshaping the phallic tip, or glans.) They also reported multiple operations following initial early vaginoplasties.

FAUSTO-STERLING, *supra* note 11, at 86 (citations omitted).

<sup>196</sup> FAUSTO-STERLING, *supra* note 11, at 45 n.2. Under some circumstances, waiting until the child is much older to do the surgery may increase the difficulty involved in an already highly technical operation. See, e.g., *Consensus Statement on 21-Hydroxylase Deficiency from The Lawson Wilkins Pediatric Endocrine Society and The European Society for Paediatric Endocrinology, Joint LWPES/ESPE CAH Working Group*, 87 J. CLINICAL ENDOCRINOLOGY & METABOLISM 4048, 4050 (2002).

<sup>197</sup> “The few long term follow up studies currently available suggest that the majority

lished as late as 1970 reported no use of painkillers for procedures on infants and young children.<sup>198</sup> And while these procedures are performed in hospitals under sterile conditions, the complications that result from them include many of the same conditions caused by FGC, such as vaginal or genital infection, chronic genital pain,<sup>199</sup> scarring, urinary problems, impaired sexual functioning, and infertility. In addition, removal of the gonads, a frequent component of sex-normalizing surgery, deprives the individual of hormones that maintain the endocrine system, particularly bone density.<sup>200</sup>

The initial surgery performed on an intersex child can be quite complex, and rarely completes the process of genital normalization. Treatment of *hypospadias* (“misplaced” urethra), for example, can include extensive suturing and occasionally skin transplants.<sup>201</sup> “A male-assigned child can receive as many as three operations on the penis during the first couple of years of life, and even more by the time puberty hits. In the most severe cases, multiple operations can lead to densely scarred and immobile penises . . . .”<sup>202</sup> Similar problems plague the procedure to construct or reconstruct vaginas, known as “vaginoplasty.” This surgery has an extremely high failure rate, with one study finding that only thirty-four percent of those performed before age four have favorable outcomes.<sup>203</sup> Especially when performed in infancy, vaginoplasties can result in rates of vaginal stenosis (narrowing of the vaginal entrance) of up to eighty or eighty-five

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of girls [with CAH and who underwent vaginoplasty as infants] will require some, and often major, revisional surgery for vaginal or introital stenosis in adolescence.” STATEMENT OF THE BRITISH ASSOCIATION OF PAEDIATRIC SURGEONS WORKING PARTY ON THE SURGICAL MANAGEMENT OF CHILDREN BORN WITH AMBIGUOUS GENITALIA (July 2001), at <http://www.baps.org.uk/documents/Intersex%20statement.htm> (last visited Sept. 13, 2004) (citing N.K. Alizai, D.F.M. Thomas, et al., *Feminising Genitoplasty for Congenital Adrenal Hyperplasia: What Happens at Puberty*, 161 J. UROLOGY 1588 (1999)).

<sup>198</sup> FAUSTO-STERLING, *supra* note 11, at 82.

<sup>199</sup> Surgery can cause residual pain in the clitoris or clitoral stump. One study found that ten of sixteen patients who had undergone clitoral recession suffered from clitoral hypersensitivity. *Id.* at 85.

<sup>200</sup> Hermer, *supra* note 131, at 210–11. Whereas some testes may not produce enough testosterone for the removal to make much of a difference, the testes of an individual with a micropenis might function just fine. *Id.* Yet they are nevertheless removed as part of the surgery to transform the child into a girl, requiring lifelong hormonal therapy to replace the lost testosterone. *Id.* Testosterone is essential to both female and male sexual feelings, sexual activities, and intensity of orgasms. OUR BODIES OURSELVES FOR THE NEW CENTURY, *supra* note 86, at 255. It belongs to the class of hormones called androgens, which contribute to muscle strength, appetite, sense of well-being, and sex drive. Androgens are often prescribed to women after menopause or hysterectomy. *Id.* at 560.

<sup>201</sup> FAUSTO-STERLING, *supra* note 11, at 62.

<sup>202</sup> *Id.*

<sup>203</sup> Morgan Holmes, *Rethinking the Meaning and Management of Intersexuality*, 5 SEXUALITIES 159, 170 (2002). According to Suzanne Kessler, in her study of physicians who provide intersex treatment, “many researchers consider that the ultimate criterion of whether the intersexed female has been successfully treated is if her vagina is the right size and can function successfully. A ‘successful vagina’ is one that is capable of, if not ‘orgasmic’ intercourse, at least nonpainful intercourse with a ‘normal-size’ penis.” KESSLER, *supra* note 21, at 58 (citation omitted).

percent.<sup>204</sup> In one study, only sixty-five percent of recipients of vaginoplasty had “satisfactory” vaginal openings, and even twenty-three percent of *those* recipients did not engage in sexual intercourse.<sup>205</sup> In another study, sixty-six percent of individuals receiving intersex surgery “had a poor overall outcome,” and forty-one percent had a “poor cosmetic result (i.e., further major surgery was recommended).”<sup>206</sup> Furthermore, “*ninety-eight percent* required further treatment to improve cosmetic appearance or facilitate tampon use or sexual intercourse.”<sup>207</sup>

In addition to the “normal” pain attendant to multiple surgeries, intersex children must sometimes undergo painful and humiliating manipulations of their sexual organs to assure successful diagnosis or healing. Fausto-Sterling reports being told that doctors sometimes masturbate young intersex boys in order to check penile function and observe an erection.<sup>208</sup> If a vagina has been constructed for a child, the entrance to the vagina must be manually dilated with vaginal inserts every day to prevent the opening from closing.<sup>209</sup> Not surprisingly, children object to such manipulations, and their parents sometimes find it difficult to perform them over the child’s objections. In an educational video released by ISNA, a speaker describes a scene involving a family that had come to the hospital seeking help with vaginal dilation. In the scene (as described in the video), a doctor tried to dilate a nine-year-old girl who was being held down, spread-eagled on the examination table by medical students, while eight to ten professionals looked on.<sup>210</sup>

Such experiences have devastating psychological effects. So do the countless instances of “medical display” that intersex children undergo, in which their naked or semi-naked bodies are revealed to numbers of anonymous medical professionals and students in sterile and frightening medical environments. While studies of the psychological effects of in-

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<sup>204</sup> FAUSTO-STERLING, *supra* note 11, at 86.

<sup>205</sup> *Id.* at 87. For further findings on the success rates of vaginoplasty, see Creighton et al., *supra* note 171.

<sup>206</sup> Hermer, *supra* note 131, at 213.

<sup>207</sup> *Id.* (emphasis added). Disturbingly, one study of physician attitudes found that, “[a]lthough physicians speculate about the possible trauma of an early childhood ‘castration’ memory, there is no corresponding concern that vaginal reconstructive surgery delayed beyond the neonatal period is traumatic.” Kessler, *Medical Construction*, *supra* note 191, at 9.

<sup>208</sup> FAUSTO-STERLING, *supra* note 11, at 86.

<sup>209</sup> The vaginal dilation is accomplished with a metal dildo that is inserted daily for six months, and monthly for several years. AMY BLOOM, *NORMAL: TRANSSEXUAL CEOs, CROSS-DRESSING COPS, AND HERMAPHRODITES WITH ATTITUDE 106* (2002). Compare that practice with this strikingly similar description of the effect of infibulation: “First sexual intercourse can only take place after gradual and painful dilation of the opening left after mutilation. In some cases, cutting is necessary before intercourse can take place.” AMNESTY INT’L, *FEMALE GENITAL MUTILATION: A HUMAN RIGHTS INFORMATION PACK*, available at <http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm> (last visited Nov. 1, 2004).

<sup>210</sup> Videotape: *The Child with an Intersex Condition: Total Patient Care* (Intersex Society of North America 2003) (on file with the author).

tersex treatments are shockingly few, testimonials from intersex treatment recipients repeatedly mention the sense of shame, humiliation, and violation that physical examinations and surgical treatments engender.<sup>211</sup> In addition, many patients experience these surgeries and examinations as acts of violence, frequently analogizing them to rape and sexual abuse.<sup>212</sup> Their statements strongly suggest that the very effects against which surgical and other treatments were designed to protect—shame, stigma, and a humiliating sense of being different—are instead the all-too-frequent *products* of those treatments and of the diagnosis of intersex bodies as abnormal. For example, one patient wrote:

I was an interesting lab rat. I call myself a lab rat because that is how intersexed kids are treated. Tested, photographed, tested again, photographed some more. . . . it was precisely my treatment and how it was inflicted on my being which really damaged me more than anything else . . . .<sup>213</sup>

Another individual expressed similar feelings:

. . . then of course [there were] the many horrible, tense visits to the pediatric endocrinologists to have my genitals gawked, fondled and stared at by hordes of what I perceived to be nasty, despicable men . . . .<sup>214</sup>

Depression is a very common side effect of intersex surgeries. Intersex individuals who have received genital-normalizing surgery report serious bouts of depression and, often, suicidal inclinations.<sup>215</sup> The silence and secrecy with which their families surround their surgeries and conditions (often on physicians' advice<sup>216</sup>) greatly exacerbate the shame and humiliation such individuals already feel due to the extensive attention directed at their genitals by physicians, parents, and others. Those emotions persist

<sup>211</sup> See, e.g., KESSLER, *supra* note 21, at 84 (quoting an intersex individual as saying, "It's the shame that the medical treatment instills . . . . It's the 'private distress' that they insist our parents have. But godammit, why the fuck should I have been grateful? They steal our ability to feel that we have the right to unconditional love.").

<sup>212</sup> Fausto-Sterling reports, "One recent evaluation of the psychological health of intersex children found: 'dilating the vagina at a younger age appeared to lead to severe psychological problems because it was experienced as a violation of the body integrity.'" FAUSTO-STERLING, *supra* note 11, at 86 n.42 (citing F. M. E. Slijper, S. L. S. Drop, et al., *Long-Term Psychological Evaluation of Intersex Children*, 27 ARCHIVES OF SEXUAL BEHAVIOR 125 (1998)). See also KESSLER, *supra* note 21, at 58–59, 63. Whether such procedures would be completely un-traumatic for adolescents seems debatable, however.

<sup>213</sup> Holmes, *supra* note 203, at 169 (Kiira Triea, patient).

<sup>214</sup> *Id.* at 170 (Diane Anger, patient).

<sup>215</sup> See, e.g., Chase, *supra* note 1, at 133–35.

<sup>216</sup> For sources providing conflicting evidence regarding the extent to which physicians still withhold diagnostic information from intersex patients, see *supra* note 172.

into adulthood. Intersex individuals often do not feel like “normal” males or females (and therefore fear that no one will want them as an intimate partner), lack information about exactly what was done to them, and have no idea that other people have been born with the same condition or have suffered the same surgical fate.<sup>217</sup> Infertility and sexual impairment that sometimes result from genital-normalizing surgery contribute to the depression that intersex patients suffer. For example, a child born with a small penis and functioning testes (that is, testes that could have produced sperm) loses his potential fertility when the penis is determined to be too small for a male, and surgery is performed to transform him into a female by removing the testes and reducing the penis.<sup>218</sup> This loss of the ability to be a biological parent can undoubtedly have a devastating effect on intersex individuals, especially when they realize that it was avoidable. Similarly, the loss or reduction of the capacity for sexual pleasure surely contributes to the emotional trauma caused by intersex surgeries. Both impaired sexual capacity itself and the resulting decreased ability to form healthy, intimate pair bonds is emotionally devastating for intersex individuals.<sup>219</sup>

An absence of data makes it difficult to know whether intersex individuals who have not received surgery suffer similar feelings of stigma

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<sup>217</sup> *Talking About It*, HERMAPHRODITES WITH ATTITUDE: ISNA NEWSLETTER (Intersex Soc’y of N. Am., Rohnert Park C.A.), Summer 1995, (statements by “David”), at <http://isna.org/newsletter/summer95/summer95.html> (last visited Oct. 17, 2004). ISNA founder Cheryl Chase puts a very human face on this experience of depression:

I had come to identify myself as lesbian at a time when lesbianism and a biologically based gender essentialism were virtually synonymous. Men were rapists who caused war and environmental destruction; women were loving beings who would heal the earth; lesbians were a superior form of being uncontaminated by “men’s energy.” In such a world, how could I tell anyone that I had actually possessed the dreaded “phallus”? I was an impostor, not really a woman but rather a monstrous and mythical creature.

Chase, *supra* note 1, at 134. Some readers might be tempted to blame Chase’s trauma on the rather narrow-minded lesbian ethos she describes. My point here, however, is that, whatever the prevailing sexual politics, current management of intersex treatment often leaves intersexed individuals feeling like sex/gender misfits.

