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# Constructing the female body: using female genital mutilation law to address genital-normalizing surgery on intersex children in the United States

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## Abstract

**Purpose** – *The purpose of this paper is to explore the harms suffered by intersex children who are subjected to medically unnecessary genital-normalizing surgery (GNS) and the possible applicability of statutes prohibiting female genital mutilation (FGM) to certain cases of GNS to redress this harm in the USA.*

**Design/methodology/approach** – *Consulting publications by medical researchers and intersex activists alike, this comment reviews the procedures undertaken as part of GNS (most commonly including clitoral reduction) and the reasons behind these procedures. It also parses the language of federal and state statutes prohibiting FGM in the USA.*

**Findings** – *Surgical practices that include clitoral cutting when the procedure is not necessary to the health of the person on whom it is performed constitute FGM and are punishable under federal and certain state laws in the USA. GNS with clitoral reduction fits the definition of FGM because it is performed for cosmetic and social reasons, not medical necessity.*

**Originality/value** – *Acknowledging GNS with clitoral reduction as FGM is a crucial strategy to ensure that female-assigned intersex children's rights to bodily autonomy are protected to the same extent as non-intersex children's rights. Intersex legal activists in the USA should press for enforcement of FGM statutes as to female-assigned intersex children until the medical practitioners who continue to defend and perform GNS see the procedures as illegal genital mutilation.*

**Keywords** *United States of America, Female genital mutilation, Ambiguous genitals, Genital-normalizing surgery, Intersex, Clitoral reduction, Bodily autonomy, Illegal genital mutilation*

**Paper type** *Conceptual paper*

## 1. Introduction

Every year, an estimated one in 2,000 babies is born with intersex traits – variations in sexual or reproductive anatomy that may cause sex to be ambiguous (Phornphutkul *et al.*, 2000). Despite the fact that these variations are nearly always medically benign (Karkazis *et al.*, 2010), intersex children are frequently subjected to GNS, invasive procedures designed to make their bodies appear more typically male or female (Tamar-Mattis, 2006). GNS has no recognized medical benefits and is performed solely for cosmetic and social reasons (Creighton *et al.*, 2012). Despite the mounting evidence that GNS is physically and psychologically traumatic (Alexander, 1997; Ford, 2001; Minto *et al.*, 2003; Crouch *et al.*, 2004; Hughes *et al.*, 2006; Schützmann *et al.*, 2009; Creighton *et al.*, 2012), some medical practitioners continue to perform these

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unnecessary genital surgeries, typically so early in children's lives that it is impossible for them to give informed consent to the procedure, or even to understand what is happening (Ehrenreich and Barr, 2005; Creighton *et al.*, 2012; Wisniewski and Mazur, 2009).

While a child born intersex, like any child, may ultimately grow to identify as any gender (Consortium on the Management of Disorders of Sex Development, 2006), most intersex children are assigned female by doctors and treated accordingly (Ehrenreich and Barr, 2005; Tamar-Mattis, 2006). For intersex children assigned female, "treatment" normally entails GNS with clitoral reduction, a procedure that removes healthy tissue from a clitoris that doctors fear would be considered too large. Cutting of the clitoris for social reasons in any other context is considered female genital mutilation (FGM) and is illegal. Federal law in the USA as well as several state statutes prohibit FGM and make no exception for clitoral cutting that occurs when the victim happens to have intersex traits. Nonetheless, the genital mutilation of female-assigned intersex children persists unprosecuted in some US hospitals.

