

# **The Case of M.C. – An Argument for Legal, Medical, and Social Recognition of Ambiguity**

By Debra Beight

**ABSTRACT.** This paper is an examination of the interconnectedness of juridical, medical, and social constructs surrounding intersex/DSD (Difference/Disorder of Sex Development) sex assignment surgeries. Looking at a pending court case involving a child that was in state custody at the time of their sex assignment surgery, we can observe the influences of the medical industry's tendency to treat intersex conditions like disabilities, as sites of therapeutic interventions. These pathologized intrusions become government-sanctioned interventions that are supported by, and in turn bolster, societal expectations of conformity and normalcy.

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Awaiting trial in a South Carolina district court is a case involving a nine year old boy referred to in court documents as "M.C.". Physicians and social service employees from the state made a decision to operate on M.C.'s ambiguous genitals and assign M.C.'s sex as female; however, M.C. has grown up identifying as male rather than female. The suit<sup>7</sup> involving M.C. was brought forth on his behalf by his adoptive parents and they are suing the

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<sup>7</sup> The suit specifies violations under the Fourteenth Amendment "that no State shall deprive any person of life, liberty, or property without due process of law"; there was no inquiry or hearing convened prior to the decision to operate on M.C. (*M.C. v. Aaronson et al.*, 2013).

doctors and government officials in an effort to vindicate his rights to “bodily integrity, procreation, liberty, and privacy” (*M.C. v. Aaronson et al.* 2013). This case illustrates the imperative critique needed on the obligations of the medical community to serve the best interests of their patients, it questions who has the right to bodily autonomy, what influences those decisions, under what circumstances is that right removed from an individual, and what steps need to be taken to protect intersex persons from medically unnecessary interventions.

M.C. was born prematurely, along with a twin sister, in November of 2004; his sister died a few months after their birth and M.C. remained hospitalized until February of 2005 (*M.C. v. Aaronson et al.* 2013). While the South Carolina Department of Social Services (SCDSS) had concerns about the parental fitness of M.C.’s biological mother and father, one week after his release from the hospital, M.C.’s parents voluntarily relinquished their parental rights and M.C. was placed into the custody of SCDSS (*M.C. v. Aaronson et al.* 2013). M.C. lived in foster care until his adoption by Pam and Mark Crawford, but was considered still in the legal custody of SCDSS until August of 2006. With legal custody came access and authorization of any and all medical treatments and procedures regarding M.C.

M.C. had been born with a condition called “ovotesticular DSD (Difference/Disorder of Sex Development)” which is characterized by the “presence of both ovarian and testicular tissue” (*M.C. v. Aaronson et al.* 2013, p. 12). M.C. was assigned as male at birth; he had a testicle, an ovotestis, which is a gonad that contains both ovarian and testicular tissues, as well as other male and female internal reproductive organs. He had an adequately large phallus and elevated testosterone levels but he also had a small vaginal opening below his phallus and “scrotalized labia” (*M.C. v. Aaronson et al.* 2013, p. 12). Following numerous hormone tests and an exploration of his internal sex organs, Dr. Amrhein, one of the defendants, defined M.C. as a “true hermaphrodite” and advised that

M.C. needed to be assigned a specific gender and undergo “surgical correction” of his ambiguous genitals (*M.C. v. Aaronson et al.* 2013, p. 13). Dr. Amrhein<sup>8</sup> collaborated with Dr. Aaronson, and Dr. Appiagyei-Dankah, co-defendants, in the decision to assign a female sex to M.C. and to perform the sex assignment surgery that would alter the external appearance of M.C.’s genitals. While it was determined that M.C. could have been assigned either sex from surgery, “due to the nature of his external genital anatomy”, the choice was still made to alter M.C.’s genitals as female and to remove all testicular tissue (*M.C. v. Aaronson et al.* 2013, p. 14).

Dr. Aaronson, who performed the actual sex assignment surgery, had noted in M.C.’s medical records concerns of the child’s testosterone levels and that the possible effects from performing an “irreversible feminizing surgery...would be devastating... on a child who might ultimately identify as a boy” (*M.C. v. Aaronson et al.* 2013, p. 15); what made his observations ironic was that in 2001 Dr. Aaronson had published a paper in which he acknowledged that feminization surgeries were simply easier to perform, and most importantly, he outlined that if feminization surgery were performed on an infant that later identified as male, it would be “catastrophic” to the individual’s well-being (Aaronson, 2001, p. 189). Even with this knowledge, the team of physicians recommended SCDSS to authorize the surgery so M.C. could be raised as a girl. In April of 2006, when M.C. was sixteen months of age, SCDSS gave authorization to perform the surgery and M.C.’s genitals were altered and all testicular tissue was removed (*M.C. v. Aaronson et al.* 2013).