<sup>218</sup> In cases like this, physicians actually *create* the intersex condition they purport to be curing. “If one of the diagnostic criteria for intersexuality is that a patient have genitals that ‘conflict’ with chromosomal sex then it seems, in fact, that genetic males with micropenises who are assigned female are actually *made into* intersexed persons.” Holmes, *supra* note 203, at 174. The treatment takes a fertile male capable of sexual intimacy and turns him into an infertile female likely to be incapable of sexual arousal. On physicians’ greater tolerance for “imperfect” females than for “imperfect” males, see *infra* Part III.B.4.a.

<sup>219</sup> See, e.g., Catherine L. Minto et al., *The Effect of Clitoral Surgery on Sexual Outcome in Individuals Who Have Intersex Conditions with Ambiguous Genitalia: A Cross-Sectional Study*, 361 LANCET 1252, 1256 (2003), available at <http://www.thelancet.com/journal> (last visited Nov. 1, 2004) (“[I]ndividuals who have had clitoral surgery are more likely than those who have not to report a complete failure to achieve orgasm and higher rates of non-sensuality—in particular, a lack of enjoyment in being caressed and in caressing their partner’s body.”). For further discussion of impaired sexual capacity caused by intersex operations, see *infra* Part II.B.2.

and isolation, as well as depression and concerns about sexual functioning.<sup>220</sup> Nevertheless, there is surely no reason to incur the other harms of genital cutting merely in order to produce a psychological state that is no better than that which the individual would have experienced without surgery. Moreover, as Morgan Holmes points out, the push for intersex surgery reinforces rather than undermines the societal perception of intersexuals as freakish anomalies: “[T]he surgery [itself] is motivated by the perception of intersexuality as monstrous, and is therefore bound to contribute to perpetuating that perception, even though the goal is to produce a child who feels completely ‘normal.’”<sup>221</sup>

## 2. *Sexual Impairment; Violations of Sexual Autonomy and Bodily Integrity*

The original approach to treating many intersex conditions was clitoridectomy. The clitoridectomy of an intersex child has an outcome virtually identical (even if differing in instruments and method used) to that of the clitoridectomies performed in societies that practice FGC. And it is clear that such surgeries, like those performed in FGC societies, have a profoundly negative impact on the patient’s ability to experience sexual arousal. Clitoral surgery, whether intersex or FGC, risks removing forever the source of orgasm in women.<sup>222</sup>

Clitoridectomies are still occasionally performed on intersex children today,<sup>223</sup> but most physicians currently prefer clitoral reduction or clitoral recession.<sup>224</sup> These procedures, while arguably less extreme than clitoridectomy, still constitute elaborate reconstructive surgeries that are likely to affect sexual sensation.<sup>225</sup> While physicians maintain that clitoral reduction and recession preserve clitoral sensitivity,<sup>226</sup> those claims remain un-

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<sup>220</sup> See *infra* text accompanying notes 233–234.

<sup>221</sup> Holmes, *supra* note 203, at 173–74.

<sup>222</sup> KOSO-THOMAS, *supra* note 38, at 25–28. This is not to say that it necessarily deprives individuals who undergo the procedure of the ability to experience sexual intimacy, arousal, or enjoyment. See *supra* note 57 for articles arguing that clitoral loss does not always destroy the capacity for sexual pleasure.

<sup>223</sup> FAUSTO-STERLING, *supra* note 11, at 81, 298 n.20 (citing E. M. Costa et al., *Management of ambiguous genitalia in pseudohermaphrodites: New perspectives on vaginal dilation*, 67 FERTILITY & STERILITY 229, 229–32 (1997); H. V. Velidedeoglu et al., *The surgical management of incomplete testicular feminization syndrome in three sisters*, 50 BRIT. J. PLASTIC SURGERY, 212, 212–16 (1997)).

<sup>224</sup> In clitoral reduction surgery, the middle portion of the phallus shaft is excised and then the shorter phallus is sewn back together. In clitoral recession surgery, the phallus shaft is hidden with a flap of skin so that less of it is visible. *Id.* at 61–63.

<sup>225</sup> These procedures are also perhaps more invasive than the symbolic “nicking” of the clitoris that has replaced more serious cutting in at least some FGC societies but is nevertheless still illegal in the United States. The language of the federal anti-FGM statute seems clearly to prohibit clitoral nicking, since it bars excision of “any part” of the labia or clitoris. 18 U.S.C. § 116(a) (2000).

<sup>226</sup> FAUSTO-STERLING, *supra* note 11, at 85, 300 n.28 (citing H. F. L. Meyer-Bahlburg, *Gender assignment in intersexuality*, 10 J. PSYCHOL. & HUM. SEXUALITY 1 (1998)).



substantiated,<sup>227</sup> and anecdotal reports suggest otherwise.<sup>228</sup> Moreover, some long-term follow-up studies of intersex surgery have found a documented failure rate for sexual sensation of twenty to thirty percent.<sup>229</sup> At a minimum, the reduced skin sensitivity that can result from scarring of both the clitoris and the (usually reconstructed) vagina seems likely to impair sexual enjoyment for many people.

In addition to suggesting a physiological impact on sexual performance and satisfaction, the available data fail to establish that genital-normalizing surgeries result in healthy and comfortable gender identities for intersex individuals. Laura Hermer reports that one of the largest published studies of psychological outcomes concluded that nearly forty percent of the subjects suffered from “general psychopathology,” and twenty-five of the forty-seven subjects who lacked such psychopathology nevertheless exhibited “deviant” gender role behavior.<sup>230</sup> It is important to remember as well that gender satisfaction is not necessarily a static or easily perceivable thing. An individual who appears to have a stable and satisfied gender identity at age four, ten, or even twenty might nevertheless feel very differently in the future.<sup>231</sup> Thus, determination of gender satisfaction is much more complex than one might initially expect.<sup>232</sup> Conclusions re-

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<sup>227</sup> *Id.* One recent study of intersex adults found that sexual function is significantly impaired in individuals who have undergone clitoral surgery. For example, while none of the control group members (individuals who had *not* undergone clitoral surgery) reported that it was impossible for them to experience orgasm, thirty-nine percent of those who had undergone the surgery reported this extreme inability. Moreover, the latter group experienced more sexual difficulties in general than the control group. Minto, *supra* note 219, at 1256. However, because this study does not distinguish between individuals who underwent clitorectomy and those who underwent clitoral reduction, it does not directly disprove physicians’ contention that the less severe forms of surgery are more successful.

<sup>228</sup> For example, Cheryl Chase describes her inability to orgasm and her sexual dysfunction after clitoral surgery. Chase, *supra* note 1, at 134. See also Angela Moreno, *In Amerika They Call Us Hermaphrodites*, LIBIDO, at <http://www.libidomag.com/nakedbrunch/archive/hermaphrodites.html> (last visited on Nov. 1, 2004) (“I would say that the clitoral reduction and vaginoplasty decreased my responsiveness by a factor of five or ten.”).

<sup>229</sup> Holmes, *supra* note 203, at 163 (citing Ricardo Azzizet et al., *Nonclassic Adrenal Hyperplasia: Current Concepts*, 78 J. CLINICAL ENDOCRINOLOGY & METABOLISM 810, 810–15 (1994); Kurt Newman et al., *Functional Results in Women Having Clitoral Reduction as Infants*, 27 J. PEDIATRIC SURGERY 180, 180–84 (1992); and Kurt Newman et al., *The Surgical Management of Infants and Children with Ambiguous Genitalia: Lessons Learned from 25 Years*, 215 ANNALS SURGERY 644, 644–53 (1991)). The studies cited by Holmes in support of this figure cover both vaginal reconstruction and clitoral reduction.

<sup>230</sup> Hermer, *supra* note 131, at 212. Of course, given that the definition of “deviant” apparently used in such studies would suggest that all lesbians and gay men exhibit “deviant” gender role behavior, for me the more telling data are those about psychopathology and general emotional well-being.

<sup>231</sup> Consider this statement by an individual with an intersex condition: “‘At 26 I was—ostensibly—happily, heterosexually married to a man; had a team of doctors shown up to ask me how I was, that is most certainly what I would have told them. Two years later I was divorced and pursuing further corrective surgery to normalize [to make more male-like] my genitalia’ to make me more attractive to females. ‘I have been living as a male since March of 1998.’” FAUSTO-STERLING, *supra* note 11, at 71, 285 n.108 (reporting personal conversation and not identifying speaker) (alteration in original).

<sup>232</sup> Adding to the complexity is the fact that gender dysphoria in individuals with inter-

garding decreased gender satisfaction among intersex individuals also assume that there is widespread gender satisfaction among non-intersex individuals, an assumption that may not be warranted.

Nor are there sufficient comparative data to reach definitive conclusions on the gender and sexual satisfaction of intersex individuals who have *not* undergone normalizing treatment. Some studies, at least, suggest that those individuals do not necessarily experience the devastating psychological trauma that physicians and medical texts predict. Fausto-Sterling and Laurent, for example, identified more than eighty examples in the literature of individuals with unaltered ambiguous genitalia who live apparently well-adjusted and satisfying lives. “Striking instances,” they reported, “include men with small penises who have active marital sex lives without penetrative intercourse.”<sup>233</sup> Amy Bloom describes one study that found those who have had surgery to be more sexually and psychologically dysfunctional than those who have not.<sup>234</sup>

Although more research on outcomes is necessary to reach definitive conclusions, it is clear that genital-normalizing surgery changes the sexual organs and gender identities of the patients upon whom it is performed without their consent. Testimonials by many intersex people attest to the anger and resentment they feel at having been operated on without being able to participate in, or even being informed of, these important decisions.<sup>235</sup> In many cases, they have been deprived of the ability to experience orgasm without ever having been consulted about whether the alleged benefits attendant to that loss were worth it to them. Thus, a survey of women who had undergone vaginal reconstruction found that ninety percent believed the surgeries should be postponed until early adolescence.<sup>236</sup> Nor is

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sex conditions may vary based on the particular type of condition they have. Thus, studies that generalize about all “intersex” people without distinguishing among particular conditions may be of limited usefulness. E-mail communications from Emi Koyama, *supra* note 157.

<sup>233</sup> FAUSTO-STERLING, *supra* note 11, at 94–95. The legal and policy implications of insufficient data about long-term (or even short-term) outcomes of genital-normalizing surgery have been a subject of discussion in the literature. After an exhaustive survey of the available studies, Anne Fausto-Sterling concludes that “the medical ‘cure’ for intersexuality frequently does more damage than good.” *Id.* at 80. Citing the medical stricture to “first do no harm,” she argues that intersex surgeries should not be performed on infants. *Id.* at 79 (“Stop infant genital surgery.”); *see also* Beh & Diamond, *supra* note 167. In contrast, Laura Hermer, while discussing possible physician liability for intersex surgeries, cites the inconclusiveness of the data as one reason for rejecting malpractice-based recoveries. For her, the fact that “small studies” and “anecdotal evidence” “strongly suggest that many classes of cosmetic genital and sex assignment surgeries have been at least as detrimental as beneficial to those on whom they were performed,” is not enough to justify physician liability. Hermer, *supra* note 131, at 219. For discussion of whether the surgeries should be criminally proscribed, *see infra* Part IV.

<sup>234</sup> BLOOM, *supra* note 209, at 126–27.

<sup>235</sup> *See, e.g.*, PREVES, *supra* note 139, at 115–18 (quoting several such statements).

<sup>236</sup> H. J. van der Kamp, F. M. E. Slijper, et al., *Evaluation of Young Women with Congenital Adrenal Hyperplasia: A Pilot Study*, 37 HORMONE RESEARCH 45 (1992), *cited in* FAUSTO-STERLING, *supra* note 11, at 94 n.63.

it really possible for anyone to know, without waiting until the intersexed individual reaches puberty or perhaps even adulthood, what the exact effect of the surgery on his or her sexuality will be. As one such person noted, “What’s been taken is a very specific . . . eroticism, . . . a hermaphroditic eroticism that must really scare people.”<sup>237</sup>

Genital-normalizing surgery sometimes can also cause patients to lose forever the tissue that could have been used for changing their sex assignment had they chosen to pursue that option as an adult.<sup>238</sup> Once they are assigned in infancy, there is often no going back. Of course, most people would not think of allowing parents and doctors to permit a sex change operation to be performed on a “normal” infant, nor would such surgery likely be held to be within the parents’ legal decision-making authority.<sup>239</sup> Yet the (admittedly limited) data on gender satisfaction<sup>240</sup> raise the possibility that intersex surgeries may more often than not have essentially the same

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<sup>237</sup> Videotape: *Hermaphrodites Speak!* (Cheryl Chase 1997), reproduced in *SexTV: Intersexuality: Redefining Sex* (CityTV of Toronto broadcast, July 22, 2000). Intersex activist Morgan Holmes has this to say about the clitoral reduction performed on her at age seven:

I like to imagine, if my body had been left intact and my clitoris had grown at the same rate as the rest of my body, what would my lesbian relationships have been like? What would my current heterosexual relationship be like? What if—as a woman—I could assume a penetrative role . . . with both women and men? When the doctors initially assured my father that I would grow up to have “normal sexual function,” they did not mean that they could guarantee that my amputated clitoris would be sensitive or that I would be able to achieve orgasm . . . . What was being guaranteed was that I would not grow up to confuse the issue of who (man) fucks whom (woman). These possibilities . . . were negated in a reasonably simple two-hour operation. All the things I might have grown up to do, all the possibilities went down the hall with my clitoris to the pathology department. Me and my remains went to the recovery room and have not yet emerged.

