No. 16-273

IN THE

Supreme Court of the United States

GLOUCESTER COUNTY SCHOOL BOARD,
Petitioner,

—v.—

G.G., BY HIS NEXT FRIEND AND MOTHER, DEIRDRE GRIMM,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF interACT: ADVOCATES FOR INTERSEX YOUTH, ET AL., AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

JONAH M. KNOBLER
Counsel of Record
ARON FISCHER
DEREK A. BORCHARDT
LAUREN M. CAPACCIO
ANTHONY C. DECINQUE
TARA J. NORRIS
PATTERSON BELKNAP WEBB & TYLER LLP
1133 Avenue of the Americas
New York, New York 10036
(212) 336-2000
jknobler@pbwt.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Other Authorities

INTEREST OF *AMICI CURIAE*

Amici file this brief in support of Respondent G.G.[1]

Lead *amicus* **interACT: Advocates for Intersex Youth** is a nonprofit organization that advocates for the rights of children born with intersex traits. It is the first and only organization in the country exclusively dedicated to this purpose. Founded in 2006 as Advocates for Informed Choice, its mission initially focused on ending harmful, nonconsensual medical interventions on intersex children. Since then, interACT has expanded its mission to include ending the shame and stigma faced by intersex youth and engaging in legal and policy advocacy on their behalf.

interACT is joined by the following *amici* with expertise in intersex issues:

- **Deanna Adkins, M.D.**: Fellowship Program Director of Pediatric Endocrinology, Duke University School of Medicine; Founder and Director, Duke Center for Child and Adolescent Gender Care, which treats youth

---

[1] Pursuant to Sup. Ct. R. 37.6, *amici* certify that no counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici*, their employees, or their counsel made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this brief.

ages 7–22 with gender dysphoria and/or differences of sex development.

- **Milton Diamond, Ph.D.**: Professor Emeritus of anatomy, biochemistry and physiology, John A. Burns School of Medicine, University of Hawai'i Mānoa; Director, Pacific Center for Sex and Society. Dr. Diamond has taught and published extensively on issues involving sexual behavior, reproduction, and development.

- **Joel Frader, M.D.**: Division Head, General Academic Pediatrics, Children's Memorial Hospital, Chicago; Professor of Pediatrics and of Medical Humanities and Bioethics, Northwestern University Feinberg School of Medicine; prior member of the American Academy of Pediatrics Committee on Bioethics and co-author of its 1995 statement on informed consent in pediatrics.

- **Katrina Karkazis, Ph.D., M.P.H.**: Senior Research Scholar, Center for Biomedical Ethics at Stanford University. Dr. Karkazis has spent the past two decades investigating the treatment of people born with intersex traits and has published extensively in this area, including the book *Fixing Sex: Intersex, Medical Authority, and Lived Experience*. Dr. Karkazis has served as an expert regarding sex-verification policies of the In-

ternational Association of Athletics Federations at the Court of Arbitration for Sport.

- **Aviva L. Katz, M.D., M.A., F.A.C.S., F.A.A.P.**: Dr. Katz is a board-certified pediatric surgeon trained in the care of neonates with intersex conditions. She has published extensively on issues impacting the intersex population.

- **Elizabeth Reis, Ph.D.**: Professor of Gender Studies, Macaulay Honors College, City University of New York; author of *Bodies in Doubt: An American History of Intersex*.

- **Joshua Safer, M.D., F.A.C.P.**: Director, Endocrinology Fellowship Training Program and Associate Professor of Medicine and Molecular Medicine, Boston University School of Medicine; Associate Editor, *Journal of Clinical & Translational Endocrinology*; Editorial Board Member, *Endocrine Practice*. Dr. Safer has lectured worldwide and published extensively on transgender and intersex issues.

- **The AIS-DSD Support Group**, founded over 20 years ago, is the largest and oldest organization in the United States dedicated to providing support to individuals and families living with a broad spectrum of differences of sex development. The group hosts the largest annual conference for this com-

> munity in the country, including a formally accredited Continuing Medical Education event for medical professionals.

This case raises issues central to *amici*'s mission as advocates for intersex youth. Petitioner maintains that the word "sex" in Title IX must refer only to an individual's so-called "physiological" sex, rather than the sex with which an individual identifies and lives every day. This is so, Petitioner argues, because "physiological" sex—purportedly unlike gender identity—is binary, objective, and self-evident. The intersex youth for whom *amici* advocate are a living refutation of this argument.

Petitioner's simplistic view of "physiological" sex is demonstrably inaccurate as a matter of human biology. Moreover, it demeans many thousands of intersex youth by erasing their bodies and lives and placing them outside the recognition of the law. Physicians who treat individuals with intersex traits recognize that the key determinant of how individuals navigate sex designations in their lives is their gender identity—their internal sense of belonging to a particular gender. *Amici* have a strong interest in ensuring that the Court does not endorse Petitioner's misguided view of "physiological" sex, and in seeing the Court interpret Title IX in a way that respects all children.

SUMMARY OF ARGUMENT

> *These [restroom policies] are being made without the knowledge that there are people out there that this [dichotomy of "physiological" sex] does not apply to. [They are] trying to boil down all the people that there are in the country into two categories, and that's just not going to work. They need to recognize that the laws they're making aren't rooted in fact or science.*

Kathryn "Kat" Caldwell, a 23-year-old interACT-affiliated youth born with intersex traits[2]

* * *

Petitioner and its *amici* argue that the word "sex" in Title IX must be construed to refer only to a student's "physiological" sex, and must exclude consideration of a student's gender identity. A common thread running through their arguments is the assumption that gender identity is an ethereal concept, whereas all schoolchildren have a binary "physiological" sex—either male or female—that is objective, indisputable, and feasible for school personnel to determine.

That assumption is wrong. Each year thousands of infants are born with intersex traits, none of whom could be easily classified as "male" or "female" under Petitioner's "physiological" test. Intersex is an umbrella term describing a wide range of natural bodily

---

[2] Telephone interview with Kathryn Caldwell, Jan. 25, 2017.

variations—in external genitals, internal sex organs, chromosomes, and hormones—that do not fit typical binary notions of male or female bodies.

Shame and stigma have kept this population in relative anonymity despite the fact that upper estimates of the number of intersex people are approximately 1.7% of the general population. Intersex people are not a new phenomenon: they have existed in all cultures throughout history—including, of course, at the time Title IX was enacted. Unfortunately, however, intersex persons have long been subject to mistreatment, including nonconsensual and dangerous surgical intervention intended to "correct" their intersex bodies.

The existence of intersex people disproves Petitioner's unsupported assumptions about "physiological" sex, thereby undercutting Petitioner's arguments in this case in three critical respects.