This comment argues that FGM laws are properly applicable to GNS procedures that involve clitoral reduction and should be enforced accordingly. This comment proceeds in six sections. Section 2 offers background on intersex traits, including their prevalence and variety. Section 3 briefly explains the process of GNS and the range of harms that result from performing non-consensual genital surgeries on children. Section 4 discusses FGM law in the USA and demonstrates how the types of GNS procedures performed on female-assigned intersex children constitute FGM, despite the fact that they are not currently prosecuted as such. Section 5 addresses possible hesitation around applying FGM law to intersex children. Chiefly, it addresses reasons why some doctors and even anti-FGM activists might not see intersex children as fitting within the protections of FGM law, then responds to potential critiques from others in the intersex rights movement who might have justifiable uneasiness over reifying a sex assignment the child in question has not had a chance to adopt or reject. Section 6 describes the approach preferred by intersex activists – that is, postpone any unnecessary genital surgery until intersex individuals can decide for themselves whether they would like any treatment or not. Finally, the comment concludes by outlining a proposal to extend the protection of FGM law to female-assigned intersex children, ensuring at last that their bodies and rights are accorded the same respect as those of their non-intersex counterparts.

## 2. What are intersex traits?

"Intersex" is an umbrella term that describes a variety of congenital traits that may cause sex to be ambiguous (Hughes *et al.*, 2006). Different traits cause ambiguity in different ways. First, biological indicia of sex may conflict, such as genital appearance and karyotype. For example, those with Androgen Insensitivity Syndrome (AIS) usually have female-typical genitals with (male-typical) XY chromosomes and internal testes (Ehrenreich and Barr, 2005). Second, the appearance of the genitals themselves may not resemble what doctors consider "normal" male or female bodies. For instance, when Congenital Adrenal Hyperplasia (CAH) affects children with XX chromosomes, their external genitals often appear somewhat masculinized due to higher levels of androgen exposure in utero (Stout *et al.*, 2010), leading to a phallic structure that is larger than a typical clitoris but smaller than a typical penis.

In almost every case, intersex traits themselves pose no medical problems (Tamar-Mattis, 2006; Karkazis *et al.*, 2010). Very rarely, genital surgery may be required – if, for example, a child is born without an opening for urine to exit the body (Hermer, 2002; Tamar-Mattis, 2006). More commonly, intersex children might need medical treatment unrelated to their reproductive or sexual anatomy. A sub-type of CAH, for example, causes a dangerous salt-wasting condition that must be treated to sustain life (Weill Cornell Medical College, 2015). However, genital surgery is not required to address salt-wasting, and in fact some practitioners have acknowledged that avoiding genital surgery is not only safe, but could be beneficial for some 46,XX CAH children (Houk and Lee, 2010).

For reasons unrelated to the health of the child, some doctors and hospitals have routinely subjected children with intersex traits to cosmetic operations known collectively as genital-"normalizing" surgery (GNS). From the 1950s until the 1990s, medical care for intersex children in the USA followed the "optimal gender policy" (Meyer-Bahlburg, 2002; Houk and Lee, 2005;

Siminoff and Sandberg, 2015), also known as the “concealment model” (Tamar-Mattis, 2006). Doctors who followed this model favored early (before 18 months) assignment of a gender of rearing, early GNS to “cement” that assignment, and “uncompromising adherence” to rearing the child in the initially assigned gender (Siminoff and Sandberg, 2015). Effective “concealment” required the doctors either to keep information about the child’s intersex status from the parents as well as the child, or to inform the parents but instruct them never to tell the child, for fear that the child’s knowledge of their trait or surgery would interrupt “normal” gender identity development (Phornphutkul *et al.*, 2000; Tamar-Mattis, 2006). More recently, doctors in the USA have been guided by the principles represented by the 2006 Consensus Statement (Hughes *et al.*, 2006), which recited prevailing standards that had been accepted in the field for some time preceding the Consensus Conference. The Consensus Statement guides doctors to consider additional factors in making the initial gender assignment, disclose complete information to the parents and involve them in decision making, and offer psychosocial support for the parents during discussions involving gender assignment and genital surgery (Hughes *et al.*, 2006). This is not to say, however, that the harms of GNS have come to an end. For intersex people and activists, questions remain about the motivations behind GNS, the sufficiency of the outcome data on which the doctors advocating GNS are basing their recommendations, and the legality of performing cosmetic surgery on children when no medical benefit has been shown (Tamar-Mattis, 2006).

The next section discusses the discrepancy between the rationales and stated goals of GNS, on the one hand, and its actual outcomes, on the other.