Michelle Morgan LeFay Holmes, *Medical Politics and Cultural Imperatives: Intersexuality beyond Pathology and Erasure* 53 (1994) (unpublished manuscript, York University), cited in FAUSTO-STERLING, *supra* note 11, at 298–99 n.22 (alterations and omissions in original).

<sup>238</sup> Hermer, *supra* note 131, at 214.

<sup>239</sup> Parents are authorized to consent to surgery for their minor children if that surgery is in the best interest of the child. PROSSER AND KEETON ON THE LAW OF TORTS 115–16 (W. Page Keeton ed., 1984). “[A] guardian cannot ordinarily give approval to a medical or surgical procedure that would involve a risk of serious injury or death, when there is no contemplated benefit.” *Id.* at 116. Courts hold different views on whether guardians can consent to surgery that benefits a relative. Some prohibit any procedure that does not directly benefit the child, while others apply the substitute judgment rule and allow the procedure if the child would have consented to it were he or she competent to make the decision. *Id.* (discussing whether a guardian can authorize a kidney transplant from his or her child when it represents a life-saving procedure for the relative involved). Since a sex change operation on a “normal” male or female infant would likely be done to benefit the parent, not the child, courts would most likely disallow it. (Different issues are raised, however, by parents wishing to support a transgendered child who affirmatively desires a sex change operation. See BLOOM, *supra* note 209, at 6–11 (describing parents who helped their child obtain hormonal and surgical sex change treatment beginning at age fourteen).

<sup>240</sup> See generally FAUSTO-STERLING, *supra* note 11, at 93–95 (surveying literature regarding the gender satisfaction of people who did not have the surgery).

effect as a sex-change operation. They may permanently and unalterably establish the sex of intersex patients without their consent—something that is never done to individuals in FGC societies. Clearly, a minor of the age at which intersex surgery is usually performed, like a child on whom FGC is performed, “does not have the ability to consent or understand the significance and the consequence of this [surgery], . . . what effect it will have on her life and health and . . . on her dignity.”<sup>241</sup> Performing the procedures in infancy guarantees that such children will be deprived of any participation in this life-determining event.<sup>242</sup>

Intersex patients experience their surgeries not only as depriving them of their sexual and gender autonomy but also as a coercive violation of their bodily integrity.<sup>243</sup> Like FGC recipients, they are sometimes physically restrained. Moreover, the combined effect of parental control, physician authority, and anaesthesia effectively makes any resistance, even by those who are beyond infancy, very difficult. Just as FGC can seem like a coercive sexual invasion of an innocent young child, so too can intersex treatments be experienced as violent invasions by the children to whom they are applied. While in both cases the practitioner may have only the best of intentions, the effect is coercive sexual violation.

### 3. *Intersex Surgery as a Contingent, “Cultural” Practice*

#### a. *Introduction*

Medical professionals do not deny that intersex treatment is socially, rather than biologically,<sup>244</sup> compelled. Indeed, the medical literature repeatedly describes the birth of an intersex child as a “psychosocial emergency.”<sup>245</sup> Immediate normalization of the infant’s body is thought to be essential—to prevent confusion and upset of the parents, stigmatization of the child (the proverbial locker-room encounter), and serious psychological trauma to both. But upon closer inspection, both these psychological

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<sup>241</sup> 140 CONG. REC. S14,243 (statements of Sen. Reid). I have repeated here Senator Reid’s statement about FGC. *See supra* text accompanying note 61.

<sup>242</sup> It is interesting to contrast the freedom that parents have to cement their children’s sex and gender identities with the strict regulations imposed upon transgendered individuals who want to have sex-changing surgery. For example, the Clarke Institute of Psychiatry requires these individuals to live as the opposite sex for a year, a requirement designed to protect them from (their *own*, not a third party’s) mistakes about whether the surgery is best for them. *See* J. MICHAEL BAILEY, *THE MAN WHO WOULD BE QUEEN: THE SCIENCE OF GENDER-BENDING AND TRANSEXUALISM* 201 (2003).

<sup>243</sup> Videotape: Hermaphrodites Speak!, *supra* note 237.

<sup>244</sup> “In most instances of an intersex problem, a *medical emergency* is not present but a *mental and/or social emergency* very likely is.” Blizzard, *supra* note 172, at 619. The primary physical danger associated with intersex conditions is undescended testes, which can become cancerous at puberty. FAUSTO-STERLING, *supra* note 11, at 65. Until that point, however, they can safely be allowed to remain in the body, which will still respond to the hormones they produce. *Id.*

<sup>245</sup> Chase, *supra* note 1, at 130.

conclusions—often drawn by urologists rather than psychologists—and the attendant medical determinations about the appropriate sex assignment reveal themselves to be cultural artifacts in the same way that beliefs about FGC are culturally based.<sup>246</sup> In fact, examination of the medical rhetoric used in support of intersex surgery reveals concerns very similar to those raised in the rhetoric justifying FGC.

Physicians' preoccupation with the stigma that can attach to someone who is not readily identifiable as male or female is not that different, for example, from FGC practitioners' conviction that women who fail to undergo genital surgery will be seen as dirty, promiscuous, and unmarriageable. In both cases, the practitioners are responding to very real societal attitudes that can reasonably be expected to negatively affect the individuals in question.<sup>247</sup> Just as people might reject and stigmatize uncircumcised females in, say, Somalia, so also might they reject and stigmatize intersex individuals with nonconforming genitalia here in the United States. But if the anti-FGC position is correct—that is, if the conviction of cultural specialists that the individual will not be accepted into the culture is an insufficient basis upon which to conclude that the harms of a surgical procedure are justified—then intersex surgery also cannot be justified solely on the basis of physicians' concerns about the stigma ambiguous body parts might produce.

One could argue that intersex surgery is different, however, because it *repairs or corrects a disability*, rather than disfigures perfectly “normal” body parts. However, this distinction between normality and disability is itself an artifact of culture. It is a product of socially constructed “knowledge” about difference and disability, as opposed to the articulation of an objective distinction based on biological “facts” about human bodies. An examination of disability theory reveals that, in fact, intersex treatment protocols not only enforce gender norms but also construct both sex and disability.

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<sup>246</sup> KESSLER, *supra* note 21, at 25. It is striking that the psychosocial concerns motivating intersex treatment protocols, relating as they do more to the “soft” science of psychology, are granted such authority among physicians, rather than being assumed to have contingent cultural content. Perhaps it is the fact that they are articulated by “hard” scientists that gives them their legitimacy. *Cf. id.* at 27–28 (reporting informant statements that urologists (who are surgeons) are least likely to try to (consciously) draw psychological conclusions, focusing instead simply on what they can “make” out of the presenting intersex body).

<sup>247</sup> Strikingly, even the particular concerns surrounding stigma are the same. One of the beliefs that supports female genital cutting is the conviction that, without it, at adolescence the clitoris of the child will grow to embarrassingly large dimensions. KOSO-THOMAS, *supra* note 38, at 7. As is discussed further below, this preoccupation with the size of the clitoris is a chief motivator of Western physicians treating intersex individuals as well. *See infra* Part III.B.4.a.

*b. Disability Studies Theory*

Many disability studies scholars reject the “medical” model of disability in favor of a “social” (or “sociopolitical”) one, shifting the focus from the “needs” of those with disabilities to the social environments in which they live.<sup>248</sup> Noting that difference is not something “inherent in the ‘different person,’” Martha Minow has famously argued that it “is instead a feature of a comparison drawn between people . . . .”<sup>249</sup> Using a person in a wheelchair as an example, Minow points out that the difference that supposedly resides within the body of that individual (the “disability” that causes her to have to use a wheelchair), thereby distinguishing her from others who can walk, disappears if she is using a building that replaces steps with ramps and narrow doorways with wider ones.<sup>250</sup> Depending on the social context in which she lives, the wheelchair user’s difference can become no more significant than her eye color. In this literature, “the condition of being positioned as ‘disabled’ [comes] to be conceptualized as an oppression, rather than an unproblematic description of the characteristics and functionings of the bodies of some individuals.”<sup>251</sup>

In their analyses, these social model theorists usually draw a distinction between an impairment—a physical trait that can be objectively described—and a disability—a disadvantage imposed on an individual *because of* his or her impairment.<sup>252</sup> These theorists argue that if society were structured so as to include the individual with an impairment in its idea of the “normal” individual, then the disability would disappear: doors would be wide enough and curbs low enough to accommodate wheelchairs, elevator buttons would include Braille characters, and so on. The difference would not make a difference.<sup>253</sup>

Mairian Corker and Tom Shakespeare, drawing on Derrida’s work with binary distinctions, have argued that the opposition between “normal” and

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<sup>248</sup> Iris Marion Young, *Forward to DISABILITY/POSTMODERNITY: EMBODYING DISABILITY THEORY* xii, xii–xiii (Mairian Corker & Tom Shakespeare eds., 2002). See generally Jonathan Drimmer, Comment, *Cripples, Overcomers and Civil Rights: Tracing the Evolution of Federal Legislation and Social Policy for People with Disabilities*, 40 UCLA L. REV. 1341 (1993) (describing medical and social-pathology models); see also Laura L. Rovner, *Disability, Equality, and Identity*, 55 ALA. L. REV. 1043, 1047–58 (2004).

<sup>249</sup> MARTHA MINOW, *MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW* 12 (1990).

<sup>250</sup> *Id.*

<sup>251</sup> Young, *supra* note 248, at xii. But see Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 658 (1999) (arguing that this model breaks down in some situations).

<sup>252</sup> Tremain, *supra* note 87, at 620.

<sup>253</sup> Moreover, even those in the disability community who embrace the disability concept may still oppose attempts to “fix” disabilities. Many in the Deaf community, for example, see themselves as a cultural/linguistic minority and oppose reparative surgeries such as cochlear implants. Bonnie Tucker, *The ADA’s Revolving Door: Inherent Flaws in the Civil Rights Paradigm*, 62 OHIO ST. L.J. 335, 385 (2001). (I owe this point to Laura Rovner).

“disabled” can be seen as a social construct that serves the interests of some people over others. Although the two terms are opposed, “‘normativism’ needs ‘disability’ for its own definition: a person without an impairment can define him/herself as ‘normal’ only in opposition to that which s/he is not—a person with an impairment.”<sup>254</sup>

Recently, moreover, some authors have begun to challenge the concept of impairment itself. Shelley Tremain critiques those espousing the social model for assuming that “impairments” actually *exist* and emphasizing only the need for society to be restructured so as to minimize or eliminate the impact they have on people’s lives. Applying Foucault’s insights, she charges that the social model ignores the extent to which social practices are in fact *constitutive* of the impairments *themselves* (and thus, of the identities of disabled individuals not only *as disabled* but also *as physically different*). In that sense, she notes, “impairment has been disability all along.”<sup>255</sup> Scholars like Tremain argue, therefore, that medical and scientific experts on impairment do not simply study and treat the impaired, as they are usually seen as doing, but actually *create* the social identity of certain individuals *as* “impaired.” Medical and scientific discourses *create* the impairments they purport to merely describe.<sup>256</sup> Thus, “subjects are produced who ‘have’ impairments because this identity meets certain requirements of contemporary political arrangements.”<sup>257</sup> Or, to put it differently, the concept of normality “has become the means through which to identify subjects and make them identify themselves in ways that make them governable.”<sup>258</sup>

### c. Applying Disability Studies Theory to Intersex Cutting

Applying this scholarship to intersex individuals, their “abnormality” reveals itself as a cultural construction.<sup>259</sup> Only in a society in which sex

<sup>254</sup> Mairian Corker & Tom Shakespeare, *Mapping the Terrain*, in *DISABILITY/POST-MODERNITY: EMBODYING DISABILITY THEORY* 1, 7 (Mairian Corker & Tom Shakespeare eds., 2002).

<sup>255</sup> Tremain, *supra* note 87, at 632. Cf. JUDITH BUTLER, *GENDER TROUBLE: FEMINISM & THE SUBVERSION OF IDENTITY* 7 (1990) (noting that sex has really always been gender).

<sup>256</sup> Tremain, *supra* note 87, at 619–20.

<sup>257</sup> Shelley Tremain, *On the Subject of Impairment*, in *DISABILITY/POSTMODERNITY: EMBODYING DISABILITY THEORY* 32, 42 (Mairian Corker & Tom Shakespeare eds., 2002) [hereinafter Tremain, *Impairment*]. See also Tremain, *supra* note 87, at 632.

<sup>258</sup> Tremain, *supra* note 87, at 620.