First, as *amici* and others who work with intersex people well know, "physiological" sex is not an objective, clear-cut classification. There are various ways that "physiological" sex could be defined—*e.g.*, on the basis of external genitalia, internal sex organs, hormones, or chromosomes—and, where these criteria do not align, determining a child's "physiological" sex (however defined) is a subjective exercise on which experts disagree. Permitting students to use binary-segregated restrooms consistent with their gender identity avoids this problem.

Second, a restroom policy based on "physiological" sex is impossible to administer. The presence of intersex students in schools across America demonstrates that "physiological" sex cannot be determined from a child's clothed appearance. Petitioner's policy would therefore require forcing schoolchildren to submit to examinations of their genitals, internal sex organs, or DNA in order to use the restroom. Such a regime would be offensive, traumatic, and likely unconstitutional. Once again, permitting students to use binary-segregated restrooms in accordance with their gender identity avoids this problem.

Third and finally, the fact that intersex students exist belies Petitioner's assumption that construing "sex" solely on a "physiological" basis would prevent students from sharing a restroom with others whose sex characteristics differ from their own. As *amici* explain below, some children are assigned male sex at birth even though they have certain female-typical sex characteristics, and vice versa. Thus, even under Petitioner's regime, students could not be sure that the person in the next stall has genitals, gonads, or sex chromosomes identical to theirs. As is currently the case across the country, the only attribute that all individuals who use the same restroom would share is the need to use the restroom.

ARGUMENT

I. INTERSEX CONDITIONS ARE DIVERSE AND HAVE BEEN RECOGNIZED FOR MILLENNIA

Petitioner and its *amici* declare that sex "is binary"—that "each child is immutably either male or female." Br. of *Amici Curiae* Dr. Paul R. McHugh, *et al.* ("McHugh Br.") 3, 6, 12. In their view, this either/or trait is so elemental that it "permeates every cell of an organism." *Id.* at 7. However, thousands of children are born each year with anatomy that is neither typically "male" or typically "female." Indeed, as discussed below, even a person's chromosomal sex may vary from one bodily cell to another. Petitioner and its *amici* have no excuse for their misstatements, as Western society has recognized intersex conditions for thousands of years—including, of course, at the time Title IX was enacted.

A. There Is A Wide Spectrum Of Intersex Conditions

A fertilized egg, which divides to form an embryo, usually has two sex chromosomes: XX or XY. For the first few weeks of gestation, XX and XY embryos look exactly the same: both possess undifferentiated gonadal tissue, a genital tubercle, and labioscrotal folds. These parts later develop in different ways depending on genetic and hormonal factors.

In male-typical sexual development, the gonads become testes; the genital tubercle develops into a penis; and the labioscrotal folds fuse and form a scrotum. By contrast, in female-typical sexual development, the gonads develop into ovaries; the genital tubercle develops into a clitoris; and the labioscrotal folds develop into the outer labia. Later, at puberty, the hormones secreted by the testes or ovaries cause the expression of male-typical or female-typical secondary sex characteristics, such as breast development, body hair, musculature, and depth of voice.[3]

A variation in sex chromosomes, hormone exposure *in utero*, and/or hormone responsiveness may alter the developmental sequence outlined above, resulting an intersex condition. It is estimated that as many as 2 percent[4] of babies are born with intersex traits—similar to the number born with red hair.[5]

---

[3] *See* I.A. Hughes et al., *Consensus Statement on Management of Intersex Disorders*, 118 Pediatrics 488, 491 (2006); Bruce E. Wilson & William G. Reiner, *Management of Intersex: A Shifting Paradigm*, in INTERSEX IN THE AGE OF ETHICS 119 (1999); National Institutes of Health, *SRY gene*, https://ghr.nlm.nih.gov/gene/SRY (all Internet links visited March 2, 2017).

[4] *See* Anne Fausto-Sterling, SEXING THE BODY: GENDER POLITICS AND THE CONSTRUCTION OF SEXUALITY 51 (2000); Melanie Blackless et al., *How Sexually Dimorphic Are We? Review and Synthesis*, 12 Am. J. Human Biol. 151 (2000).

[5] United Nations Office of the High Commissioner for Human Rights, Free & Equal: UN for LGBT Equality, *Fact Sheet: Intersex* (2015), https://www.unfe.org/system/unfe-65-Intersex_Factsheet_ENGLISH.pdf; Fausto-Sterling, *supra* note 4, at 51.

And there is evidence that the incidence of intersex conditions is on the rise.[6]

As detailed below, intersex conditions vary widely. They may involve the external genitalia, gonads and other internal sex organs, sex hormones, and/or sex chromosomes.[7] And they may present at different ages depending on the condition and symptoms. For example, atypical external genitalia may permit an intersex diagnosis at birth, but variations in internal organs or sex chromosomes may not become apparent until puberty or until an individual attempts to conceive.[8]

Intersex children are generally assigned a sex at birth based on some combination of their genitalia, gonads and other internal organs, and chromosomes.[9,10] Some intersex people continue to identify

---

[6] *Id.* at 54.

[7] Hughes, *supra* note 3 at 488; Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics & The Law*, 11 Ann. Health L. 195, 204 (2002); Carla Murphy et al., *Ambiguous Genitalia in the Newborn: An Overview and Teaching Tool*, 24 J. Pediatric Adolescent Gynecology 236, 236–37 (2011).

[8] Consortium on the Management of Disorders of Sex Development, *Clinical Guidelines for the Management of Disorders of Sexual Development in Childhood* 2–5 (2006), https://goo.gl/bKQcES (hereinafter "Clinical Guidelines").

[9] Hughes, *supra* note 3, at 491.

with that assigned sex throughout their lives; others later identify differently.[11] As many as 25% of intersex people (and for some intersex conditions, as high as 40%) do not identify with their originally assigned sex.[12] Physicians assign a birth sex to intersex babies with full knowledge that the child's gender identity may ultimately differ from the sex assigned on the birth certificate—and when it does, they recognize that the appropriate sex designation is that which correlates to the child's eventual gender identity.[13]

The Intersex Society of North America ("ISNA") recognizes approximately 20 different intersex conditions,[14] including the following:

---

[10] The emphasis on which characteristic should prevail in determining a person's sex has changed over time. For a history of intersex management, see generally Elizabeth Reis, BODIES IN DOUBT: AN AMERICAN HISTORY OF INTERSEX (2009).

[11] interACT, *Understanding Intersex and Transgender Communities*, at 1, https://goo.gl/CY53ZZ.

[12] Julie A. Greenberg, INTERSEXUALITY AND THE LAW 20 (2012); Hughes et al., *supra* note 3, at 491; P.S. Furtado et al., *Gender Dysphoria Associated with Disorders of Sex Development*, 9 Nat. Rev. Urol. 620 (Nov. 2012).

[13] Hughes, *supra* note 3, at 491; Katrina Karkazis, FIXING SEX: INTERSEX, MEDICAL AUTHORITY, AND LIVED EXPERIENCE 95, 100–02 (2008).