### 3. GNS: the solution, or the problem?

As discussed, the vast majority of the time, intersex traits cause no medical problems. Yet, an intersex birth is still treated in many hospitals as a “medical emergency” (Tamar-Mattis, 2006). The doctors assign the child a sex – male or female – and then surgically alter the child’s body to more closely resemble what is considered typical of that sex. In addition to GNS, this sometimes also involves the removal of internal reproductive organs if they are deemed incongruous with the assigned sex (Wisniewski and Mazur, 2009).

This section describes the process of sex assignment and GNS and the impact of these procedures on intersex people. Next, it addresses questions of ethics and legality related to GNS in its own right before tracing these threads through the more familiar debate on FGM.

#### 3.1 The process of “Normalization”

In some cases, intersex traits are not obvious until a child reaches puberty, or may never be discovered at all (Tamar-Mattis, 2006). In the cases where a baby is determined to be intersex shortly after birth, it is usually because the medical attendants perceive the baby’s genitals – or the combination of genitals and internal reproductive organs – to be atypical or ambiguous (Tamar-Mattis, 2006). At this point, doctors usually examine the baby’s chromosomes, internal reproductive organs, and external genitals to gain the information on which they will ultimately base the sex assignment decision (Tamar-Mattis, 2006). However, these factors are not equally weighted, and interpretation of the “best” assignment has been influenced by heteronormative assumptions and sex stereotypes – that is, assumptions that the child will grow up to be heterosexual and to desire “traditional” (penile-vaginal) intercourse (Houk and Lee, 2010), and that intercourse requires a sufficiently large penis (Committee on Genetics, 2000) and capacious vagina (Rossiter and Diehl, 1998). For example, in hospitals that perform GNS, a phallic structure that is larger than a typical clitoris but smaller than a typical penis (as is often present in children with CAH or partial AIS) is likely to be deemed an “inadequate penis” (Houk and Lee, 2010) and is at risk for surgical reduction. A “worthy” penis is one that will ultimately be large enough to penetrate a vagina and allow for standing urination (Beh and Diamond, 2000; Creighton *et al.*, 2012). If doctors project that these goals are unattainable, the child will not be considered a good candidate for a “functional” male and will instead be assigned female.

In the shadow of these gender norms, most intersex babies fail to “measure up” and are raised as girls (Ehrenreich and Barr, 2005; Creighton *et al.*, 2013). In addition, if the child could be fertile in the female-typical way due to the presence of a functioning uterus and ovaries, this will almost always

result in a female assignment, regardless of any evidence (e.g. hormone production, genital virilization) that a male assignment might be indicated (Tamar-Mattis, 2006; Houk and Lee, 2010). Possible fertility as a male is not determinative in the same way. Even when functioning testes are present, female assignment has been the most likely outcome if the phallic structure is judged too small for an “adequate” penis (Creighton *et al.*, 2013), although some doctors report that this has changed (Lee and Houk, 2006). Because the loss of potential fertility does not give the doctors pause unless the mode of fertility would “match” the assigned sex (Wisniewski and Mazur, 2009), testes are often removed once they become incongruous with the female sex assigned. This means that intersex children (without uteruses) assigned female will often suffer sterilization in addition to GNS.

When a child is assigned female, the child may be subject to vaginoplasty, clitoral surgery, or both in the process of genital “normalization” (Creighton *et al.*, 2013; Weill Cornell Medical College, 2015). The standards for a “functional” female are much less demanding than for a male, with a penetrable vagina being all that is strictly necessary to constitute a good surgical outcome (Rossiter and Diehl, 1998; Beh and Diamond, 2000). A sensate clitoris is not considered necessary (Tamar-Mattis, 2006). Appearance is more important than function, with some doctors admitting that the goals of clitoral reduction are to “reduce the size of the clitoris whilst maintaining a feminine appearance” (Creighton *et al.*, 2012), and to facilitate gender development as a girl (Mouriquand *et al.*, 2014) without the “confusion” possibly introduced by having a clitoris that is too large.