In June of 2006, Pam and Mark Crawford viewed M.C.’s profile on the South Carolina’s adoption website and contacted SCDSS to begin the adoption process; Mrs.

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<sup>8</sup> Dr. Amrhein filed a separate appeal to be removed as a defendant from the case stating justification for the surgery was based on the fact that M.C.’s birth mother (who had already relinquished custody) had told him that she always had wanted a baby girl (*M.C. v. Amrhein*, 2013).

Crawford had some familiarity with intersex conditions and indicated that they did not want sex assignment surgery performed on M.C. but it was already too late; the Crawfords took custody in August and the adoption process was finalized by December of 2006 (*M.C. v. Aaronson et al.* 2013). While the Crawford family initially raised M.C. as a girl to support his gender/sex assignment, it became obvious that he was showing “strong signs of developing a male gender” (*M.C. v. Aaronson et al.* 2013, p. 19). With support from family, friends, and community, M.C. is being raised as male. The resulting suit against the physicians who made the decision to operate on M.C. and against the SCDSS<sup>9</sup> employees who were responsible for his health and welfare, hopes to not only receive validation that M.C.’s rights were violated, but to also prevent this type of standardized practice that violates bodily autonomy of intersex individuals.

Nearly all of these kinds of procedures are medically unnecessary, performed on infants and children who are incapable of giving informed consent, and they cause more harm to intersex persons than should be accepted. M.C. and the Crawfords are seeking juridical relief, and while legal power is one element of influence in the management and monitoring of intersex persons, medicalization of intersex conditions exist as a fundamental administration that shapes the law and at times, supersedes it. When one is structuring an environment of intelligibility out of assumed norms and practices, it is often medical edicts that govern our means of recognition and modalities of authenticity that can forcibly define the comprehensibility of persons in a society and subject them to the law.

Is it a boy or girl? This is the first question pondered when one learns of a new pregnancy. Secondary are thoughts of health and happiness, which underline

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<sup>9</sup> Seven defendants from SCDSS were named in the suit for acting as an agent of the state while making medical decisions on behalf of M.C. that were not medically necessary (*M.C. v. Aaronson et al.* 2013).

assumptions of self-sufficiency and prosperity, but it is the initial desire to classify the sex of this future child in order to adequately imagine a proper future for him or her. The imaginary future is assumed to be able-bodied, mobile, self-sustaining as well as heterosexual, capable of continuing a lineage and the family name. Unless the parents have a disability themselves, or identify as queer, the assumption of normality is never called into question. Research shows that 1 in 2000 births can result in intersex conditions; this can present as a baby designated female with an abnormally large clitoris, one designated male with a micro penis, or a baby with no immediate designation because it does not have easily recognizable male or female genitals (Astorino & Vilorio, 2012). Although medical guidelines have shifted to recommend psychological support first and surgical intervention only if requested by the intersex person in question (Astorino & Vilorio, 2012), the perceived visibility of the condition and the reaction that is standardized from the medical community and an expectant society, puts pressure on physicians and parents to repair these bodies at an early age. An intersex baby creates a space where parents are confronted with the collapse of a “traditional sex/gender divide” and experience a “failure at what was supposed to come naturally” (Holmes, 2009, p. 5). The fear is that the parents will experience, first a critical doubt in producing a child with a deficiency seen as a disability, which extends to doubting the future that had been imagined for this child, and then a precipitous desire is to correct the body and thereby correct the path for this child to ensure their sustainability once again.

Alison Kafer (2013) offers a framework of critique from her observations of the exploitation of disabled and impaired bodies, such as featured in the For a Better Life (FBL) campaign. This narrative centers the visibility of disability and the ways in which this view of the body is interpreted by the public as elements of deficiency. Marking a body as deficient, lacking, or broken, gives rise to opportunities to repair, optimize and ultimately to monitor.

In terms of intersex individuals, those persons born with physical or chromosomal traits that defy placement into singular, binary categories of male or female, it is how society views that bodies are not only supposed to be gendered a particular way but also sexed in a particular way in order to make sense of an individual, to map out life expectations for them and to bring comfort to those who must interact with these persons. Public demands are placed on a private issue in order to ensure this individual lives up to the expectations of privatized living and to not rely on or bring questions of identity to the public sphere. The unbridled messiness of genitals, hormones and assumed gender roles conflates the private matter of sex classification into a public debate of normality and acceptability.