[14] *See* Clinical Guidelines, *supra* note 8, at 5–7.

a. ***Congenital Adrenal Hyperplasia (CAH)*:** CAH occurs in babies with XX chromosomes when a variant form of an enzyme leads to heightened production of androgenic hormones *in utero*. This causes varying degrees of virilization, *i.e.*, development of typically "male" physical characteristics. Individuals with CAH may have female-typical internal organs and masculinized external genitalia, such as an enlarged clitoris and/or the lack of a vaginal opening. CAH can also cause development of male-typical secondary sex characteristics like body hair, a receding hairline, deep voice, and prominent muscles. CAH occurs in approximately 1 in 14,500 births each year.[15]

b. ***5-Alpha Reductase (5-AR) Deficiency*:** People with 5-AR deficiency have an XY chromosomal pattern and testes, but their bodies produce lower-than-typical levels of the hormone dihydrotestosterone (DHT),

---

[15] Walter L. Miller & Selma Feldman Witchel, *Prenatal Treatment of Congenital Adrenal Hyperplasia: Risks Outweigh Benefits,* 208 Am. J. Obstetrics & Gynaecology 354, 354 (2013); Phyllis W. Speiser, et al., *Congenital Adrenal Hyperplasia Due to Steroid 21-Hydroxylase Deficiency: An Endocrine Society Clinical Practice Guideline*, 95 J. Clin. Endocrinology & Metabolism 4133–60 (2010); Blackless et al., *supra* note 4, at 154–55; ISNA, *Congenital Adrenal Hyperplasia (CAH)*, https://goo.gl/8Ki1FH; Fausto-Sterling, *supra* note 4, at 51–53 & Tbl. 3.2; Clinical Guidelines, *supra* note 8, at 6.

which impacts formation of the external genitalia. Many are born with external genitalia that appear typically female. In other cases, the external genitalia appear neither male- nor female-typical. Still other affected infants have genitalia that appear predominantly male, often with an unusually small penis (micropenis) and the urethral opening on the underside of the penis (hypospadias). During puberty, people with 5-AR deficiency develop some typically male secondary sex characteristics, such as increased muscle mass and a deep voice. However, they do not develop much facial or body hair. Children with 5-AR deficiency are often raised as girls. However, about half of them have a male gender identity and live as male beginning in adolescence or early adulthood.[16]

c. ***Androgen Insensitivity Syndrome (AIS)*:** People with AIS have an XY chromosomal pattern, but due to a variation in the androgen receptor, their cells have a reduced or absent response to testosterone or other androgens. As a result, they do not form typically male genitalia. In "complete" AIS, babies are usually born with a vaginal opening and clitoris indistinguishable from those seen in typical female babies. The diagnosis

[16] Hermer, *supra* note 7, at 207.

is ordinarily not suspected until puberty, when menstruation fails to occur. Investigation at that point reveals that these individuals are XY, that they have undescended testicles, and that neither a uterus nor ovaries are present. In "partial" AIS, the body's cells have limited response to androgens, and as a result, the external genitalia fall somewhere between typically male and typically female in appearance. While individuals with complete AIS almost always have a female gender identity, approximately 50% of individuals with partial AIS have a female gender identity while the other 50% have a male gender identity. AIS occurs in approximately 1 in 20,000 individuals.[17]

d. ***Swyer Syndrome*:** In this condition, an XY child is born with "gonadal streaks" (minimally developed gonadal tissue) instead of functional testes. Externally, a child born with Swyer Syndrome may appear female-typical; however, because streak gonads are incapable of producing the sex hormones that bring about puberty, the child will not

---

[17] Blackless et al., *supra* note 4, at 153; Fausto-Sterling, *supra* note 4, at 52; Hughes, *supra* note 3, at 491; ISNA, *Androgen Insensitivity Syndrome*, https://goo.gl/GJziJL.

develop most secondary sex characteristics without hormone replacement.[18]

e. ***Kallman Syndrome*:** This is a condition that occurs in both XX and XY children, characterized by delayed or absent puberty and an impaired sense of smell. It is a form of hypogonadotropic hypogonadism, or absence of certain hormones that direct sexual development. XY children with Kallman syndrome often have an unusually small penis (micropenis) and undescended testes (cryptorchidism). At puberty, most affected individuals do not develop typical secondary sex characteristics, such as the growth of facial hair and deepening of the voice in XY adolescents, or menstruation and breast development in XX adolescents.

f. ***Klinefelter Syndrome*:** A child with Klinefelter syndrome has the sex-chromosome pattern XXY, as opposed to the typical patterns XX and XY. This occurs when one parent's sperm or egg has an "extra" X

---

[18] L. Michala, et al., *Swyer syndrome: presentation and outcomes*, 115 BJOG: An Int'l J. of Obstetrics & Gynaecology 737–741 (2008); Georgiann Davis, CONTESTING INTERSEX: THE DUBIOUS DIAGNOSIS 2 (2015); Fausto-Sterling, *supra* note 4, at 52 & Tbl. 3.1; Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 Ariz. L. Rev. 265, 284 (1999).

chromosome as a result of atypical cell division. The testes and penis of a person with Klinefelter syndrome may be smaller than in typical XY individuals. Klinefelter syndrome has a prevalence of about 1 in 500 children raised as boys, and is not ordinarily diagnosed before puberty.[19]

g. ***Turner Syndrome*****:** A child with Turner syndrome has only one sex chromosome (X) present in their cells, instead of the usual two (XX or XY). This occurs when one parent's sperm or egg is lacking an X chromosome as a result of atypical cell division. Children with Turner syndrome may have underdeveloped ovaries; their external genitalia generally appear female-typical, but may be less developed. People with Turner syndrome generally will not develop menstrual periods or breasts without hormone treatment. Turner syndrome affects between 1 in 2,500 and 1 in 5,000 newborns.[20]

---

[19] Blackless et al., *supra* note 4, at 152; Greenberg, *supra* note 18, at 283; Albert de la Chapelle, *The Use and Misuse of Sex Chromatin Screening for Gender Identification of Female Athletes*, 256 J. Am. Med. Ass'n 1920, 1922 (1986).