Clitoral reduction, where the middle of the shaft is removed and the shorter sides are sewn back together, and clitoral recession, where a flap of skin is placed to obscure the shaft, are the most common types of clitoral surgeries performed on female-assigned intersex children (Ehrenreich and Barr, 2005; Creighton *et al.*, 2013). However, as recently as 2000, some still underwent clitorodectomies – complete clitoral removal (Fausto-Sterling, 2000). There is currently no way to know precisely how many intersex children experience clitoral reduction, recession, or removal in the USA. However, the KIDS Inpatient Database reported 59 instances in 2009 alone of “operations on clitoris, amputation of clitoris, clitoridotomy, [or] female circumcision” (Tamar-Mattis, 2013). As reporting to this database is voluntary, this number does not include all US hospitals, and the total number of such operations is likely larger. Even so, on at least 59 occasions that year, a doctor removed healthy clitoral tissue, sacrificing sexual sensation and function, for reasons of cosmetic appearance and perceived conformity with prevailing cultural gender norms in the USA.

### 3.2 Impact of GNS

The negative consequences of GNS range across physical and psychological territory. Simply as the result of removing genital tissue, GNS survivors may experience nerve damage, scarring, chronic pain, incontinence, and the inability to achieve sexual arousal or orgasm (Ford, 2001; Minto *et al.*, 2003; Crouch *et al.*, 2004; Hughes *et al.*, 2006; Creighton *et al.*, 2012). The fact that that tissue was irrevocably removed without the child’s consent compounds the physical complications. Intersex children who underwent GNS go on to experience sexual anxieties, great bodily insecurity, depression, post-traumatic stress disorder, gender dysphoria, and an increased risk of suicide (Tamar-Mattis, 2006; Schützmann *et al.*, 2009).

There are no recognized medical benefits to GNS; GNS procedures collectively are “cosmetic surgery performed to achieve a social result” (Fausto-Sterling, 2000). That intended social result is a decrease in caregivers’ discomfort with their child’s “different” body (Hughes *et al.*, 2006; Consortium on the Management of Disorders of Sex Development, 2006) – ostensibly for the child’s benefit inasmuch as GNS is surmised to prevent parental rejection of the child. However, the authors of the Consensus Statement admit that “systematic evidence for this belief is lacking” (Hughes *et al.*, 2006). Furthermore, even if GNS succeeds in making parents more comfortable, serious ethical questions exist as to whether it is acceptable to “treat” parental distress through performing elective surgery on a child. If parental distress is observed, psychological counseling for the parent(s) would target the intervention at the proper issue – parental adjustment, not the child’s body (Consortium on the Management of Disorders of Sex Development, 2006).

In addition, some doctors claim that GNS facilitates “normal” gender identity development and averts the psychological problems that can come from feeling “different” or having a body that does not look sex-typical (Meyer-Bahlburg, 2002; Weill Cornell Medical College, 2015). However, this is not supported by the evidence (Lloyd *et al.*, 2005; Tamar-Mattis, 2013). Contrary to the

goal of creating a sex-typical appearance, one study reported that 41 percent of GNS patients had a “poor cosmetic result” (Creighton *et al.*, 2001). In addition, far from supporting psychological health and gender identity development, there is evidence of high levels of psychological trauma and gender dysphoria following GNS. GNS survivors show levels of depression, post-traumatic stress disorder, and suicidality comparable to levels among survivors of child sexual abuse (Alexander, 1997). Many intersex people who underwent GNS as children describe the experience as similar to being raped or sexually violated (Ehrenreich and Barr, 2005). In addition, the lingering secrecy around intersex conditions and GNS “enforce[s] feelings of isolation, stigma and shame – the very feelings that such procedures are attempting to alleviate” (Preves, 1998). Further, doctors can only make guesses at a child’s future gender identity, with rates of post-GNS gender assignment rejection as high as 40 percent within some intersex traits (Hughes *et al.*, 2006). There is evidence that doctors who perform GNS are aware of the risk of gender misassignment and that they proceed with surgery nonetheless. For example, approximately 10 percent of those with CAH ultimately reject their gender assignment, yet some doctors still believe that irreversible genital surgery is advisable in these cases (Furtado *et al.*, 2012).