<sup>259</sup> In applying this constructivist model, I do not mean to suggest that the challenges of living with a differently abled body are insignificant, or to minimize the personal grief associated with bodily limitations. Someone who likes to ride horses and can no longer do so has obviously lost something, and the broader society has not necessarily *caused* that loss. Nevertheless, especially in the intersex context, it seems important to emphasize the social construction not only of the notion that someone is disabled (or so physically impaired as to be unable to live a successful social and sexual life without surgery), but also of the notion that the person is impaired (fundamentally physically different from other human beings). See *infra* note 260 (discussing the fact that nearly half of males are consid-

is understood in binary terms (everyone is either male or female) does the hermaphroditic body become abnormal. Rather than conceptualizing such individuals as a “normal” third sex or as occupying various points along a sex continuum,<sup>260</sup> our society chooses to see them as suffering abnormalities that require repair. Indeed, since the early nineteenth century, Western scientists have used a very narrow definition of the “true hermaphrodite,” causing the phenomenon of intersexuality to be pathologized.<sup>261</sup> Treating most intersex conditions as instances of failed or “unfinished” development of the individual’s “true” sex, and thus assuming that virtually all intersex individuals actually belong to one sex or the other,<sup>262</sup> physicians have enforced the idea that male and female are fundamentally different, with virtually no overlap, and that intersex individuals are “failed” instances of both.<sup>263</sup> An intersex individual is either a male (with certain “abnormalities”), or a female (with certain “abnormalities”). Scientists rarely treat an intersex person as either a combination of both sexes or a third, distinct sex.<sup>264</sup> Note the irony here: In the medical discourse about intersex,

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ered to have a “misplaced” urethra at birth). (This footnote was prompted by an exchange of ideas with Emi Koyama. That is not to say, however, that she would necessarily endorse its content).

<sup>260</sup> Many evocative data suggest that a sex continuum is a more accurate image. For example, *hypospadias*, the condition of having a misplaced opening of the urethra in the penis (rather than the “normal” placement at the tip), has been found to occur in forty-five percent of men. FAUSTO-STERLING, *supra* note 11, at 57. But if nearly half the male population actually suffers from this “abnormality,” that raises serious questions about whether it is an abnormality at all. Perhaps the placement of the urethra at the tip of the penis should not be seen as “normal”—or, rather, perhaps we should simply conclude that urethra placement varies. *Cf.* Holmes, *supra* note 203, at 175 (“When we appreciate that the difference between intersexed and not intersexed can be only millimeters it seems clear that no one is truly intersexed, but that we are all, in our infinite differences from each other, intersexed.”). Of course, to conclude that “natural” urethral placement varies to such an extent would threaten one of the major physiological distinctions that supposedly separate the sexes: the ability to urinate standing up. The need for males to have that ability in order to avoid stigma is a significant concern of physicians working in the intersex area. FAUSTO-STERLING, *supra* note 11, at 57. Interestingly, I can report, based on having lived in a small village in Togo, West Africa, that West African women used to urinate standing up, and many still do—although the practice appears to be decreasing, perhaps as a result of Western influence.

<sup>261</sup> FAUSTO-STERLING, *supra* note 11, at 39–42. Fausto-Sterling notes that, before that time, hermaphrodites were “objects of awe and astonishment.” But with the rise of medical science in general and obstetrics in particular, they came to be seen as people with pathological conditions—mistakes of nature that could be corrected. *Id.* at 37.

<sup>262</sup> Under this view, the role of the physician is simply to “determine” what is the “true” sex of the individual. Kessler, *supra* note 191, at 10. But, as Kessler notes, this assumption that sex is inherent in an individual would seem to conflict with the assumption, which also informs most intersex treatment, that early childhood socialization is extremely important for the sex assignment to “take.” *Id.* at 16–17.

<sup>263</sup> As Fausto-Sterling also points out, it is interesting that the rise of this narrow definition of hermaphrodite (and the resultant reinforcement of the sharp distinction between the sexes) coincided with the beginning of the nineteenth-century women’s movement. FAUSTO-STERLING, *supra* note 11, at 39–40. On intersex treatment as gender subordination, see *infra* Part III.B.4.

<sup>264</sup> *Id.* at 37–38.



bodies that are produced in nature are seen as unnatural, while reconstructed bodies produced with human technology are seen as “natural,” even when they bear little similarity to “normal” human bodies.<sup>265</sup>

Interestingly, though, even while physicians publicly talk about merely *discovering* what the “true” sex of the child is, they privately acknowledge that they are essentially *constructing* a gender identity for a child who does not have one.<sup>266</sup> Scholars such as Kessler argue that this inconsistency does not represent hypocrisy on the part of the doctors. Instead, it derives from their inability to see that gender is no more binary than sex. While they see the physical proof that bodies come in more than two types, they nevertheless cannot see human gender identities as coming in more varieties than masculine and feminine.<sup>267</sup> Thus, they feel compelled to conform bodies to binary gender norms, rather than seeing that gender itself is socially constructed.<sup>268</sup>

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<sup>265</sup> As Kessler puts it,

Although the deformity of intersexed genitals would be immutable were it not for medical interference, physicians do not consider it natural. Instead they think of, and speak of, the surgical/hormonal alteration of such deformities as natural because such intervention returns the body to what it “ought to have been” if events had taken their typical course. The nonnormative is converted into the normative and the normative state is considered natural. The genital ambiguity is remedied to conform to a “natural,” that is, culturally indisputable, gender dichotomy.... The belief that gender consists of two exclusive types is maintained and perpetuated by the medical community in the face of incontrovertible physical evidence that this is not mandated by biology.

Kessler, *supra* note 191, at 24–25. *See also* Ford, *supra* note 133, at 483 (“To argue that a woman with no clitoris at all has ‘normal’ genitalia is ludicrous . . . . The awful truth for many intersexuals is that the deformation of post-surgery genitals is ‘a fact immediately obvious to anyone who glances at the “after” photos claimed as successes.’”) (citing Bruce E. Wilson & William G. Reiner, *Management of Intersex: A Shifting Paradigm*, 9 J. CLINICAL ETHICS 360, 364 (1998)).

<sup>266</sup> Kessler, *supra* note 191, at 24.

<sup>267</sup> In contrast, many other societies explicitly recognize this diversity of both sexes and genders. For example, among certain villagers in the Dominican Republic, there are large numbers of children born with feminized external genitalia, whose testes descend and secondary male characteristics emerge at adolescence. Those children, called “guevadoche” (“balls at twelve”) by the villagers, are simply accepted as a third sex. When their identity is revealed by the changes that occur at puberty, children who were previously thought to be girls are now recognized as boys. Zachary I. Nataf, *Transgender: As the Stars in the Sky / Beyond the Pink and Blue*, in *THE NO-NONSENSE GUIDE TO SEXUAL DIVERSITY* (Vanessa Baird ed., 2001), <http://www.ai-lgbt.org/transgender.htm> (last visited Nov. 1, 2004). *See also* TWO-SPIRIT PEOPLE: NATIVE AMERICAN GENDER IDENTITY, SEXUALITY, AND SPIRITUALITY 2, 13, 258–61 (Sue-Ellen Jacobs et al. eds., 1997) (describing various non-binary gender systems among Native American groups).

<sup>268</sup> Kessler, *supra* note 191, at 24–25. Of course, as Judith Butler points out, if sex itself is socially constructed—that is, if we *gender* the sexes as male/masculine and female/feminine, then there’s no real distinction between sex and gender. Both are social constructs. BUTLER, *supra* note 255, at 7. Thus, for Butler, “[g]ender is instead the means through which ‘sexed nature’ is produced and established *as natural*, as *prior* to culture and as a politically neutral surface *on which* culture acts.” Tremain, *supra* note 257, at 41 (describing Butler’s view).

In summary, like FGC, intersex treatment, including its identification of intersex conditions as disabilities requiring fixing and impairments reflecting difference, is a cultural practice. It is based on a set of four entrenched cultural convictions. First, intersex treatment relies upon the assumption of gender binarism—the idea that people are divided into two groups, men (those with masculine traits) and women (those with feminine traits). Second, it relies upon the assumption of sex binarism—the idea that people are divided into two sexes, male and female, and that anybody who varies from those two models is “abnormal.” Third, it is grounded on the belief that, as a descriptive matter, sex and gender correlate—that people with male sexual equipment have masculine traits and those with female sexual equipment have feminine traits.<sup>269</sup> Finally, it relies upon the normative belief that sex and gender therefore *should* correlate—that anomalous bodies should be surgically “corrected” for the good of both the child and family involved. Encountering non-binary examples of sex (bodies that are, as Julia Epstein puts it, “either/or, neither/both”<sup>270</sup>), physicians thus try to conform those bodies to binary gender norms, creating males and females so that those occupying the bodies can become men and women.

In doing so, however, doctors treating individuals with intersex conditions actually *create* the disability they purport to be curing. Unconsciously enforcing the cultural categories of their society,<sup>271</sup> physicians, through the “knowledge” they disseminate and the treatments they perform, convey the message that those born with intersex conditions are abnormal, pathological, and needing correction. In observing, studying, and treating intersexuals, they also *produce* the intersex identity as one of disability, deviance, and dysfunction. Thus, intersex surgery is not a medical necessity dictated by human biology. Nor is it a psychosocial necessity to stem a natural (pre-cultural) aversion to objectively identifiable physical abnormality. Rather, such surgery is performed because it reinforces (and enforces) a belief in the binary division of sex and gender that prevails in the culture of which it is a part.<sup>272</sup>

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<sup>269</sup> See generally BUTLER, *supra* note 255, at 17–25 (arguing that gender is not an artifact of biological sex, but rather is “performed”); see also, Corker & Shakespeare, *supra* note 254, at 10 (describing Butler as “criticiz[ing] the . . . idea that femininity and masculinity are the cultural expressions of material fact, namely the female or the male body,” rather than performative acts). As will be discussed further below, these assumptions about men and women also include the assumption that they are “naturally” heterosexual—that each group naturally forms intimate relationships with the opposite sex. See *infra* Part III.B.5.

<sup>270</sup> J. Epstein, *Either/or—Neither/both: Sexual Ambiguity and the Ideology of Gender*, 7 *GENDERS* 99 (1990).

<sup>271</sup> Chase gives a great example of how physicians “can be blind to their complicity in constructing the objects they study,” describing how one doctor said to her, “[W]ho is the enemy? I really don’t think it’s the medical establishment. Since when did we establish the male/female hegemony?” Chase, *supra* note 1, at 139.

<sup>272</sup> See FAUSTO-STERLING, *supra* note 11, at 8 (“Since intersexuals quite literally em-

#### 4. *Intersex Surgery as Gender Subordination*

Intersex surgery does more than enforce binary cultural norms regarding sex and gender. It also helps to maintain gender subordination. Like FGC, intersex surgery enforces patriarchal gender norms and male control over female sexuality. Intersex treatment protocols are based on and impose a traditional, patriarchal understanding of human sexuality, pronatalist assumptions about women's social roles, and a sexist dismissiveness of female physical and psychological harm. By reinforcing the binary understandings of sex and gender discussed above, such protocols perpetuate a patriarchal system that is premised upon the assumption of female inferiority and difference.<sup>273</sup>

In determining which physiological anomalies indicate that a child should be “normalized” to become a girl and which indicate the child should be transformed into a boy, doctors define who is a woman and who is a man.<sup>274</sup> The boundary drawing they perform *creates* males and females out of bodies that are, in fact, either/or, neither/both. In the words of Cheryl Chase, “[S]cience produces through a series of masked operations what it claims merely to observe.”<sup>275</sup> Not surprisingly, the “rules” doctors use to make these decisions are premised upon traditional, stereotypical understandings of the nature of and differences between the sexes.

##### a. *Penis Envy*

For instance, physicians use a phallogocentric definition of both males and females. They determine whether a child is a male by measuring the size of the penis. If the penis is too small (under 2.5 cm stretched<sup>276</sup>), the child must undergo surgery to be transformed into a girl. That transformation necessarily includes reducing the phallus, because a clitoris larger than 1 cm<sup>277</sup> is considered inappropriate for a female. Even if the child with a small penis would be a fertile male—that is, he has functional tes-

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body both sexes, they weaken claims about sexual difference.”); Kessler, *supra* note 191, at 25 (“[G]enital ambiguity is ‘corrected’ not because it is threatening to the infant’s life but because it is threatening to the infant’s culture.”).

<sup>273</sup> Intersex treatment protocols also, as discussed below, perpetuate heteronormative beliefs about the unnaturalness of same-sex relationships. See *infra* Part III.B.5.

<sup>274</sup> “[E]ven as fierce arguments over gender identity, gender role development, and social construction of gender rage in psychology, feminism, and queer theory, we have literally delegated to medicine the authority to police the boundaries of male and female . . . .” Chase, *supra* note 1, at 132.