The medicalization of intersex conditions treats variance of sex characteristics in the same vein as children born with visible disabilities. The primary purpose is corrective, to repair what is wrong with this individual and make them more “normal”. It comes from not only a place of medicalized urgency but also from one of “social urgency” (Feder, 2014, p.1). In Dr. Aaronson’s 2001 article, he specifies this urgency in designating the proper functions of male and female sex assignment as being aligned with societal expectations and legal recognitions. He notes that untreated intersex conditions could lead to an inability to “form lasting heterosexual relationships” and with girls expressly can increase “incidence of bisexuality and homosexuality”; his primary focus resides in the necessity to “marry and have children” (Aaronson, 2001, p. 189) as the only way to fully integrate effectively into society. An individual’s obligation is not only to fit in to their community but to obey and support structures of dominance and this is done first by normalizing their physicality to solidify gender roles and responsibilities set forth by the medical community and societal expectations overall.

Harkening back to the expectant parents and their vision for their child’s future, it is brought into question

with the inability to determine if their child is a boy or girl. This classification is the linchpin of self-sufficiency and is not meant as just the sufficiency of the impaired individual but for the family, community, state, and nation overall. For intersex individuals it is taking their place in the proper social order and in propagating a hegemonic way of life which relies on marriage, children, normalcy and unquestioning adherence to authority, including medical authority. The thought is that this can only be accomplished when one is definitively sexed and gendered as either male or female.

Social theorist and philosopher Michel Foucault presents the “process of problematization” (as cited in Feder, 2014, p. 200) which examines how and why certain issues, in this case bodies and identities, are interpreted as being a problem to be corrected. A medical intervention means that intersex individuals are seen as disabled bodies; they are problems in and of themselves in their own corporeality, and as a problem for the rest of us in society. Corrections must be made to ensure others feel comfortable and can continue perceptions of the way things are supposed to work without having assumptions challenged. So a child that presents with ambiguous genitals must be defined as either male or female in order for society to continue functioning uninterrupted. The choice for the medical community is then to perform normalizing surgery and administer needed hormone therapies (Holmes, 2009) to ensure the child grows up with definitive sex and gender expectations. At this point it is not just the medical profession exerting power over an individual, it is the parents of this child abdicating power to society and physicians in order to achieve a child that will not upset the demands of a binary defined system. In M.C.’s case, it was not the parents abdicating power to doctors, but the agents of the state itself.

Into these social relationships, between doctors and patients, parents and children, and families and society, legibility protocols that influence distribution of visibility and power are at play in the recommendations and

decisions made on behalf of intersex children. It is assumed that intersex bodies must be made normal lest further concerns erupt over sexual identity, sexual preferences, sexual functioning and propagation of normative life structures. Every facet of an individual's life including their ability to marry and reproduce becomes a primary function in order to sustain the social stability of their family and by extension, the country. This can only be done if one understands themselves as a body and an identity, without ambiguity or distraction to the contrary; an overt implication of normalcy placed on individual subjectivity. To maximize one's contribution to the family and the state, one must function unencumbered by confusion of physicality and with clear distinctions made of one's own sex. At least this is supported by the medical industry that preferences corrective measures to intersex conditions. Along this line of thinking it is in the state's best interest to legally support structures that maintain the functionality of intersex bodies in ways that maximize utility and minimize impediments, as defined by medicine and by society.

In trans activist and legal scholar Dean Spade's (2011) discussion on the decentralization of power in terms of incorporated monitoring and "ways of knowing" (p. 21), it is an internalization that contributes to the abdication of autonomy over to medicalized power, a willingness to imbue physicians with authority to designate what constitutes acceptable in our social structures. A body that reads as ambiguous through atypicality of sex, presents a challenge to normative functions of a contributing citizen. The idea of being a burden is highly stigmatized and is often seen as not just an inability to participate meaningfully in current structures but also an unwillingness to participate; if one would only try harder one could become self-sufficient and not need familial support or continued medical assistance to function properly

This indicts intersex persons in that there is expectation to have ambiguity corrected so they will function normally in society and not be a burden, not draw



attention to their condition, not complain of steps made to correct them and to be grateful of the steps taken to make them normal. Intersex persons that criticize treatments made, without consent, are seen as problematic in the sense that they are ungrateful to a system that sought to spare them difficulty of growing up different in a society that prizes conformity and normality (Holmes, 2009). Challenging an identity placed upon them does not serve the public good in that it would require “normal” people to address uncomfortable inconsistencies around gender and sex roles. This could interfere with an individual’s assimilation into conventional practices because if they are not maintaining the status quo, which is easier and more beneficial for the larger society, then intersex persons are calling into question society’s obligations to those outside of the norm, the marginalized entities that are easier forgotten and disregarded.