Most telling of all, perhaps, is the fact that every intersex person who has spoken publically about GNS has condemned the practice (Tamar-Mattis, 2006). While the propriety of GNS is debated by the medical community (Consortium on the Management of Disorders of Sex Development, 2006; Mouriquand *et al.*, 2014), the intersex community – the only people with a direct interest in the resolution of this question – has already spoken. Doctors who defend GNS are fond of claiming that the majority of their patients are satisfied with the results (Aliabadi, 2004; Lerner, 2003), and yet they have not managed to put these words in the mouth of any actual intersex person. Anne Tamar-Mattis, the founder of interACT (formerly Advocates for Informed Choice), speculates that an intersex person could “command a national audience” by coming forward to defend the practice of GNS (Tamar-Mattis, 2006). To date, none has.

Simply put, there is no evidence that GNS accomplishes its intended outcomes, and the list of negative consequences is sufficient to prompt serious questions about the wisdom – and legality – of performing GNS on children.

### 3.3 Is GNS legal?

While Malta has recently banned unnecessary genital surgery on minors (Viloria, 2015), no law in the USA explicitly addresses GNS as performed on intersex children. Strong legal arguments exist, however, that GNS is illegal by virtue of violating children’s fundamental rights to privacy, bodily integrity, and reproductive autonomy as guaranteed by the Constitution (Haas, 2004). In 2013, interACT (formerly known as Advocates for Informed Choice) filed *M.C. v. Aaronson*, the first public lawsuit in the USA to address the issue, alleging that performing GNS on a child without the full and informed consent of his caregivers violated that child’s due process rights (interACT, 2013). Contemporaneously, interACT also filed a state case on gross negligence and medical malpractice grounds. (The Constitutional case was ultimately dismissed on an interlocutory appeal at the Fourth Circuit after the state actors argued they were entitled to qualified immunity and thus could not be held liable, while the state case survived several motions to dismiss and continues to proceed at this time (interACT, 2015).) Additionally, intersex activists have serious questions whether unnecessary genital surgery is a procedure to which parents or other decision makers should be able to give consent on behalf of children (Tamar-Mattis, 2006).

At least as concerns GNS involving clitoral reduction, there is clear law on point: unnecessary cutting of the clitoris is FGM, which is a crime under federal law and several state statutes as well. Several scholars have noted that these surgeries on intersex children could be successfully prosecuted under laws prohibiting FGM (Ehrenreich and Barr, 2005; Haas, 2004). However, this has yet to be seriously attempted.

## 4. FGM law

### 4.1 Definition and laws

Federal law in the US punishes any person who “knowingly circumcises [or] excises [...] any part of the labia majora or labia minora or clitoris of another person who has not attained the age

of 18 years,” unless the procedure is “necessary to the health of the person on whom it is performed” (18 USC §116). Approximately half of the states have also enacted their own statutes prohibiting FGM (National District Attorneys Association, 2013). New York’s law (NY CLS Penal §130.85) is virtually identical to the federal law, which makes no exceptions for surgeries on girls with intersex traits. In fact, given the consequences outlined above, it is clear that GNS is detrimental to their health – quite the opposite of “necessary.”

Three of the states that have FGM statutes provide for exceptions that may exempt GNS from the laws’ coverage. North Dakota and Wisconsin carve out of their FGM statutes any procedure intended to “correct an anatomical abnormality” (ND Cent. Code §12.1-36-01; Wis. Stat. Ann. §146.35), and Oklahoma allows otherwise prohibited surgery if it is “necessary [...] for purposes of cosmetic surgery” (Stat. Ann. Tit. 21 §760). These states almost certainly intended to shield GNS practitioners from prosecution under their FGM laws. This fact, however, does not damage the argument put forth in this comment. First, if anything, this shows that these states recognized that the procedures they exempted would have otherwise qualified as FGM. Second, federal law does not carve out either of these exceptions. Thus, GNS with clitoral reduction is still entirely prosecutable under federal law: no matter how a state writes its statute, it cannot be convincingly argued that clitoral cutting performed for cosmetic reasons is “necessary” to the “health” of any child when no medical benefit has been shown, but direct harm has.