[20] Kutluk Oktay, et al., *Fertility Preservation in Women with Turner Syndrome: A Comprehensive Review and Practical Guidelines*, 29 J. Pediatric & Adolescent Gynecology 409–16 (2016); Blackless et al., *supra* note 4, at 152; Greenberg, *supra* note 18, at 284.

h. ***Persistent Müllerian Duct Syndrome (PMDS)*:** Persons with PMDS have an XY chromosomal pattern and typical male reproductive organs and external genitalia, but also have a uterus and Fallopian tubes. This condition occurs when the Müllerian ducts—internal structures that ordinarily break down in the XY fetus—fail to do so, and instead develop as they would in an XX fetus. PMDS is ordinarily not diagnosed at birth, and individuals with this syndrome often have a male gender identity.[21]

i. ***Ovotestes / "true hermaphroditism"*:** Ovotestes are gonads that contain both ovarian and testicular tissue. People with ovotestes are predominantly XX, but some are XY or have different chromosomal patterns in different bodily cells (*see* "Mosaicism," *infra*). Some people with ovotestes have external genitalia that look typically male; others have external genitalia that look typically female; and still others have ambiguous genitalia.[22]

j. ***Mosaicism*:** As a result of atypical cell division in early embryonic development, some

---

[21] Greenberg, *supra* note 18, at 285.

[22] Hughes, *supra* note 3, at 492; Fausto-Sterling, *supra* note 4, at 21.

> people are born with a mosaic karyotype, meaning that their chromosome pattern varies from cell to cell. A person with mosaicism may have an XX chromosomal pattern in some bodily cells, and an XY pattern in others.[23] *Contra* McHugh Br. at 7 (stating, without evidence, that binary sex "permeates every cell of an organism").

Other conditions may or may not result in an intersex diagnosis, depending on the subjective approach of the attending physician.[24] For example, *aphallia* (a.k.a. penile agenesis) is a condition where the penis is absent from an XY infant with otherwise male-typical anatomy. Some would not consider this an intersex condition because a person with aphallia does not have any *female*-typical sex characteristics.[25] Historically, however, babies born with aphallia were assigned a female sex and raised as girls.[26]

---

[23] Wilson & Reiner, *supra* note 3, at 122; Clinical Guidelines, *supra* note 8, at 7; L. Sax, *How Common is Intersex? A Response to Anne Fausto-Sterling*, 39 J. Sex. Res. 174, 175 (2002).

[24] *See, e.g.*, Alexander Springer & Laurence S. Baskin, *Timing of Hypospadias Repair in Patients with Disorders of Sex Development*, in UNDERSTANDING DIFFERENCES AND DISORDERS OF SEX DEVELOPMENT 197–202 (O. Hiort & S.F. Ahmed, eds., 2014).

[25] ISNA, *Aphallia*, https://goo.gl/wh0a8R.

[26] Vernon A. Rosario, *The History of Aphallia and the Intersexual Challenge to Sex/Gender*, in A COMPANION TO LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER STUDIES 269–72 (2015).

Still other individuals may be labeled intersex because physicians consider their external genitalia cosmetically unacceptable.[27] This may include children with *hypospadias*, in which the urethral opening is located along the underside of the penile shaft. It may also include children with *micropenis* or *clitoromegaly*, in which the penis is much smaller, or the clitoris much larger, than average.[28]

B. Intersex People Have Been Recognized For Millennia—Including At The Time Title IX Was Enacted

Intersex conditions are not new. To the contrary, they have existed throughout history and have often been expressly recognized by the law. *Amici* provide just a few examples here.

Classical Jewish writings identify six sex categories—male, female, and four that would be recognized today as intersex: *androgynos* (a person with both male and female genitalia); *tumtum* (a person whose genitalia are obscured); *aylonit* (a person designated

---

[27] *See, e.g.*, Karkazis, *supra* note 13, at 146, 162 (noting that clinicians interviewed by the author "often referred to an enlarged clitoris in highly subjective and pejorative terms, using expressions such as grotesque, deformed, or abnormal").

[28] *See* Fausto-Sterling, *supra* note 4, at 52, 57–61 & Tbl. 3.1; Nancy Ehrenreich & Mark Barr, *Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of "Cultural Practices*," 40 Harv. C.R.-C.L. Rev. 71, 121–22 (2005).

female at birth who does not develop female-typical secondary sex characteristics and whose "voice is deep and cannot be distinguished from that of a man"); and *saris* (a person designated male at birth who lacks male-typical genitalia). These variations are mentioned hundreds of times in the Jewish Mishnah, Talmud, and legal codes.[29] According to some traditions, Adam, the first human, was *androgynos*, and Abraham and Sarah, the progenitors of the Jewish people, were both *tumtum*.[30]

Intersex conditions were also recognized in Greco-Roman culture. The Greeks venerated a deity called Hermaphroditus, whom Ovid described as a "creature of both sexes."[31] Pliny's Natural History refers to "those who belong to both sexes, [whom] we call by the name of hermaphrodites … [or] Androgyni."[32] And the Roman emperor Justinian permitted children

---

[29] Sojourn Blog, *More Than Just Male and Female: The Six Genders in Classical Judaism*, June 1, 2015, https://goo.gl/5BsHzS; Avraham Steinberg, ed., 1 ENCYCLOPEDIA OF JEWISH MEDICAL ETHICS 51, 90–92, 123–29, 462 (1998); Julia M. O'Brien, ed., 1 OXFORD ENCYCLOPEDIA OF THE BIBLE AND GENDER STUDIES 311–12 (2014).

[30] O'Brien, *supra* note 29, at 313.

[31] Ovid, 4 METAMORPHOSES 346–88 (A.S. Kline, ed. 2000), https://goo.gl/RGhGcH.

[32] Pliny, NATURAL HISTORY 7:3 (John Bostock trans., 1855), https://goo.gl/nHahlm.

with ambiguous genitalia to choose their own sex prior to marriage.[33]

In medieval and Renaissance Europe, "hermaphrodites" were often regarded as a third sex and recognized by law or custom.[34] Twelfth-century French theologian Peter Cantor noted that the Church "allow[ed] a hermaphrodite … to use the [sex] organ by which (s)he is most aroused or the one to which (s)he is most susceptible" and to "wed as a man … [or] as a woman" accordingly.[35] De Bracton's thirteenth-century treatise on English law classified people as "male, female, or hermaphrodite."[36] And, in a treatise regarded as a founding document of English common law, sixteenth-century jurist Lord Coke wrote that "[e]very heire is either a male[, a] female[, or] a[] hermaphrodite," and that a hermaphrodite "shall be

---

[33] Ilana Gelfman, *Because of Intersex: Intersexuality, Title VII, and the Reality of Discrimination "Because of … [Perceived] Sex"*, 34 N.Y.U. Rev. L. & Soc. Change 55, 67 (2010).

[34] Sharon E. Preves, *Sexing the Intersexed: An Analysis of Sociocultural Responses to Intersexuality*, 27 Signs 523, 535 (2002); Cary Nederman & Jacqui True, *The Third Sex: The Idea of the Hermaphrodite in Twelfth-Century Europe*, 6 J. History of Sexuality 497, 503 (1996).

[35] Preves, *supra* note 34, at 536–37.