The pathologicalization of alternative bodies gives way to how medical intervention is seen as neutral; the medicalized view is not perceived as an agenda setting entity that seeks to destroy uniqueness but as one set on correcting abnormality and encouraging individuals the ability to thrive. These interventions are predicated on a narrow scope of defining normalcy, gender and sexuality in heteronormative terms as established by a patriarchal system that expects individuals to thrive in order to become invisible into a collective society. Unlike disabled bodies that are meant to serve as a warning or an inspiration, as seen in the FBL campaign, intersex bodies are designed to be kept from public view. It is not to be discussed in public; no confirmation surrounding the details of one’s genitals is necessary because it is assumed they should look and function normally and it is an individual’s problem to fix if they don’t. It is the privatization of a pervasive public assumption. This seems to be both the best and worst that state sanctioned ideals have to offer the intersex body; reconstruction to function as an anonymous individual or remain whole and risk ostracization and stigma from being impaired. A parent, or

in this case, a social services agent, accepting a doctor's recommendation at normalizing surgery would see reconstructing a child as being the best decision for the child's future happiness.

Issues surrounding intersex individuals can serve as a bridge between legal, medical and social critiques; they are seen as an impairment while existing as a conflation of socially contracted gender and sex roles. As ideals of normality are predicated on survival of the fittest and just as disabled bodies are at a perceived disadvantage here, so are intersex bodies because they can't survive without medical intervention to ensure their placement into a functional social structure. While a "division of the sexes has been taken to be foundational to social order" (Feder, 2014, p. 206) it is the challenges to these entrenched views that give insight to seeing bodies in all their glorious variations as not just ambiguously sexed or deficient, but as differently abled and not simply impaired and in need of correction. Addressing the discrepancies of who qualifies as able-bodied or normal is the first step in reevaluating terms of self-sufficiency and burden. Intersex bodies must be valued in and of themselves for their own variance without regard to imagined futures of marriage, procreation and contributions to state formulated systems. Embracing the messiness of genitals, chromosomes, and gender roles can lead to points of resisting normalization of bodies and the ability to find dignity in physical anomalies that would allow intersex persons to carve out a space and revel in their ambiguity to reclaim so-called deficiencies as merely alternatives on a broad spectrum of physical options.

For M.C. and individuals like him, the law functions as an "institutionalized piece of gender accountability" (Meadow, p. 818) based on a gender classification system established in medicine and validated by society. While judicial classification appears as a neutral agent, one that describes identity and formulates relational statuses to the identity, there are systematic underpinnings that sustain hierarchal constructions of power and validity that act as an extension of medicalized policing and social monitoring.

We are trained to accept that particular relational formations and essentializations of gender and sex roles are the only means of recognizing the legibility of certain bodies and the way those bodies relate to other bodies.

Although we are conditioned to defer to medical science as being expert in areas of biology, endocrinology, manifestations of physicality, etc., we are also conditioning our legal systems to this same deference. If no one questions this cycle how can we realistically expect radical changes to a system that embraces the binary as a driving force? The case of M.C. argues on one point that physicians and social workers made the decision to operate without the benefit of a pre-operative hearing or review by an ethics board. The question must be posed that if a hearing had been convened or a board consulted and the same conclusion was drawn, does that suddenly make it justified and the entirety of this case moot? In this realm, bioethics still exists as “another source of power” (Spurgas, 117) so decisions of the self are still abdicated to an authority without investment of the outcome. Traditional binary metrics are employed across the spectrum of interventions, medical and judicial and as long as intersex or even trans persons are seen as only facsimiles of authentic persons, there will be rectifications and narrow interpretations of practices and laws without real systemic change and radical improvement. The question becomes, “can a legal paradigm that embraces scientificity also provide room for individual notions of self and relationship” (Meadow, 830) and the answer must be, only when we demand that it does.

As agents of biosociality, both medical and juridical institutions create gender and sex as tangible resources based on biological conditions without acknowledging the artificial construction of biological dictates. This manufactures sanctioned bodies that exist in fixed amounts likened to fabricated products that are controlled and distributed by the state. Any population that is in tension with the reproduction of cis-heteronormative practices is at risk and must be freed from institutional constraints that allow the repetition of limiting norms rather than

embracing one's unique embodied subjectivity; intersex bodies, trans bodies, disabled bodies, colored bodies, non-citizen bodies, or any bodies that require recognition from medical or legal entities, will only benefit from a total reevaluation and restructuring of these systems, rather than an integration or assimilation into them. M.C. should be afforded judicial relief as a first step in acknowledging that the system failed not only him, but it is failing everyone in the margins and must be held accountable; then, the work must continue.

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