#### 4.2 Human rights response

Multiple international human rights bodies have recognized the grave harms attendant to FGM. Both the UN Special Rapporteur on Torture and the UN Special Rapporteur on Violence Against Women define FGM as torture and have clarified that “medicalizing” FGM does not immunize it from classification as a human rights violation (Mendez, 2013; Coomaraswamy, 2002). In addition, the Special Rapporteur on Torture has recognized the harm of GNS specifically:

Children who are born with atypical sex characteristics are often subject to irreversible sex assignment, involuntary sterilization, involuntary genital normalizing surgery, performed without their informed consent, or that of their parents, “in an attempt to fix their sex”, leaving them with permanent, irreversible infertility and causing severe mental suffering [...] The Special Rapporteur calls upon all States to repeal any law allowing intrusive and irreversible treatments, including forced genital-normalizing surgery, involuntary sterilization, unethical experimentation, [or] medical display [...] when enforced or administered without the free and informed consent of the person concerned. He also calls upon them to outlaw forced or coerced sterilization in all circumstances and provide special protection to individuals belonging to marginalized groups (Mendez, 2013).

The World Health Organization has also affirmed that “[i]ntersex persons, in particular, have been subjected to cosmetic and other non-medically necessary surgery in infancy, leading to sterility, without informed consent of either the person in question or their parents or guardians” (World Health Organization, 2015). With acknowledgements like this, it is clear that, from a human rights perspective, GNS is no more excusable than FGM.

#### 4.3 Discrimination in the USA

Despite these strong statements at the international level, FGM still occurs in USA hospitals when doctors unnecessarily cut or reduce the clitoris or labia of children with intersex traits (Weill Cornell Medical College, 2015). Why do these practices persist? Perhaps cultural norms in the USA regarding binary sex and genital appearance have blinded some doctors and anti-FGM activists to the parallels between GNS with clitoral reduction and FGM as practiced on non-intersex children. For example, the three states that made their FGM statutes inapplicable when the cutting is done to “correct an anatomical abnormality” (ND Cent. Code §12.1-36-01; Wis. Stat. Ann. §146.35), or “for purposes of cosmetic surgery” (Ok. Stat. Ann. Tit. 21 §760) consider medically unnecessary clitoral/labial cutting legal if its purpose is to make the child’s body fit within the perceived sex binary. In fact, FGM and GNS are similarly situated in terms of the harms they cause and the reasons for which they are performed. As Ehrenreich and Barr (2005) discuss, the cultural motivations and traumatic consequences of FGM are applicable in the GNS context as well, with both types of procedures giving rise to lifelong physical and psychological suffering, and neither type conferring any medical benefit.

Crucially, the rationale for GNS is no less cultural than the reasons for which FGM occurs. Critics of FGM point out that it is performed to hamper female sexual pleasure and promote women's marriageability – essentially enforcing the norms of a patriarchal culture, which these critics are quick to denounce (Ehrenreich and Barr, 2005). If the follow-up studies done on GNS patients are any indication, the reasons for which GNS is performed look strikingly similar. Genital appearance, gender-conforming behavior, heterosexual intercourse, and (heterosexual) marriage rates are sought as evidence that GNS has “worked” (Tamar-Mattis, 2013; Liao *et al.*, 2012; Wisniewski and Mazur, 2009). Often, inquiry into the patient's sexual pleasure, psychological wellness, and overall satisfaction is subordinated to these other concerns (Tamar-Mattis, 2013). It is easy to forget that ideas of what makes an adequate man or woman, what a “normal” body looks like, and the very notions of binary (and opposite) sex and gender are social constructs, but they are (Chase, 2002; Ehrenreich and Barr, 2005). Conformity with these cultural norms is what is truly being enforced through GNS, the “success” of which is measured by cosmetic dimorphism and participation in heterosexual institutions of marriage and penetrative sexual intercourse. Therefore, the process of assigning “a sex” (i.e. male or female) to an intersex child and performing GNS to eradicate any components that are seen as inconsistent with that sex is a cultural practice through and through.