[36] Henry de Bracton, 2 ON THE LAWS AND CUSTOMS OF ENGLAND 31 (Thorne trans., 1968), https://goo.gl/GuZmfy.

heire, either as male or female, according to that kind of sexe which doth prevaile."[37]

In the Victorian era, prevailing medical thought divided humans into five sex classifications. In addition to male and female, this included "true hermaphrodites," with both testicular and ovarian tissue; "male pseudo-hermaphrodites," with testicular tissue and female-typical or ambiguous external genitalia; and "female pseudo-hermaphrodites," with ovarian tissue and male-typical or ambiguous external genitalia.[38] Sigmund Freud discussed "hermaphroditism" in his writings,[39] as did pioneering sexologist Richard von Krafft-Ebing.[40]

Intersex people had not been forgotten by 1972, when Title IX was enacted. In a widely-read 1955 paper on "human hermaphroditism," psychologist John Money observed that there were six factors that define "sex"—chromosomes, gonads, hormones/second-

---

[37] Sir Edward Coke, 1 INSTITUTES OF THE LAWS OF ENGLAND 8.a; Greenberg, *supra* note 18, at 277–78.

[38] *See generally* Geertje Mak, DOUBTING SEX: INSCRIPTIONS, BODIES AND SELVES IN NINETEENTH-CENTURY HERMAPHRODITE CASE HISTORIES (2012).

[39] Sigmund Freud, THREE CONTRIBUTIONS TO THE THEORY OF SEX 7 (A.A. Brill trans., 1910); Reis, *supra* note 10, at 55-81.

[40] Richard von Krafft-Ebing, PSYCHOPATHIA SEXUALIS 304 (Charles Gilbert Chaddock trans., 1894); Reis, *supra* note 10, at 55-81.

ary sex characteristics, internal reproductive structures, external genitalia, and sex of rearing—and that these factors do not always align.[41] And by the 1960s, the causes of specific intersex conditions such as congenital adrenal hyperplasia (CAH), androgen insensitivity syndrome (AIS), and Klinefelter syndrome were already understood and documented.[42]

Accordingly, when Congress enacted the provision at issue here, it knew—or, at minimum, should have known—that not all students could be straightforwardly categorized as "male" or "female" based on their anatomy alone. Congress could not have believed otherwise without ignoring millennia of Western history, science, and law.

C. Intersex People Experience Severe Mistreatment And Discrimination

Despite longstanding recognition by society, individuals who do not fit Petitioner's binary notion of

---

[41] John Money, et al., *An Examination of Some Basic Sexual Concepts: The Evidence of Human Hermaphroditism*, Bull. Johns Hopkins Hosp. Johns Hopkins Univ. 97 (4): 301–19 (Oct. 1955).

[42] *See* Leon A. Peris, *Congenital Adrenal Hyperplasia Producing Female Hermaphroditism with Phallic Urethra*, 16 Obstetrics & Gynecology 156 (1960); GENETIC DIAGNOSIS OF ENDOCRINE DISORDERS 249 (Roy E. Weiss & Samuel Refetoff, eds. 2010) (describing Lawson Wilkins' demonstration of androgen resistance in 1950); Harry F. Klinefelter, *Klinefelter's syndrome: historical background and development*, 79 So. Med. J. 1089–93 (1986).

"sex" are routinely mistreated, discriminated against, and even subjected to procedures that human rights experts consider a form of torture.[43] The Court must assess Petitioner's proposed restroom policy, with its demeaning impact on intersex youth, in light of that pervasive mistreatment.

Since the 1960s, children born with intersex traits have often faced nonconsensual surgical intervention, including the removal and reconstruction of internal and external sex organs.[44] Only rarely are these surgeries medically necessary (as when a child's body has no outlet for urination); almost always, they are performed for cosmetic purposes.[45] They are frequently performed in the first two years of life—often by six months of age—when the intersex child is too

---

[43] Juan E. Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 77, UN Doc. A/HRC/22/53 (Feb. 1, 2013); interACT, *Recommendations from interACT: Advocates for Intersex Youth Regarding the List of Issues for the United States for the 59th Session of the Committee Against Torture* (June 2016) at 1, https://goo.gl/GeA5xg; Anne Tamar-Mattis, *Report to the Inter-American Commission on Human Rights: Medical Treatment of People with Intersex Conditions as a Human Rights Violation*, Advocates for Informed Choice (March 2013) at 7–9, https://goo.gl/Nf7Xt7.

[44] Jeremy Toler, *Medical and Surgical Intervention of Patients with Differences in Sex Development*, Gay & Lesbian Med. Ass'n (Oct. 3, 2016) at 1; Karkazis, *supra* note 13, at 57–58, 60–61.

[45] Toler, *supra*, note 44, at 1; Tamar-Mattis, *supra* note 43, at 2–3, 9; Hermer, *supra* note 7, at 207.

young to understand what is taking place, let alone provide informed consent, and long before their gender identity can be known.[46]

The consequences of these surgeries are dire and permanent. The child may be rendered sterile, may suffer a lifelong diminution or loss of sexual sensation and function, and may experience scarring and incontinence.[47] Children who undergo these procedures are often subjected to repeated examination, catheterization, and photography of their genitals, which they may experience as shameful or exploitative.[48] The pain and suffering experienced by children subjected

---

[46] Karkazis, *supra*, note 13, at 57–58; Tamar-Mattis, *supra* note 43, at 2; Daniela Truffer, "It's a Human Rights Issue!" *in* VOICES: PERSONAL STORIES FROM THE PAGES OF NIB – NORMALIZING INTERSEX (hereinafter, "VOICES") 26–29 (James M. DuBois & Ana S. Iltis, eds., 2016) (describing a gonadectomy performed at 2 months of age).

[47] Toler, *supra* note 44, at 1; Recommendations from interACT, *supra* note 43, at 2; Tamar-Mattis, *supra* note 43, at 3–5; Peter Lee et al., *Review of Recent Outcome Data of Disorders of Sex Development (DSD): Emphasis on Surgical and Sexual Outcomes*, 8 J. Pediatric Urol. 611 (Dec. 2012); Sarah Creighton et al., *Objective Cosmetic and Anatomical Outcomes at Adolescence of Feminising Surgery for Ambiguous Genitalia Done in Childhood*, 358 Lancet 124 (2001).

[48] Hughes, *supra* note 3, at 493; Karkazis, *supra*, note 13, at 205; Recommendations from interACT, *supra* note 43, at 1; Tamar-Mattis, *supra* note 43, at 2, 5–6, 12; Konrad Blair, "When Doctors Get it Wrong," *in* VOICES, *supra* note 46 at 5–7; Laura Inter, "Finding my Compass," *in* VOICES, *supra* note 46, at 10–13.

to these procedures is comparable to that of child rape or sexual abuse survivors.[49] For all the harm they entail, there is no persuasive evidence that these surgeries provide the benefits that they have been presumed to provide, such as improved socialization and acceptance among peer groups.[50]

Today, these surgical interventions are widely condemned by the intersex community, and have been decried by prominent human rights groups including the United Nations, the World Health Organization, and Amnesty International.[51] Yet *amici* continue to receive reports from families across the Unit-

---

[49] S.F. Human Rights Comm'n, *A Human Rights Investigation into the Medical "Normalization" of Intersex People* 17–18 (2005), https://goo.gl/trBnGT; Tamara Alexander, *The Medical Management of Intersexed Children: An Analogue for Childhood Sexual Abuse*, ISNA (1997), https://goo.gl/fy9jae; Tamar-Mattis, *supra* note 43, at 12.