<sup>275</sup> *Id.* at 133. See generally MICHEL FOUCAULT, *POWER & KNOWLEDGE: SELECTED INTERVIEWS & OTHER WRITINGS, 1972–1977*, 78–108 (Colin Gordon et al. eds., 1977) (power as exercised through knowledge discourses that construct what they purport to merely observe).

<sup>276</sup> ALICE DOMURAT DREGER, *HERMAPHRODITES & THE MEDICAL INVENTION OF SEX* 183 (1998).

<sup>277</sup> *Id.*

tes that could produce sperm—he is still considered to be more appropriately raised as a girl. Similarly, the fact that the child is chromosomally male will not preclude surgical conversion into a female if his penis is considered too small.<sup>278</sup> In these cases, it is apparently considered (relatively) unimportant that the resulting girl will be infertile,<sup>279</sup> or that reduction of her phallus/clitoris might deprive her of sexual sensation.<sup>280</sup> On the other hand, if the child's penis is considered adequate, but there is a chance of *female* fertility, then fertility trumps penis size and the child will be rendered female.<sup>281</sup> (And, again, because the *female* phallus cannot be too large, it will be reduced.) Thus, for successful performance of the masculine social role, gender conformity (as measured by penis size) is considered more important than fertility, sexual satisfaction,<sup>282</sup> or innate genetic makeup. Similarly, gender conformity (as measured by clitoris size) is considered more important than sexual satisfaction for females (with fertility in turn privileged over sexual sensation).

Medical authorities explain the need for boys to have adequately long penises in two ways. First, physicians use a penetrative—and heteronormative—definition of male sexuality, emphasizing that a man must be able to penetrate a woman. Second, they cite the risk of social ostracism (teasing and harassment) that boys with small penises will likely suffer. Some medical authorities emphasize that a man must be able to engage in penetration in order to give sexual pleasure to his (female) partner,<sup>283</sup> but given the clitoricentric nature of female sexuality,<sup>284</sup> that emphasis seems misplaced. Nor does male sexual gratification seem a likely explanation for this emphasis on penetration, since a micropenis is likely to be perfectly capable of erection and ejaculation even if it cannot penetrate.<sup>285</sup>

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<sup>278</sup> Kessler, *supra* note 191, at 12–13.

<sup>279</sup> When a chromosomal male with a micropenis is turned into a girl, the child will not be fertile because she will most likely have a constructed vagina and no ovaries or uterus.

<sup>280</sup> Similarly, “[a] constructed ‘vagina’ does not have to have any [abilities other than penetrability]. It is not required to be self-lubricating or even to be at all sensitive to count as ‘functional.’ . . . In fact, intersexuality doctors often talk about vaginas in intersex children as the absence of something, as a space, a place to put a penis.” DREGER, *supra* note 276, at 184.

<sup>281</sup> Chase, *supra* note 1, at 130. Fausto-Sterling quotes the following rule: “Genetic females should always be raised as females, preserving reproductive potential, regardless of how severely the patients are virilized. In the genetic male, however, the gender of assignment is based on the infant’s anatomy, predominantly the size of the phallus.” FAUSTO-STERLING, *supra* note 11, at 57 (citing P. K. Donahoe, D. M. Powell, et al., *Clinical Management of Intersex Abnormalities*, 28 CURRENT PROBS. IN SURGERY 513, 527 (1991)).

<sup>282</sup> There is at least some evidence to suggest that men with micropenises can have perfectly satisfying sex lives. See FAUSTO-STERLING, *supra* note 11, at 95.

<sup>283</sup> Kessler, *supra* note 191, at 19–20.

<sup>284</sup> See OUR BODIES OURSELVES IN THE NEW CENTURY, *supra* note 86, at 239–40.

<sup>285</sup> A. P. van Seters & A. K. Slob, *Mutually Gratifying Heterosexual Relationship with Micropenis of Husband*, 14 J. SEX & MARITAL THERAPY 98 (1988). Of course, it is possible that, for some people at least, the inability to penetrate would significantly reduce sexual satisfaction even if the ability to orgasm were retained.

However, it is clear that having a small penis is stigmatizing for males in this society, and surely an inability to engage in penetration might be stigmatizing as well. Thus, the first explanation seems to collapse into the second: the need to avoid social stigma.

Despite some evidence that individuals born with nonconforming genitalia do not suffer emotional trauma,<sup>286</sup> medical authorities still justify intersex surgeries by citing the emotional hardship that a boy with a micro-penis or a girl with a large clitoris would likely experience due to social stigmatization and teasing.<sup>287</sup> At times the medical literature, especially the texts from before 1970 or so, is rather melodramatic in its depiction of the trauma that an intersex birth can cause, not only to the child, but to the parents as well: “One can only attempt to imagine the anguish of the parents. That a newborn should have a deformity . . . (affecting) so fundamental an issue as the very sex of the child . . . is a tragic event which immediately conjures up visions of a hopeless psychological misfit doomed to live always as a sexual freak in loneliness and frustration.”<sup>288</sup> But even more modern protocols emphasize the psychological impact of nonconforming genitalia on both child and parents. A 1997 *New York Times* article reported one doctor as saying, “I don’t think parents can be told, this is a normal girl, and then have to be faced with what looks like an enlarged clitoris, or a penis, every time they change the diaper.”<sup>289</sup> Thus, just as proponents of FGC base their conduct on the need to protect women from harmful social stigma, so do practitioners of intersex surgery base their position on protecting their patients from social ostracism. However, as discussed above,<sup>290</sup> existing data do not support this concern about stigma. Furthermore, current medical protocols *create* stigmatizing appearances while reinforcing the very norms that generate the stigmatization in the first place.<sup>291</sup> Therefore, just as the stigma of not being circumcised does not justify the practice of female circumcision, so the stigma concerns about intersex conditions detailed above do not justify intersex cutting.

By using mutually exclusive phallic criteria (a man’s is always larger than X, a woman’s is always smaller than Y, and there is a safe no-man-

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<sup>286</sup> See *supra* text accompanying note 282.

<sup>287</sup> See KESSLER, *supra* note 21, at 34.

<sup>288</sup> C. J. Dewhurst & R. R. Gordon, *THE INTERSEXUAL DISORDERS* (1969), *quoted in* FAUSTO-STERLING, *supra* note 11, at 47.

<sup>289</sup> Natalie Angier, *New Debate Over Surgery on Genitals*, N.Y. TIMES, May 13, 1997, at C1. Physician concern with *parental* embarrassment and discomfort is also a factor, as these quotes illustrate. Of course, parental pressures probably play a role in FGC as well. However, in neither context does parental reaction justify allowing the surgeries—any more than it would be appropriate to allow parents to order plastic surgery on a child with an “ugly” nose, or liposuction on a child who was “fat,” or lightening of the skin of a child who was “too dark,” merely because they were embarrassed at having offspring with any of those traits. See *supra* note 239 (discussing legal rules regarding when third party interests can be used to justify surgery on a child).

<sup>290</sup> See *supra* text accompanying note 271.

<sup>291</sup> See *infra* text accompanying note 313.

or-woman's land in between), intersex treatment protocols reinforce the notion that the sexes are opposed and mutually exclusive. It is considered a tragedy for a male child to "look female" or vice versa only because the genders are considered to be such diametric opposites. Such gender binarism is central to a patriarchal system that is very harmful to women (as well as men<sup>292</sup>). The belief that the sexes are diametrically opposed and mutually exclusive grounds an ideology of sexual difference that paints women as naturally inferior to men and justifies their exclusion from paradigmatically "male" activities and roles.<sup>293</sup> In defining the sexes as fundamentally different, intersex treatment protocols reinforce that ideology. They also reinforce pejorative constructions of the female. As we know from Freud's infamous "penis envy" explanation for female pathology, the presence or absence of the penis is one of the primary means by which the distinction between male and female is symbolized (and hierarchized) in Western society.<sup>294</sup> Feminists have, of course, frequently attacked this phallocentrism as elevating the male and defining the female condition as one of lack.<sup>295</sup> Equating maleness with having a penis of a certain size and femaleness with not having anything that could possibly be construed as a penis, traditional intersex treatment protocols reinforce this pejorative equation of femaleness with lack.<sup>296</sup>

*b. Back to the 1950s*

The medical literature on intersexuality reduces sex to penetration for *women*, as well as men. In conforming intersex children's bodies to female models, physicians take great care (and cause great suffering to the intersex children, as detailed above) to construct vaginas so that the girls they create can grow up to have penetrative sex. However, the doctors appear significantly less concerned about preserving the functionality of the clitoris—the major source of sexual gratification in women—as demonstrated by the prevalence of clitoral reduction and recession.<sup>297</sup> As Cheryl

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<sup>292</sup> See *infra* Part III.B.4.c.

<sup>293</sup> On the social construction of the sexes as diametrically opposed and the separate spheres ideology supported by that construction, see Wendy W. Williams, *The Equality Crisis: Some Reflections on Culture, Courts, and Feminism*, 14 WOMEN'S RTS. L. REP. 151, 153–54 (1992).

<sup>294</sup> See Simone de Beauvoir, *Introduction to the Second Sex* of NEW FRENCH FEMINISMS: AN ANTHOLOGY 41 (Elaine Marks & Isabelle de Courtivron eds., 1980); Hélène Cixous, *Sorties*, in NEW FRENCH FEMINISMS: AN ANTHOLOGY, *supra*, at 90; Luce Irigaray, *The Sex Which is Not One*, in NEW FRENCH FEMINISMS: AN ANTHOLOGY, *supra*, at 99.

<sup>295</sup> See De Beauvoir, *supra* note 294; Cixous, *supra* note 294; Irigaray, *supra* note 294.

<sup>296</sup> Chase, *supra* note 1, at 131.

<sup>297</sup> An alternative theory is that the importance of the clitoris to female sexuality is still not widely appreciated, perhaps not even among physicians. Widespread inattention to such an important biological fact would seem unlikely—but then again, the prevalence of such inattention in the film industry, as witnessed by the penetration fixation of most cinematic sex scenes, suggests that perhaps other groups suffer from similar blinders. Cf. Frances Olsen, *The Myth of State Intervention in the Family*, 18 U. MICH. J.L. REFORM 835,

Chase puts it, “Most medical intersex management is a form of violence based on a sexist devaluing of female pain and female sexuality. Doctors consider the prospect of growing up male with a small penis to be a worse alternative than living as a female without a clitoris, ovaries, or sexual gratification.”<sup>298</sup> Nor, clearly, do they seem to appreciate the challenges facing a “girl who will struggle to convince people that in spite of her facial hair, dense musculature, low voice and inability to reproduce, she is actually female.”<sup>299</sup>

What *are* these doctors concerned with, then? I would suggest that the medical preoccupation with constructing vaginas and, more importantly, with reducing the size of clitorises, betrays a (no doubt subconscious) fear of female sexual power, as well as an aversion to the blurring of sex-gender boundaries. In this context, it is striking that the females produced by intersex surgery fit exactly the 1950s stereotype against which modern feminists have fought for decades: the woman as passive recipient of sexual penetration with no sexual impulses of her own. Given that the penis is our cultural symbol of male power, a woman who has a clitoris that in any way approaches the size of the male phallus is threatening. She evokes the sexual power usually reserved for men, and she threatens the hegemonic use of that power that is preserved by a sex-gender binary in which only men have penises.<sup>300</sup> Thus, intersex surgery enforces a desexualized, passive, penetrative model of female sexuality and a traditional, patriarchal image of women’s inferior social status. Just as FGC enforces a norm of sexual inactivity for women, intersex surgery enforces a similar norm—woman as passive recipient of penetration.

### c. *The Burden of Perfect Masculinity*

It is worth noting, however, that the gender normalization effected by intersex surgery is—like patriarchy itself<sup>301</sup>—harmful to males as well as females. Ninety percent of such surgery is aimed at changing the inter-

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857 n.57 (1985) (discussing an Ann Landers survey that found that seventy-two percent of women were dissatisfied with sex as practiced).

<sup>298</sup> Chase, *supra* note 1, at 145. “Medical intervention literally transforms transgressive bodies into ones that can safely be labeled female and subjected to the many forms of social control with which women must contend.” *Id.*

<sup>299</sup> Holmes, *supra* note 203, at 174. Both sexes must conform to gender expectations—male norms of sexuality that valorize penis size and dismiss fertility, and female norms of reproduction that valorize fertility and dismiss sexuality.

<sup>300</sup> She also threatens to replace men in the politico-sexual order. Many parents fear that their intersex children will grow up to be lesbians, and physicians do little to disabuse them of the notion that that would be a “bad” result. FAUSTO-STERLING, *supra* note 11, at 72 n.112.