The tolerance of procedures performed on intersex children when the same procedures would be prosecuted if performed on non-intersex children is discrimination. This discrimination has been tolerated in the USA, perhaps due to an inability to see the gender and sexual norms in service of which GNS is performed as impermissible cultural reasons for invasive genital surgery on children. Even as intersex children are pronounced “female” and suffer “normalizing” measures that are only deemed warranted because they are female – i.e., if the child is not female, the clitoris is not too large because it is not a “clitoris” at all – they are denied the protection accorded to other female children from the same harm.

## 5. Why (not) FGM law?

The proposal to apply FGM law to GNS procedures that involve cutting of the clitoris or labia is not without controversy. In fact, even some opponents of FGM have dismissed the intersex cause with an allusion to “biological exceptions” beyond their scope, or by emphasizing that their area of activism concerned “a harmful cultural or traditional practice on young girls” (Chase, 2002). These objections show the character of two likely hesitations (by doctors as well as intersex activists) going forward: first, opposition to the use of a law intended to protect female minors, and second, unwillingness to see GNS procedures involving clitoral or labial cutting as mutilation. This part addresses these in turn.

### 5.1 *Who counts as female?*

One reason that some doctors and laypeople might hesitate to apply FGM law to clitoral surgeries on intersex children is the perception that the bodies of children subject to GNS with clitoral reduction cannot truly count as female – and so FGM law must be inapposite. This objection at once reflects notions of binary sex that are too narrow to admit intersex bodies in either category and reveals the flaw in its own premise: if female-assigned intersex children are not to be counted as female, but as something else, then how can the notion of binary sex differentiation remain sufficiently rigid to mandate that intersex bodies must be made to fit into it?

This section explores the dialectic relationship between the illusion of binary sex differentiation, on the one hand, and medical interference with intersex bodies via GNS procedures, on the other. If intersex bodies are conveniently seen as not female until they are made so through surgery, what would be impermissible clitoral cutting (if the tissue were acknowledged as a clitoris) does not qualify because there is no “clitoris” until after GNS creates one. Similarly, the functioning testes of a female-assigned intersex child are removed without qualm because there is no perceived female fertility to preserve (Tamar-Mattis, 2006). When it comes to intersex children, the doctors who perform GNS are both literally and socially constructing the female body.

The main irony in this process is that the reasoning underlying GNS – the idea that a body must be “one or the other” – presupposes that there are already distinct, even opposite, categories, when



the natural existence of intersex bodies refutes this. However, complementary binary gender differentiation relies on a certain amount of sexual dimorphism for the appearance of the “naturalness” and “inevitability” that is essential to the categories’ reification and survival (Butler, 2004; Fraser, 2015). Although the doctors who perform GNS might believe they are merely responding to the social framework that demands the social construction of “opposite” sexes, they are reproducing that framework by literally constructing bodies that cling to the poles of a continuum and erase the existence of the middle. If intersex bodies were left alone, made visible, and celebrated, their visibility would be an effective rebuttal to the system of binary sex (and, hence, gender) that structures much of the medical and social discrimination experienced by intersex, transgender, and gender-nonconforming people (Fraser, 2015). Utilizing FGM law is but one means to ending some of the GNS procedures performed on intersex children, protecting their bodies’ integrity and enhancing their visibility.

In light of the high risk of gender assignment rejection after GNS, there are certainly sensitive considerations involved in dubbing a swath of the intersex population “female,” at once critiquing doctors’ actions on them as FGM and seeming to endorse those same doctors’ determinations that led to the surgeries in the first place. However, for rhetorical and legal purposes, this framing serves a point: intersex children’s bodies are constructed as female – literally – on the operating table, but not as female for the purposes of FGM law. The same doctor should not be allowed to assign a child female to claim the too-large clitoris must be reduced to a more “feminine” size, and then be insulated from prosecution under a law designed to prevent clitoral cutting for social reasons. In fact, both opponents of GNS and the doctors who perform it recognize GNS involving clitoral reduction as a procedure that affects young girls (Battan, 2010; Dreger and Feder, 2010; New York-Presbyterian Hospital, 2015). The application of FGM law to female-assigned intersex children, then, should not be taken as a reification of the binary categories that medicine foists on intersex people. Rather, it is a necessary strategic move to thwart a pattern of discrimination that until recently seemed legally intractable.