[50] Sarah Creighton et al., *Timing and Nature of Reconstructive Surgery for Disorders of Sex Development — Introduction*, 8 J. Pediatric Urol. 602 (2012); Hughes, *supra* note 3, at 493; S.F. Human Rights Comm'n, *supra* note 49, at 19; Toler, *supra* note 44, at 1; Tamar-Mattis, *supra* note 43, at 3.

[51] Méndez, *supra* note 43; Toler, *supra* note 44, at 1; World Health Organization, *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement* (OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO) (2014), https://goo.gl/nzXm6f; Amnesty International, *Policy Statement on the Rights of Intersex Individuals* (2013).

ed States that unnecessary genital surgery has been pressed upon their children.[52]

The mistreatment of intersex people does not end with childhood surgery. They may be denied necessary medical treatment in adulthood by physicians who are unfamiliar with or who stigmatize intersex conditions.[53] *Amicus* interACT received a report of an adult intersex man who died of vaginal cancer after being refused treatment at several U.S. medical facilities due to his intersex condition.[54] Even when doctors are willing and able to treat them, some intersex people report a level of trauma and fear of doctors that renders them unable to access medical care.[55]

Intersex people are also mistreated outside the medical arena. The United Nations has observed discrimination against intersex people in education, public services, employment, and sports.[56] interACT-affiliated youth Kat Caldwell explains that life is con-

---

[52] Toler, *supra* note 44, at 1.

[53] Tamar-Mattis, *supra* note 43, at 2, 7; *Fact Sheet – Intersex*, *supra* note 5, at 2.

[54] Tamar-Mattis, *supra* note 43, at 7.

[55] S.F. Human Rights Comm'n, *supra* note 49, at 23; Tamar-Mattis, *supra* note 43, at 12; Davis, *supra note* 18, at 109–10 (quoting an intersex adult: "I don't like doctors. I don't go to the doctor very often. I don't trust doctors. That's a very triggering environment for me.").

[56] *Fact Sheet – Intersex*, supra note 5, at 1.

stantly impacted by "[t]he lack of understanding" about intersex people, and that Kat feels unsafe around people Kat does not know and trust.[57]

II. KOOMAH'S STORY: THE EXPERIENCE OF ONE INTERSEX YOUTH

It is one thing to describe intersex conditions in the abstract. It is quite another to hear the stories of intersex youth in the first person, as *amici* do every day. Here, *amici* relate the story of Koomah, a 30-year-old intersex individual affiliated with inter-ACT.[58]

Koomah was born with a form of mosaicism. *See supra* at 17–18. As Koomah explains, this "means that I have two sets of DNA in my body … one [set] has XX chromosomes, and the other set has XY chromosomes." Koomah was also born with "uniquely intersex" anatomy:

> [T]he term that [the doctors] used was "bisected scrotum," which means, like, a scrotum that was split, but I did not have descended testes. And I had what appeared to be either a very large clitoris or an undersized penis, with a urethra opening … on the underside [of the]

---

[57] Telephone interview with K. Caldwell, *supra* note 2.

[58] *See generally* Telephone interview with Koomah, Feb. 8, 2017 "Koomah" is this individual's adopted stage name. *See generally* VOICES, *supra* note 46, for additional first-person narratives of growing up intersex.

> base …. I [also] had what's called a unicornuate uterus, which is kind of half of a uterus, and internal ovotestes.

Koomah was assigned female sex on their birth certificate and raised as a girl, but did not have surgery to "normalize" their genitalia.

Koomah always understood that they were "different" from other girls:

> I've always kind of understood that – but it was always something that I was told not to talk about, that there wasn't anybody else like me, it was something that was this big secret … There's a lot of shame and guilt around it. You're made to feel like it's your fault, like you're some freak …. [W]e just don't talk about it, you're a girl, and that's it.

About the time Koomah started high school, their body began to change, and things got "very, very complicated":

> I started to go through what was very similar to a typical male puberty: my voice dropped, and I started to get a more masculine shape, as far as shoulders, and muscles, I had a little bit of facial hair. I had gone through a little bit of a typical female puberty before that as well: I didn't have a menstrual cycle at all, but I did have some breast growth – it was very asymmetrical – and I had a little bit of hips….

> I had attempted to live as female, and was not able to be female enough, I guess …. I started to masculinize a little bit, and so my parents presented it as "look, you're not going to be a girl, you need to be a boy, so … we will switch you from estrogen and get you on testosterone." … I did have a mastectomy done, much to my chagrin.

Although Koomah's changing appearance was outwardly evident, nobody at school knew that they had an intersex condition. Koomah described their fear of being "found out":

> [Y]ou're kind of really forced to [feel shame and stigma] because there's no information presented to you [about your condition] and you're told that you're the only person like you and that people are going to freak out if they find out …. I was scared of what would happen if someone found out. I was already made fun of a lot, I didn't want to put myself in a situation to be more of a target for ridicule.

Koomah's teenage years made still more difficult because they were periodically homeless, and frequently absent from school, as a result of "the gender and intersex stuff, and fighting with that."

Koomah's experience using school restrooms is sadly typical. As a child, Koomah used the girl's restroom without incident. However, when they entered puberty, and their body began to masculinize, they

were unsure "how [they] would be received in a girl's restroom." As a result, Koomah tried to avoid the restroom whenever possible, but when they could not, they "used whichever [restroom] was closest." Ultimately, however, Koomah was barred from using school restrooms altogether:

> [I] was in a boys' restroom, and someone saw that I went in there, and then complained to my counselor, who then said "Well, you can't use the boys' restroom, so you have to use the girls' restroom." And I was like "ok, fine, whatever." But … there [were] then complaints that I was using the girls' restroom. And I was told, "Well, you can use the nurse's restroom."
>
> Now, … the nurse was on the complete opposite side of the entire building …. So if I was in the middle of class, I would have to leave, and I would be gone for 10-15 minutes, so of course my teachers didn't like that. So I was told "You can't use the nurse's restroom …. There is a single-stall restroom in the special education area, which is near where your classroom[s] are, so you can use that one." And I was like "fine, ok." And I used that one for a bit and was then told that I couldn't use that one….
>
> At that [point] … I was told "Well, you don't have a full school schedule, so you can just hold it." So yeah, for the last semester, at least, I

> just wasn't allowed to use the restroom at the high school at all.