<sup>301</sup> See, e.g., NANCY LEVIT, *THE GENDER LINE: MEN, WOMEN, & THE LAW* (1998) (discussing negative effects of patriarchy on men); Ehrenreich, *Masculinity and American Militarism*, *supra* note 23, at 45–46.

sex child into a girl.<sup>302</sup> This fact is disturbing in both a symbolic and a material sense. In the material sense, it raises the possibility that a number of children who would be more comfortable being raised as boys are misassigned. That would certainly seem to be true for at least *some* children—perhaps, for example, those born with XY chromosomes, functioning testes, and micropenises. The John/Joan case discussed above confirms the assumption underlying this point—that physiology affects sex identity (whether someone feels that s/he is a man or a woman).<sup>303</sup> On the other hand, the existence of transgendered people cuts the other way, for those individuals have a sex identity that differs from the sex associated with their physical bodies. Thus, perhaps the best that one can say is that under the law of averages, which would suggest that some people grow up feeling like males and others like females (and perhaps others like something else altogether), turning most intersex children into females will go against the wishes that at least *some* of them would have had as adolescents or adults. In other words, many intersex children may be psychological boys<sup>304</sup> suffering in feminized bodies that do not fit their own sex/gender identity.<sup>305</sup>

At a symbolic level, the gender binarism reinforced by intersex treatment protocols harms men as well, as studies of the constraining effect of masculinity norms are beginning to reveal.<sup>306</sup> In addition, the tendency to turn any child without perfect male anatomical features into a girl—regardless of the fact that she will lack many of the features usually associated with females—reinforces a Western cult of masculinity that is harmful to males as well as females. The tendency of mainstream United States culture to expect males to conform to dehumanizing, comic-book-sized stereotypes of masculinity—stereotypes that disallow crying, weakness, emotionality, aesthetic sensibility, and so on<sup>307</sup>—is limiting and detrimental to males in this society. Yet it is reinforced by the message conveyed by intersex surgeries: that the male cannot be diluted with the female in any way. Just as women can elevate their sex by wearing male-identified clothing such as pants while it is still not socially acceptable (150 years after

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<sup>302</sup> “Surgery is essentially a destructive process. It can remove tissue and to a limited extent relocate it, but it cannot create new structures. This technical limitation, taken together with the framing of the feminine as a condition of lack, leads physicians to assign 90 percent of anatomically ambiguous infants as female by excising genital tissue.” FAUSTO-STERLING, *supra* note 11, at 131. See also KESSLER, *supra* note 21, at 20–21.

<sup>303</sup> See generally Kipnis & Diamonds, *supra* note 177.

<sup>304</sup> By this, I simply mean children who feel more comfortable presenting themselves as boys.

<sup>305</sup> I realize that, in a sense, I am reifying here the very binary gender norms I have criticized. But I think it is unavoidable that, in a society that understands gender dimorphically, at least some children *will* psychologically identify as boys.

<sup>306</sup> See, e.g., MEN & MASCULINITIES: A SOCIAL, CULTURAL & HISTORICAL ENCYCLOPEDIA (Michael Kimmel & Amy Aronson eds., 2003).

<sup>307</sup> See, e.g., *Queer Eye for the Straight Guy* (Bravo) (television program that reinforces stereotype of gay men as aesthetes and straight men as aesthetically challenged).



bloomers made their appearance) for men to wear skirts, so it is more acceptable for the female body to include parts associated with the higher-status gender than for the male body to be “polluted” by any female parts. Thus, intersex surgery helps to maintain gender norms that harm men as well as women.

In summary, intersex surgery—like FGC—creates male superiority (through reinforcing opposing, negative stereotypes of women), exerts control over women’s sexuality (by enforcing a norm of female sexual inactivity and passivity), and consigns women to the traditional roles of sex object and mother (through pronatalist protocols that emphasize penetrability and female fertility over female sexual gratification). Moreover, in the intersex case, as with FGC, the focus on preventing stigma obscures the larger problem of surgical practices that enforce traditional conceptions of men’s and women’s roles, thereby reinforcing patriarchy.<sup>308</sup>

##### 5. *Intersex Surgery as Enforcing Heteronormativity*

Intersex surgery enforces another set of cultural categories that is not usually discussed in the FGC literature: cultural assumptions about the naturalness of heterosexuality.<sup>309</sup> When doctors evaluate the “success” of gender normalizing surgery, they look at the sexual orientation of the patient as one indicator of “appropriate” gender identification.<sup>310</sup> This criterion, of course, is heteronormative. It elevates heterosexuality as “natural”<sup>311</sup> and constructs homosexuality as deviant. Gender criteria that focus on preparing females for penetration by penises and males for penetrating vaginas also betray a heteronormative bias. Thus, while both FGC and intersex surgery reinforce gender subordination, intersex treatment supports another subordinating system as well: compulsory heterosexuality.<sup>312</sup> This

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<sup>308</sup> “In so far as these technologies circulate as remedial measures performed on the basis of spurious projections about the future best interests of a given infant, their disciplinary character is depoliticized; in addition, the role they play in naturalizing the binary sex-gender and upholding heterosexual normativity remains disguised.” Tremain, *supra* note 257, at 40–41.

<sup>309</sup> See FAUSTO-STERLING, *supra* note 11, at 71–73.

<sup>310</sup> Fausto-Sterling contends that the ability to be a successful heterosexual is in fact the central criterion for sex assignment in intersex treatment practices. ANNE FAUSTO-STERLING, *BODY BUILDING: HOW BIOLOGISTS CONSTRUCT SEXUALITY* (forthcoming), cited in KESSLER, *supra* note 21, at 106. Cf. John Money et al., *Sexual Incongruities and Psychopathology: The Evidence of Human Hermaphrodites*, 98 BULL. JOHNS HOPKINS HOSP. 43, 49 (1956) (illustrating the use of this heterosexual norm).

<sup>311</sup> See Tremain, *Impairment*, *supra* note 257, at 40–41. Interestingly, physicians report that parents sometimes confuse the terms hermaphroditism and homosexuality, FAUSTO-STERLING, *supra* note 11, at 72, perhaps unconsciously illustrating societal assumptions about the intersexed.

<sup>312</sup> Indeed, the fact that sexuality is socially constructed raises broader questions about whether it is even *possible* to assess the success of genital-normalizing surgery in gender terms. Consider, for example, the criteria of success cited in current medical texts. While

further demonstrates that intersex surgery is a harmful cultural practice rather than a necessary medical intervention.

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As this review of intersex surgery reveals, not only is it a cultural practice like female genital cutting, but it may actually cause even more harm than FGC. Although it is performed under hospital conditions with sterile surgical instruments, it entails many more surgical interventions than does FGC, with the attendant risk of death (from anesthesia), infection, pain, and discomfort. It not only alters the physical attributes of the patient, but also cements the person's assigned sex/gender role in ways that may not turn out to be comfortable for that person, causing years of confusion and depression for many intersex individuals. It reinforces gender subordination, as well as subordination based on sexuality, employing heteronormative criteria of success. Finally, it does all this in the name of preventing a shame and stigma that it ultimately *fails* to avoid—and may actually exacerbate. Whereas women with FGC appear to at least receive the benefit promised—conformity to cultural norms and the attendant social acceptance—many intersex patients may never attain the sense of normalcy and acceptability that is the promised result of their surgeries. Rather, those surgeries perpetuate—and sometimes create—their status as stigmatized gender anomalies.<sup>313</sup>

The similarities between the two types of genital cutting, and the applicability of the same critiques to both of them, undermine the privileged position of moral superiority from which North American feminists

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the medical establishment no longer disparages the clitoris as unnecessary to female sexuality, *but see* Milton T. Edgerton, *Discussion: Clitoroplasty for Clitoromegaly due to Adrenogenital Syndrome without Loss of Sensitivity*, 91 *PLASTIC & RECONSTRUCTIVE SURGERY* 956, 956 (1993) (reporting that in forty years of clitoral surgery, “[n]ot one [person] has complained of loss of sensation, *even when the entire clitoris had been removed*”), it still advises parents to monitor their children's behavior for signs of gender nonconformity. Yet in this post-feminist world, it is difficult to imagine an appropriate example of such non-conforming behavior. Examples cited in the literature (applied, the reader will remember, mostly to “girls”), such as acting aggressively or climbing trees, FAUSTO-STERLING, *supra* note 11, at 74, restate (and seem almost to caricature) gender stereotypes that feminists have attacked for years. In other words, the fact that gender is socially constructed (and constructed in a way that enforces a gendered social hierarchy), confounds the entire enterprise of determining the success of genital-normalizing surgery by reference to objective gender criteria. Similarly, if one rejects heteronormative assumptions, it becomes that much harder to measure success. Indeed, the only viable criterion of success would seem to be personal gender and sexual satisfaction on the part of the individual patient.

<sup>313</sup> In fact, I would argue that some of the justifications traditionally given for intersex surgery apply with equal force to FGC. Especially when female circumcision is performed in the sterile conditions of a hospital (as it sometimes is), the justification for the procedure—parents' concern that their daughter will otherwise be stigmatized for being different from others in the community—cannot meaningfully be distinguished from U.S. parents' concern that their intersex child needs surgery so as not to be ostracized because of *her* “difference.”

have articulated their critique of FGC (as well as the culture/science dichotomy on which that critique is based). These similarities reveal that Western medicine is not immune to contingent “cultural” influences and that harmful cultural practices exist in the United States as well as in Africa. Such a revelation makes the rhetorical foundation of mainstream anti-FGC discourse—the United States’ role as educator and civilizer of primitive and barbaric African societies—much less convincing, since we have our own form of cultural cutting here at home. Thus, the intersex issue exposes the white privilege that undergirds the mainstream anti-FGC position. Similarly, it reveals that the refusal of North American feminists to recognize and condemn the harms caused by intersex cutting arises, at least in part, from their exceptionalist beliefs and their investment in white privilege.<sup>314</sup>

#### IV. THE IMPLICATIONS OF SIMILARITY: ALTERNATIVE APPROACHES TO INTERSEX REFORM

A more nuanced understanding of female genital cutting than that articulated by mainstream critics has implications for intersex analysis and for policies aimed at ending the practice. While resisting the language of child abuse and barbarism, these policies should nevertheless identify FGC as a harmful procedure that enforces conformity to gender norms. Recognizing that individual practitioners may be benignly motivated and unaware of the harm they are causing, an enlightened policy will still call for elimination of the practice. Finally, given that the impact of African genital cutting depends greatly on the particular procedure performed, this policy should distinguish between the more severe surgeries and the more superficial cutting practice of “nicking.”

In light of the similarities between female circumcision and intersex cutting, any attempt to address the problem of intersex cutting should be equally nuanced.<sup>315</sup> Therefore, in condemning the practice of intersex surgery, I do not mean to demonize those performing these procedures or to label the parents of intersex children as ignorant captives of a patriar-

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<sup>314</sup> The reluctance of FGC opponents to condemn intersex surgery may also stem from a conviction that doing so would be politically costly and would therefore undermine the effectiveness of their own efforts. In the short term, at least, that assessment may be correct. After all, intersex cutting is probably still supported by a majority of the medical community, and the arguments against it can be seen to undermine binary understandings of gender, making opposition to the surgeries politically controversial. My argument, however, is that opposing intersex cutting would, in the long run, actually *strengthen* the anti-FGC movement. See *infra* Part V.

<sup>315</sup> Of course, subtlety is desirable not only because the similarities between the two practices suggest that they should be treated similarly, but also because it is valuable in its own right. For the same reasons that the alternative critique of female circumcision is more intellectually defensible than the mainstream critique, a nuanced analysis of intersex surgery is preferable as well. Avoiding stereotyping and name-calling, it emphasizes the seriousness of the issue while recognizing its cultural complexity.

chal culture. Nor do I mean to lump together as equivalent the huge variety of intersex surgeries (although I am not aware of any intersex procedure that is as minor as nicking) or to deny the fact that some medical practitioners and parents refrain from imposing genital surgeries on intersex children. Moreover, before presenting the policy analysis that follows, I should emphasize what I am *not* saying about intersex treatment protocols. I am not saying that doctors should identify a third sex—or multiple sexes—and categorize intersex individuals as one of those. Nor should parents be urged or compelled to raise their intersex children as “its” or “others.” These extraordinarily difficult familial issues can only be resolved within the particular contexts of individual families and circumstances. Like ISNA,<sup>316</sup> I am concerned first and foremost with preventing trauma and preserving individual choice, not with sacrificing children on the altar of gender indeterminacy.

Any policy proposal regarding intersex cutting must struggle with the tension between the twin goals of preserving individual autonomy by eliminating childhood cutting and refraining from demonizing doctors or parents who participate in intersex surgical practices. Moreover, policy proposals regarding the intersex issue cannot be formulated in a vacuum. If FGC and intersex surgeries share substantial similarities, both in the harm they cause and in their patriarchal rationales and effects, then a commitment to consistency should govern legal reform efforts regarding the two types of procedures. Simply put, if the two practices are essentially similar, they should be treated the same way.