### 5.2 *Mutilation or medicine?*

The second reason that some might struggle to see FGM law as applicable is the perception that the genital surgeries performed on intersex children are medical treatments conducted to correct their “abnormalities” – in other words, that the reasons for the surgeries cast them outside the scope of FGM law. The three state statutes that have functionally excepted GNS involving clitoral reduction from FGM law exemplify this belief. However, as explored above, GNS has not been shown to be medically beneficial, nor has growing up with ambiguous genitals been shown to be detrimental. Furthermore, the cosmetic appearance that GNS involving clitoral reduction aims to “correct” is only considered abnormal because of the medical and social erasure of naturally occurring intersex variation. There is no medical agreement on what constitutes “normal” appearance or dimensions for the labia or clitoris, and wide variation exists even among women who are not considered to have intersex traits (Lloyd *et al.*, 2005; Creighton *et al.*, 2013). Whether a clitoris is small enough to be “normal” or large enough to be “abnormal,” then, is a subjective inquiry dependent on cultural norms regarding the appearance of “normal” female bodies (Lloyd *et al.*, 2005). Therefore, the act of distinguishing GNS involving clitoral reduction as permissible correction of an “abnormality” instead of as punishable FGM reveals its own logical flaw. The initial pronouncement of a clitoris as too large proves that GNS is undertaken for culturally specific cosmetic reasons, and as such is just the sort of harm that FGM law was intended to prevent.

## 6. Conclusion: the alternative

This comment has provided an overview of intersex traits, GNS, and FGM law. By examining the motivations for, and consequences of, GNS, it has shown that GNS that includes clitoral reduction fits the definition of FGM – a federal crime in the USA. This comment has also shown that the failure to prosecute clitoral reduction on female-assigned intersex children as FGM when it satisfies the definition of criminal conduct constitutes discrimination. While non-intersex female-assigned children can claim the protection of FGM law in the USA, female-assigned intersex children heretofore have not been offered that protection – possibly because the local cultural norms underlying the concept of genital “normalization” prevent those in the USA from regarding GNS as mutilation.

All of the harm of GNS could be avoided merely by adopting the approach that intersex activists have advocated for decades: postpone GNS until the child is old enough to make an independent decision about whether any treatment is desired or not (Tamar-Mattis, 2006; Intersex Society of North America, 2008). Despite the simplicity of this request, and the strong interests of intersex children in autonomy and bodily integrity, the segments of the medical community that defend GNS have been hostile to proposals to discontinue the practice. One surgeon, when publically confronted by his former patient Saifa Wall, defended his actions, saying he had “no regrets” about performing the surgery that sterilized Saifa – even though it was clear that the doctor missed his guess at Saifa’s future gender identity (Nightline, 2015).

Saifa described the trauma resulting from this unnecessary surgery, and yet his surgeon still attempted to minimize the harm he inflicted. This is not an uncommon reaction; doctors who perform GNS on intersex children frequently defend themselves by alluding to satisfied patients (Lerner, 2003; Aliabadi, 2004) – none of whom have ever come forward. If these same doctors performed unnecessary clitoral surgeries on non-intersex children, there would doubtless be more of an outcry about their actions and continued nonchalance. As it is, intersex activists are growing tired of arguing with doctors over their basic right to bodily integrity in what feels like round after round of “debating ethics with butchers” (Wall, 2015). If those in the medical community who continue to advocate GNS, including clitoral reduction, refuse to see their actions as wrong, perhaps a more direct means of communication is needed. It is time to enforce criminal laws prohibiting FGM against the hospitals and doctors who continue to justify GNS as an act of medicine rather than one of mutilation.

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