As *amici* explain below, Koomah's experience—like the similar experiences of countless other intersex youth—illustrates the unworkability of a restroom policy based solely on "physiological" sex.

III. INTERSEX CONDITIONS REFUTE PETITIONER'S ARGUMENT THAT "SEX" UNDER TITLE IX MUST REFER TO "PHYSIOLOGICAL" SEX

As the above discussion illustrates, Petitioner's arguments in this case suffer from at least three fundamental flaws.

First, "physiological" sex is nowhere near as clear-cut as Petitioner would have the Court believe. The term has no single accepted meaning, and experts can disagree on a given child's "physiological" sex.

Second, determining a child's "physiological" sex (however that term is defined) requires intrusive examinations of their anatomy and genome. Such examinations are traumatizing, impracticable, and likely unconstitutional. Ascertaining gender identity, on the other hand, is noninvasive: the student self-identifies.

Third, limiting access to restrooms based on "physiological" sex is no more protective of students' privacy interests than a policy that permits students to access restrooms in accordance with their identity. Assuming sharing a restroom with people with differ-

ent bodily characteristics implicated a privacy interest, even under Petitioner's preferred regime students will frequently have to share restrooms with intersex peers whose sex characteristics do not align with their own.

A. "Physiological" Sex Is Often Neither Clear-Cut Nor Objective

The arguments of Petitioner and its *amici* rest on the assumption that "physiological" sex is a "clearly defined" term with a universal meaning. *See, e.g.*, McHugh Br. at 6. As the above discussion makes clear, that assumption is wrong.

Petitioner states, rather circularly, that "physiological" sex refers to the "the physiological distinctions between males and females." Pet. Br. at 2, 20, 26–28. Beyond that, though, Petitioner remains coy. It refers in passing to "reproductive organs," "reproductive functions," and "sex chromosomes." *Id.* at 28. However, as discussed above, these factors can—and regularly do—point in different directions. Petitioner and its *amici* do not explain which of these "distinctions" should be controlling under Title IX—let alone why.

The answer is far from self-evident. Is Petitioner suggesting that schools classify children by their *external genitalia*? If so, what about children born with ambiguous or absent genitalia, or who are born with external genitalia typical of one sex, but who have the chromosomal patterns, gonads, or secondary sex

characteristics typical of the other? By their *internal sex organs*? If so, what about children who have streak gonads or ovotestes? By their *sex chromosomes*? If so, what about children who are XY but appear phenotypically female (*e.g.*, as a result of AIS); or children who are XX but appear phenotypically male (*e.g.*, as a result of CAH); or children with atypical chromosomal combinations such as XXY; or children with mosaicism, whose sex chromosomes vary from cell to cell? Or is Petitioner suggesting a *holistic* test that balances all of these factors?[59] If so, what is the weighting to be assigned to each factor, and whose task is it to weigh them?

Koomah, whose story *amici* related above, summarizes the problem vividly:

> I have [both] XX and XY chromosomes …. Can I use … both [restrooms]? Can I not use either of them? …. Genetics are far more complicated than just XX or XY ….
>
> There's a lot of diversity in anatomy as well! …. [W]hat does that mean for those [like me] with … "uniquely intersex genitals?" Because not everyone has binary genitals.

---

[59] *See* Pet. Br. at 31 n.10 (quoting *Black's Law Dictionary* definition of "sex" as "*[t]he sum* of the peculiarities of structure and function that distinguish a male from a female organism" (emphasis added)).

> My question would probably be "What restroom would I use, in that case?" If we're going to base it on chromosomes, what restroom would I use? If we're basing it on genitals, which restroom would I use?[60]

Kat Caldwell, another interACT-affiliated youth, expressed similar concerns. As a result of AIS, Kat was born with XY chromosomes, internal testes, and female-typical external genitalia. Kat explains: "If it comes down to my chromosomes, I'm supposed to use the men's room." If the rule is based on genitalia, however, "my genitalia and my chromosomes don't match up. So essentially [the rule] leaves no place for people like me."[61]

Notably, the legal system has struggled for decades to answer the definitional question that Petitioner simply begs. By the time Title IX was enacted, courts well recognized that "[t]here are several criteria or standards which may be relevant in determining the sex of an individual." *M.T. v. J.T.*, 355 A.2d 204, 206–08 (N.J. App. Div. 1976) (listing chromosomes, external genitalia, gonads, secondary sex characteristics, and hormones, as well as gender identity).[62] Commentators have noted the "variability

---

[60] Telephone interview with Koomah, *supra* note 58.

[61] Telephone interview with K. Caldwell, *supra* note 2.

[62] *See also Littleton v. Prange*, 9 S.W.3d 223, 227 (Tex. Ct. App. 1999) (noting "four criteria for assigning the sexual identity of an individual," *i.e.*, "[c]hromosomal factors," "gonadal factors,"

of standards that courts employ" in making such determinations.[63] Even courts in the same jurisdiction have disagreed about how to determine sex when physiological features do not align.[64]

Petitioner and its *amici* also assert that "physiological" sex has the virtue of being an "objective" classification. Pet. Br. at 32; McHugh Br. at 3–6, 12–13. Gender identity, they suggest, is "fuzzy and mercurial," *id.* at 8, while "physiological" sex simply *is*. But the foregoing discussion should make clear that this assertion is similarly flawed. An intersex student's "physiological" sex may depend entirely on which physiological trait one chooses to privilege. Indeed, because of the diversity of medical perspectives, trained experts can and do disagree on the "correct" sex to assign to an intersex child.[65]

---

and "genital factors," as well as "psychological factors"); *Richards v. United States Tennis Ass'n*, 400 N.Y.S.2d 267, 269–70 (N.Y. Sup. Ct. 1977) (listing chromosomes, external genitalia, "gonadal and ductal structures," and hormones, as well as "psychological and social sex").

[63] Chinyere Ezie, *Deconstructing the Body: Transgender and Intersex Identities and Sex Discrimination—The Need for Strict Scrutiny*, 20 Colum. J. Gender & L. 141, 162–63 (2011).

[64] *Compare Anonymous v. Weiner*, 270 N.Y.S.2d 319, 322 (N.Y. Sup. Ct. 1966) ("chromosomal[]" sex must prevail) *with Richards*, 400 N.Y.S.2d at 272–73 (chromosomes "should not be the sole criterion").

[65] *See, e.g.*, Tamar-Mattis, *supra* note 43, at 5 ("There is still controversy and uncertainty about gender assignment in [cases

Interpreting "sex" to refer to a student's gender identity would avoid (or at least mitigate) these problems. Unlike "physiological" sex, all parties appear to agree on what gender identity means: it is "[an] individual's 'innate sense of being male or female.'" Pet. Br. at 36; *cf.* Resp. Br. at 2 (similar). It is not subject to competing definitions depending on which expert or court is consulted. Moreover, unlike "physiological" sex, a student's gender identity *by definition* cannot be subject to differences in medical opinion: each student is the ultimate arbiter of their own gender identity, as they (and they alone) experience it first-hand.