Opponents of FGC have supported both criminal and educational approaches to eliminating the practice. They often emphasize the importance of educating those in cultures where female circumcision is practiced about its harmful nature. But they also often favor encouraging (or even forcing) such societies to abandon the practice through various incentive (or coercive) measures, including criminal prohibition and threats of foreign aid reduction.<sup>317</sup> In the United States, opposition to FGC has been expressed principally through its criminalization. The question raised by the analysis presented here is whether similar strategies should be used to deter intersex surgeries.

If we shy away from punishing physicians for performing intersex procedures, we should think twice about imposing criminal sanctions on those who perform FGC. Likewise, if we resist concluding that Western doctors who treat the intersexed are ignorant, primitive, backward people

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<sup>316</sup> See INTERSEX SOC'Y OF N. AM., ISNA'S RECOMMENDATIONS FOR TREATMENT (1994), at <http://isna.org/library/recommendations.html> (last visited Oct. 14, 2004).

<sup>317</sup> Cf. Boyle & Preves, *supra* note 2, at 713–15, 721–22 (comparing assimilative and coercive reform efforts); Holly Maguigan, *Will Prosecutions for “Female Genital Mutilation” Stop the Practice in the U.S.?*, 8 TEMP. POL. & CIV. RTS. L. REV. 391 (1999) (questioning the utility of criminal prosecution).

who need educating by those from more enlightened cultures, we should resist such unsympathetic images of practitioners of female genital surgery.

These theoretical concerns are exacerbated by practical considerations. Policymakers attempting to eliminate intersex surgeries would not be writing on a blank slate. For example, if mainstream Western anti-FGC activists were to decide to incorporate opposition to intersex surgeries into their campaigns, they would necessarily find their rhetorical strategies constrained by the framework of condemnation of FGC within which they have been working. It is difficult, moreover, to imagine how a unified campaign could be constructed out of the current widely divergent legal approaches, according to which FGC is criminally proscribed and intersex surgery continues completely unregulated. Nevertheless, although the fact that the federal government and some states have already criminalized FGC<sup>318</sup> might seem to preclude anything other than a generalized criminal approach to both surgeries, it would be a mistake not to consider other options.

In formulating and evaluating the following alternative approaches to intersex surgery, I have been guided by three concerns: autonomy, consistency, and subtlety. An acceptable policy proposal regarding genital cutting issues should: (1) preserve individuals' autonomy by eliminating the procedures (at least when performed on children); (2) acknowledge the similarity between intersex and FGC issues; and (3) avoid demonizing practitioners of either surgery and discussing the harms those surgeries produce in voyeuristic or orientalizing ways.<sup>319</sup>

Below, I consider three types of policy approaches to the intersex and female circumcision issues: a strategy based on criminalization, a strategy based on education, and a strategy based on tort liability.<sup>320</sup> Applying the autonomy, consistency, and subtlety criteria, I assess the pros and cons of each approach.

#### A. Criminalization

The most obvious advantage to a unified campaign built around criminalization is that such an approach would clearly serve the interest in

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<sup>318</sup> See *supra* text accompanying note 5.

<sup>319</sup> For example, such a policy would refrain from labeling either female genital cutting or intersex surgery as "mutilation" or "child abuse."

<sup>320</sup> Relevant to each of these strategies would be arguments based upon international law. Many authors have argued that FGC violates international accords. See, e.g., Wood, *supra* note 22, at 372–83 (discussing Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Declaration on the Elimination of Violence Against Women, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and Convention on the Rights of the Child, among others). Similar arguments could probably be made regarding intersex cutting. Such international law arguments would certainly lend credence to positions advocating either criminalization, education, or tort remedies.

autonomy, immediately stopping all cutting of intersex children.<sup>321</sup> This approach would also be consistent with current approaches to the FGC issue within the United States.<sup>322</sup> A final advantage of criminalization is that such a policy would reflect the legitimate sense of harm and violation that many intersex individuals feel as a result of their surgeries, and would represent a societal recognition that the practice is hurtful and lacks justification. The physical and psychological harms of intersex surgeries catalogued above not only establish the practice's similarity to FGC but also stand as independent justifications for criminalization.

The glaringly obvious disadvantage with legislation that outlaws intersex surgeries is its lack of subtlety. First, such legislation would punish and stigmatize as criminals physicians who are likely motivated by a sincere desire to help intersex children and their parents. Second, it would limit parents' ability to make important health decisions for their children, setting up a blanket rule that applies no matter what the particularities of the individual family. Third, it would continue (and implicitly condone) the stigmatizing, punitive approach to female circumcision that was the product of the problematic anti-FGC rhetoric I have criticized in this Article. Extending such an extreme policy to intersex surgeries would garner stiff opposition. Even if this approach could overcome the political might of the medical profession and become law, it might generate a backlash in which the doctors and parents assumed the position of victims.<sup>323</sup> Instead of generating sympathy and support for the children who

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<sup>321</sup> This conclusion assumes adequate enforcement, of course. The federal anti-FGC statute, for example, is not really enforced at all, given that no funds have been appropriated for that purpose. *See supra* note 128.

<sup>322</sup> In fact, a push for criminalization might initially seem appealing because it could piggy-back on the work already done with respect to state and federal anti-FGC legislation. It is appealing to imagine banning intersex surgeries simply by mandating that the "medical exception" clauses built into most anti-FGC statutes not apply to such surgeries. This advantage is more illusory than real, however. Some procedures, such as hypospadias surgery, might not be included because they do not involve the cutting of *female* genitalia, which is usually the only kind prohibited by anti-FGC statutes. *See, e.g.*, Federal Prohibition of Female Genital Mutilation Act, Pub. L. No. 104-208, 110 Stat. 3009-709 (1996) (codified at 18 U.S.C. § 116 (2004)) (providing that "whoever knowingly circumcises, excises, or infibulates the whole or any part of the *labia majora* or *labia minora* or *clitoris* of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both." (emphasis added)). Moreover, in the intersex context, application of the anatomical labels used in such statutes is complicated by the fact that the sex of the patient, and the corresponding anatomical labels, are ambiguous to begin with and may undergo transformation during surgery. These conceptual difficulties lead to the conclusion that intersex legislation cannot be simply grafted onto the current anti-FGC legislation.

<sup>323</sup> In questioning a policy of criminalization that might actually enhance the reputation of intersex surgeons, I do not want to imply that the actual motives of these doctors are malevolent. Instead, as I have tried to make clear, I believe there is an important distinction between the practices and the practitioners. Undoubtedly, the doctors who engage in these surgeries do so with the best of intentions. Therefore, a policy of criminalization that seems to punish those good intentions will correspondingly make it more difficult for others to see past the good intentions and recognize the harm that is produced.

undergo these operations, a complete ban, if instituted prematurely, might lead to the view that surgeons are humanitarians prevented from using their skills to “fix” malformed children,<sup>324</sup> and parents are helpless victims of a law that prevents them from consenting to operations that would make their children “normal.”<sup>325</sup>

Of course, these problems might still be avoided, or at least reduced, without abandoning the criminalization approach. For example, the procedures could be reclassified as misdemeanors instead of felonies. Alternatively, the punitive statutory scheme could be accompanied by meaningful (meaning well-funded) educational campaigns concerning both types of genital cutting. However, such an approach would still suffer from some of the harsh effects discussed above and would also be politically difficult to put into effect. The tone of moral condemnation that has characterized mainstream United States discourse against FGC would make it difficult to retain a criminal approach while reducing the severity of the criminal sanction that could be imposed on practitioners of female circumcision.

One final disadvantage of criminalization is revealed by a closer examination of the practical effect of making intersex surgery a crime. The “on paper” consistency that criminalizing both FGC and intersex cutting would produce might mask an inconsistency in practice. As previously mentioned, the successful passage of many anti-FGC statutes was due in part to the fact that those laws allowed conservative legislators to garner easy credit among feminists by supporting laws that would have few practical consequences.<sup>326</sup> Few FGC practitioners live in the United States, and there have been no prosecutions since the passage of criminal prohibitions.<sup>327</sup> Passage of legislation banning intersex surgeries, however, *would* have dramatic real-life consequences, since the practice is engrained within the medical establishment and hundreds of operations are performed each

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<sup>324</sup> Although debate over intersex cutting is increasing within the medical community, many physicians still view it as a beneficial intervention. See Ford, *supra* note 133, at 470–71; Gorman & Cole, *supra* note 186, at 55–56. Many hospitals will fund intersex surgeries for families without insurance, see, e.g., Holmes, *supra* note 203, at 161 (Canadian public insurance covers them as necessary medical treatments), and I have heard (but have been unable to confirm) that intersex surgeons are beginning to participate in medical missionary trips to Third World countries to perform the surgeries there, much like the more recognized and heralded efforts of Western doctors to help with problems like cleft palates.

<sup>325</sup> Of course, the same objections could be made to the statutes criminalizing female circumcision. They could, in other words, be seen as prohibiting well-intentioned parents and medical practitioners from preventing stigma and embarrassment to the girls on whom they are performed. But those objections seem to carry more weight in the intersex context, precisely *because* the patriarchal cultural content that informs justifications for intersex surgery is *North American* cultural content, and therefore less recognizable as such in the United States.

<sup>326</sup> See *supra* text accompanying note 128.

<sup>327</sup> Maguigan, *supra* note 317, at 406; Paresi, *supra* note 108, at 166 (FBI reports no arrests under the U.S. statute). Nor have there been any published court decisions involving prosecutions under state statutes.

year. Therefore, although this approach would appear to support strongly the principle of consistency, with both procedures criminalized, it might have wildly inconsistent practical consequences.

### *B. Education*

A second approach would be to work to eliminate both FGC and intersex surgery through an educational campaign designed to inform medical professionals and parents about the harms caused by both. This approach would easily accommodate the concern for subtlety, since it completely avoids stigmatizing physicians as either willful child abusers or negligent professionals (as would happen if they were subjected to either criminal sanctions or tort liability). An educational approach recognizes that medical practitioners, whether they be physicians performing intersex surgeries or African midwives performing female circumcisions, are well-meaning individuals unaware of the role they play as enforcers of their cultures' gender norms.

Educational efforts could theoretically also satisfy the consistency criterion, but only if the politically difficult task of repealing criminal prohibitions against FGC was accomplished. The irony of the educational approach is that while a unified educational campaign would probably increase the credibility of the anti-FGC movement,<sup>328</sup> the history of that very movement makes such an approach politically problematic. On the one hand, including the intersex issue in their efforts would certainly strengthen the arguments of Western anti-FGC critics, defusing charges of cultural imperialism such as those I have articulated here. On the other hand, the educational option is not as easily attained today, now that many North American feminists have painted themselves into a rhetorical corner with their strident denunciations of FGC. Since we live in a society where FGC is a felony and intersex surgeries continue unabated, the question is how to introduce an educational strategy to a culture steeped in the rhetoric of moral condemnation. It would seem to be politically uncomfortable for anti-FGC feminists to suggest that the criminal legislation they so vociferously demanded be repealed, yet it is difficult to see how they could avoid charges of hypocrisy if they continued to endorse that legislation while advocating a far less punitive educational approach to intersex cutting.

Finally, an educational approach does less to further the goal of personal autonomy. Such an approach is much more incremental in effect and therefore would not accomplish the immediate elimination of either FGC or intersex cutting. This is, of course, a serious disadvantage. Thus, those considering this approach (and, to a lesser extent, the tort approach) must confront the question of whether, given the extremely harmful effects of both FGC and intersex surgery, it is ethically justifiable to seek

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<sup>328</sup> See *infra* Part V.



anything less than a complete ban. In short, does the difficulty of condemning a practice without condemning the practitioners justify stopping short of criminalizing procedures that are so obviously harmful? Would it be possible, for example, to develop a strategy that avoids the demonization of practitioners so prevalent in anti-FGC rhetoric while at the same time urging a statutory ban?<sup>329</sup>

### C. Tort Liability

The third approach to developing consistent policies towards both FGC and intersex surgery would be to create a scheme of tort-based liability. Given that current medical opinion still tends to favor intersex surgeries, the reasonably prudent physician standard would likely bar lawsuits for negligent treatment,<sup>330</sup> and lawsuits for breach of informed consent requirements would probably succeed only in those minority jurisdictions where the reasonable patient standard is used to determine what risks, benefits, and alternatives a doctor is required to reveal.<sup>331</sup> However, tort liability could still be created statutorily. I discuss three different statutory approaches below.

#### 1. *Informed Consent Statutes Mandating Information To Be Given to Parents*

Activists could lobby for the passage of “informed consent” statutes that specified in detail the information that physicians were required to give to parents considering intersex surgery on their children.<sup>332</sup> Such provisions could be modeled after current “informed consent” abortion stat-

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<sup>329</sup> I also wonder whether a purely educational approach would result in a non-uniform practice involving intersex surgeries. For example, if the surgery became controversial, would only those individuals who are not fully informed about intersex surgery be convinced to expose their children to it? Alternatively, would hospitals and insurance companies stop paying the bill so that only the rich would have access to it? Cf. Ehrenreich, *supra* note 86, at 492–505 (contrasting pressures on privileged women to “choose” C-sections with coercive imposition of C-sections on outsider women); DAVIS, *supra* note 23, at 210 (describing how, in the birth control movement of the nineteenth century, “[w]hat was [initially] demanded as a ‘right’ for the privileged came to be interpreted as a ‘duty’ for the poor”).