B. Determining A Student's "Physiological" Sex Is Invasive And Impracticable

Petitioner argues that allowing students to use restrooms that match their gender identity "would be impossible to administer," as it would require schools to "undertake case-by-case evaluations of a student's gender presentation." Pet. Br. at 22. By contrast, Petitioner suggests, a regime assigning students to restrooms based on "physiological" sex would be easy and straightforward to administer.

---

of partial AIS], and it can go either way, depending largely on the doctor's judgment."); David A. Diamond et al., *Gender Assignment for Newborns with 46XY Cloacal Exstrophy: A 6-Year Followup Survey of Pediatric Urologists*, 186 J. Urol. 1642, 1643 (2011) (reporting that only 79 percent of surveyed clinicians agreed on a male gender assignment in 46XY cloacal exstrophy).

As the above discussion makes clear, that is completely backward. Setting aside the definitional question just discussed, determining a child's "physiological" sex requires inspections of their genitalia, internal sex organs, and/or DNA. The notion of lining schoolchildren up for forced examination of their sex organs, palpation of their gonads, or extraction of their genetic material to determine restroom access is horrifying. One could hardly think of a greater affront to the dignity of every American schoolchild.[66]

The Court need not take *amici*'s word that school-sponsored "sex tests" would be traumatizing and demeaning. It has already observed that far less intrusive bodily searches in the school context cause "serious emotional damage" and violate "both subjective and reasonable societal expectations of personal privacy." *Safford Unified Sch. Dist. v. Redding*, 557 U.S. 364, 374–75 (2009) (finding this was the case where school officials forced an adolescent student to "'pull out' her bra and the elastic band on her underpants," even though they did not see her breasts or genitals). The psychological harm would be especially pronounced for intersex students, who may already suffer from trauma, depression, and suicidality as a re-

[66] Setting aside the affront to students' dignity and privacy, it goes without saying that most American schools lack access to the technology needed to assess a student's internal sex organs, sex hormones, and sex chromosomes.

sult of years of medical examinations of their genitals and worse.[67]

The specter of universal "sex testing" cannot be waved away as an unlikely hypothetical. Because there are intersex students in most American schools, it is impossible to tell from a student's clothed appearance what their sex organs look like or what their chromosomal patterns are. And one cannot simply *ask* students what their "physiological" sex is; not only would that force them to disclose sensitive medical information, but moreover, intersex students often lack knowledge of their condition. Even their families and physicians may not know. For example, interACT-affiliated youth Hann Lindahl did not know she had an intersex condition until age 15, when she learned she had been born with XY chromosomes and gonads that were neither testes nor ovaries. This would never have been apparent to Hann's schoolteachers or principals, because Hann was assigned "female" sex at birth and her appearance is "very feminine."[68] Only a universal "sex testing" regime would have revealed that Hann's sex characteristics were not typically female.

Permitting students to use restrooms matching their gender identity would avoid this dystopian scenario. To determine a student's gender identity, you

---

[67] *Supra* at notes 48–49 and accompanying text.

[68] Telephone interview with Hann Lindahl, Jan. 17, 2017.

simply ask them their gender identity. There is no need to engage in "case-by-case evaluations of a student's gender presentation," as Petitioner conclusorily asserts. Pet. Br. at 22. And even if "case-by-case evaluations" occasionally had to be made (*e.g.*, to ensure that students are not professing a gender identity that they do not sincerely hold), such a regime would still be vastly easier to administer—and far less invasive and demeaning—than the regime of universal sex examinations that Petitioner's rule would require.

C. Assigning Students To Restrooms Based On "Physiological" Sex Does Not Advance Privacy Interests

Finally, Petitioner argues that students must be assigned to restrooms on the basis of "physiological" sex in order to protect their "privacy." Pet. Br. at 1, 7–9, 20–22, 35.

As a threshold matter, Petitioner never explains how a student's "privacy" is violated merely because a child in an adjoining stall has sex characteristics different from their own. In today's schools, students generally do not see each other fully nude—especially in the restroom. Petitioner also overlooks the obvious point that any infringement of privacy stemming from the presence of different-bodied students in neighboring restroom stalls pales in comparison with the privacy violations that would attend a regime of forced genital, gonadal, or DNA examinations by school personnel.

Beyond those issues, however, the presence of intersex youth in many or most of our nation's schools means that students will inevitably share restrooms with peers whose sexual anatomy differs from their own, *even if Petitioner's position prevails*. Whichever "physiological" sex an intersex student is deemed to possess, and whichever restroom they are consequently assigned to use, the other students who use that restroom will have to relieve themselves in the vicinity of a student whose genitals, gonads, and/or sex chromosomes do not resemble theirs.[69] Thus, in addition to the serious drawbacks discussed above, using "physiological" sex to assign students to restrooms will not even provide the ostensible privacy benefit that Petitioner trumpets as its main redeeming feature.

* * *

In sum, Petitioner's arguments in support of its "physiological" reading of "sex" under Title IX do not withstand scrutiny. Petitioner's preferred regime would be *less* clear-cut, *less* administrable, and *less* protective of students' privacy than a regime that permits students to use the restroom consistent with their gender identity.

---

[69] That is, unless all students with intersex traits are somehow identified and forced to use separate, intersex-only restrooms. Not only would this be severely stigmatizing, it would require the same invasive "sex testing" discussed above, and it would compel schools to construct expensive new facilities.

CONCLUSION

Because G.G. is transgender, this has been framed as a case about transgender students only. But the Court's decision will also directly and profoundly affect the lives of many thousands of intersex youth. Indeed, if Petitioner's invasive and demeaning regime is implemented, the Court's decision will negatively impact the lives of *all* children.

The rule that the Court adopts in this case must be workable in light of the reality of intersex students' bodies, and it must respect their dignity and human rights. Permitting students to use the facilities that match their identity and the way they live their lives is the only way to comply with the manifest purpose of Title IX: ensuring that students are not deprived of educational opportunities on the basis of sex characteristics, whatever those may be.

The Court of Appeals' judgment should be affirmed.

Respectfully submitted.

JONAH M. KNOBLER
Counsel of Record
ARON FISCHER
DEREK A. BORCHARDT
LAUREN M. CAPACCIO
ANTHONY C. DECINQUE
TARA J. NORRIS
PATTERSON BELKNAP
WEBB & TYLER LLP
1133 Ave. of the Americas
New York, NY 10036
(212) 336-2000
jknobler@pbwt.com

Counsel for Amici Curiae

March 2, 2017