<sup>330</sup> Hermer, *supra* note 131, at 215. *But see* Beh & Diamond, *supra* note 167, at 16–34 (arguing that medical standard of treatment has been based only on anecdote, not hard scientific evidence, and therefore does not deserve deference).

<sup>331</sup> See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (leading case for the minority view). On the potential success of informed consent suits, see Beh & Diamond, *supra* note 167, at 30–43; Ford, *supra* note 133, at 474; Hermer, *supra* note 131, at 220–25. See also, Martin, *supra* note 143, at 146. For discussion of other possible causes of action by intersex individuals, including violation of privacy and violation of the fundamental right to marry, see Haas, *supra* note 11, at 55–56.

<sup>332</sup> Clinicians who are not guided by informed consent statutes often provide parents with limited and misleading information, see Beh & Diamond, *supra* note 167, at 47–50; Ford, *supra* note 133, at 486–88.

utes.<sup>333</sup> By regulating rather than punishing physician behavior, these statutes would have the benefit of subtlety, avoiding harsh or stigmatizing treatment of medical practitioners. Once again, consistency could be attained if existing criminal statutes governing female circumcision were repealed and replaced (or ignored and supplemented) by informed consent provisions covering FGC, a politically difficult task as discussed above (though less difficult perhaps if the criminal statutes were just ignored). Finally, even though informed consent provisions would not directly eliminate the practice of intersex surgery, they would nevertheless go a long way towards preserving the autonomy of those with intersex conditions. They would enable parents to consider much more fully the ramifications of surgical interventions and would therefore likely deter a significant number of parents from consenting to them. However, that autonomy would not be complete. Parents motivated by their own embarrassment might not adequately consider their child's interests.

### 2. *Statutorily Established Standard of Care*

A second tort approach would entail statutorily defining intersex surgery as a breach of the standard of care, so that a doctor who performed such surgery would be negligent. Similar to criminalization, this approach would further individual autonomy by stopping (or at least deterring) the surgeries, but it would compromise the concern with subtlety by imposing tort liability upon individuals who might not be particularly culpable. (This approach is, however, more subtle than one entailing criminal punishment.) Given the political power of the medical profession, it seems somewhat unlikely that this sort of approach would be politically feasible. And, once again, consistency could only be achieved if statutes criminalizing FGC were repealed and the tort regime was installed in their place.

### 3. *Statute Limiting Parental Authority to Consent*

A third tort approach would be to limit the legal authority of parents to consent to genital cutting procedures. Such a statute could, for exam-

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<sup>333</sup> Such statutes require physicians providing abortions to give their patients detailed descriptions of fetal development, sometimes including pictures, and the like, before obtaining consent to the procedures. *See, e.g.*, UTAH CODE ANN. § 76-7-305.5 (2004); MONT. CODE ANN. § 50-20-104 (2004); 18 PA. CONS. STAT. § 3205 (2003). "Informed consent" provisions, despite being intended to deter the legally protected right to an abortion, have been consistently upheld by the courts. *See, e.g.*, Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992) (upholding statute requiring that certain information, including picture of fetus, be provided at least twenty-four hours before the abortion). One concern about using such an approach, however, might be that an informed consent statute about intersex treatment could have the unfortunate effect, for those concerned with abortion rights, of legitimating this anti-choice tactic.

ple, codify the approach adopted by the Supreme Court of Colombia, the only national supreme court to consider the intersex surgery issue thus far. In two 1999 companion cases, that court held that parental consent to intersex surgery is valid only if it is both fully informed and enduring. Parents cannot consent unless they have been given accurate information about the risks of the surgery and about alternative treatment approaches. They must also consistently consent over an extended period of time.<sup>334</sup> Reasoning that gender identity is fixed at a very young age, the court further held that parents cannot consent at all to genital-normalizing procedures on children over five years old.<sup>335</sup> This in-between approach preserves a significant amount of patient autonomy, both by ensuring thoughtful and informed parental decision making (again, likely to result in fewer surgeries) and by directly prohibiting some surgeries altogether.<sup>336</sup> Legislation that limits the parental ability to agree to the surgeries also avoids demonizing doctors, by focusing not on the culpability of the practitioners who perform the procedures but instead on the authority of parents to consent. As with the other tort approaches, consistency could be attained here, but only through decriminalization of FGC.

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While none of these proposed legal regimes is perfect, neither is the current situation in which intersex surgery is completely unregulated. The harms of intersex cutting are simply too great, and the justifications too weak, to allow the practice to continue unabated. Moreover, the problematic nature of the discourse used by the anti-FGC movement (discussed above) makes regulating intersex surgeries imperative as well. As I discuss more fully below, it is only by acknowledging the United States' own version of harmful genital cutting—intersex surgery—that anti-FGC activists can legitimately avoid the charge of cultural imperialism that the campaign against female circumcision otherwise deserves.

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<sup>334</sup> Sentencia SU-337 de 99 (1999) [Colombia Supreme Court], available at <http://www.isna.org/drupal/book/view/166> (last visited Oct. 17, 2004) (requiring that consent be “qualified, persistent [and] informed”) (this case is available only in Spanish, but has been summarized in detail in Greenberg & Chase, *supra* note 170). The lawsuit was brought by physicians who were seeking to clarify the legal status of intersex surgery after a 1995 case, Sentencia T-477/95, involving a man who had been reassigned female as an infant after an accident destroyed his penis. There, the Colombia Supreme Court held that parents cannot consent on a child’s behalf to surgeries designed to determine sexual identity. *Id.*

<sup>335</sup> Greenberg & Chase, *supra* note 170.

<sup>336</sup> It could also be combined with an informed consent statute codifying the specific information that must be provided to the parents.

## V. CONCLUSION: INTERSEX SURGERY AND INTERSECTING SUBORDINATIONS

This Article has argued that intersex surgery, like female circumcision, is a cultural practice that enacts patriarchal gender norms. To acknowledge this point is to challenge the fundamentally exceptionalist assumptions that ground the mainstream anti-FGC discourse—assumptions about the superiority of Western culture and the uncivilized nature of African societies. Of course, were the mainstream anti-FGC movement in the United States to embrace the critique of intersex surgery, it might face a backlash stemming from the general public's resistance to any argument that seems to challenge both established medical opinion and entrenched binary gender categories. Indeed, the notion of a sex/gender continuum may be threatening to feminists as well, given that "intersexuality undermines the stability of the category 'woman' that undergirds much first-world feminist discourse."<sup>337</sup>

Nevertheless, recognition of the harms of intersex surgery would ultimately *strengthen*, rather than weaken, the anti-FGC position. First, to the extent that Western feminists refuse to oppose intersex treatment protocols, they perpetuate medical practices that rely upon and enforce the very gender norms and stereotypes they have long challenged. As long as intersex treatment protocols continue to be based on pronatalist and phallocentric definitions of the sexes, to perpetuate passive and penetration-oriented understandings of female sexuality, and to enforce binary constructions of sex and gender, the equality goals of the mainstream feminist movement will be more difficult to attain.

Second, rejection of the intersex issue disadvantages anti-FGC activists by perpetuating harmful, orientalizing attitudes towards the very women they are trying to help. By cleaving to the contrasting images of African societies as ignorant, misogynist, and barbaric and Western societies as enlightened, scientific, and benevolent, activists racialize and stigmatize the very women upon whom the surgeries they attack are performed. To the extent that such orientalizing has the effect of reducing the sympathy that Westerners can feel towards African women, it actually diminishes the likelihood of success of the anti-FGC movement.

Third, in obscuring our own society's patriarchal and problematic gender-normalizing practices, anti-FGC activists' exclusion of the intersex issue is likely to elicit defensive reactions that will make their reform work much more difficult. In the same way that African American feminists in this country have refused to endorse white feminist arguments that expose African American men to mistreatment,<sup>338</sup> opponents of FGC

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<sup>337</sup> Chase, *supra* note 1, at 145.

<sup>338</sup> See, e.g., Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist*

in African societies are less likely to join forces with a movement that stereotypes and demonizes their cultures. Moreover, even if African anti-FGC activists are not disturbed by such rhetoric, their work is clearly made that much harder by association with a movement that appears to apply double standards to genital cuttings at home and abroad. Acknowledging the error of our own cultural practices of genital surgery would greatly enhance the legitimacy of Western critiques (and critics) of FGC.<sup>339</sup>

Fourth, embracing the intersex cause would free anti-FGC activists from the false choice between cultural relativism and feminism—a choice that has led to pejorative characterizations of African “cultures” in order to justify dismissing them in favor of women’s health interests. Once the two sides of the culture/science binary are deconstructed, the conflict that mainstream anti-FGC discourse posits between respect for other cultures and protection of women’s equality dissipates. The female circumcision issue reveals itself as posing a conflict not between two societies (one “feminist,” the other “patriarchal”), but rather between *opponents* of genital cutting and *proponents* of such disciplinary gender practices, *in both societies*.<sup>340</sup> Such a reframing shows the struggle over genital cutting to be just one example of the many social contexts in which gender and power are negotiated in complex and dynamic ways in both Western and African countries. Both cultures (African and North American) are revealed to be sites of social struggle and contestation, sometimes characterized by enlightened, pro-woman policies and sometimes bound by patriarchal practices and beliefs. Thus, the supposed conflict between “feminist” Western cultural norms and “patriarchal” African norms disappears.<sup>341</sup>

This alternative, more nuanced understanding of the concept of “cultural practices” provides the basis for a more convincing and defensible critique of female genital cutting. Whereas the discourse of mainstream opponents is based upon the problematic assumption that “our” culture is *better* than “theirs” (leaving that position open to critiques based on cultural relativism), the alternative approach recognizes the flaws of both African and Western societies, and relies instead upon a commitment to

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*Politics*, 1989 U. CHI. LEGAL F. 139, 157–60 (1989) (discussing anti-rape discourse).

<sup>339</sup> The fact that defense of FGC among African countries increased during the time of the struggle for liberation from colonial powers provides some support for this argument. See JEREMY MURRAY-BROWN, KENYATTA 134–51 (1979); Allison Slack, *Female Circumcision: A Critical Appraisal*, 10 HUM. RTS. Q. 437, 477–78 (1988). The use of the veil by Muslim women in Algeria as a symbol of resistance to French colonialism—no doubt partly in response to French use of the veil as a symbol of patriarchal oppression from which they need to be “protected”—also supports this argument. A modern version of that resistance is currently being played out in France, with debates over the nation’s new law banning headscarves (and other religious insignia) in schools. See *French Muslims Protest Ban on Religious Insignia*, CHICAGO SUN-TIMES, Dec. 22, 2003, at 34.

<sup>340</sup> Cf. Volpp, *supra* note 85 (arguing that those who find a conflict between feminism and multiculturalism erroneously assume that cultures are static and homogeneous).

<sup>341</sup> See *id.*

ending genital “normalizing” surgeries *wherever* they are practiced.<sup>342</sup> This approach provides the basis for a powerful critique of both female circumcision *and* intersex surgery by avoiding the North American exceptionalism that plagues mainstream arguments against female circumcision.

This discussion of how the failure to condemn intersex surgery can actually have a *negative* effect on efforts to eliminate FGC provides an example of the ways in which systems of subordination mutually reinforce one another by setting up overlapping networks of power and privilege. Although mainstream anti-FGC feminists may be correct in anticipating at least a temporary backlash were they to join forces with intersex activists, their investment in the race and class privilege that attends their position in Western society may also prevent them from recognizing that their exclusion of intersex surgery ultimately harms their cause as much as helps it.<sup>343</sup> Although acknowledging that we in the United States have our own version of genital cutting would undermine the privileged moral position that Western feminists enjoy, it might ultimately work more to their benefit than their detriment, helping to forge intergroup coalitions and undermine the ideological apparatus that sustains patriarchy.

A critique that condemns all types of genital surgery, no matter where performed—but also recognizes the complexity of such social practices, as well as the benign intentions of the cultural authorities (whether midwives or physicians) assigned the task of performing them—is far more persuasive than the alternative. Challenges to social practices both deserve and receive more credibility when they come from a position of humility, self-consciousness, and auto-critique.

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<sup>342</sup> Proponents of the alternative critique of FGC make this commitment explicit by not only mentioning but also condemning intersex surgeries in the United States. *See, e.g.*, Gunning, *supra* note 2, at 210–11 (implicitly condemning intersex surgery).

<sup>343</sup> On this notion of “ideological investment” as a mechanism by which systems of subordination support each other, see Ehrenreich, *supra* note 33, at 313–16.