15-2056

IN THE

United States Court of Appeals

FOR THE FOURTH CIRCUIT

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

Plaintiff-Appellant,

—v.—

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant-Appellee.

(*Caption continued on inside cover*)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA AT NEWPORT NEWS

BRIEF FOR *AMICI CURIAE* interACT: ADVOCATES FOR INTERSEX YOUTH, ET AL. IN SUPPORT OF PLAINTIFF-APPELLANT

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Amici Supporting Rehearing Petition.

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT
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Disclosures must be filed on behalf of all parties to a civil, agency, bankruptcy or mandamus case, except that a disclosure statement is **not** required from the United States, from an indigent party, or from a state or local government in a pro se case. In mandamus cases arising from a civil or bankruptcy action, all parties to the action in the district court are considered parties to the mandamus case.

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(name of party/amicus)

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1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

2. Does party/amicus have any parent corporations? ☐ YES ☑ NO
If yes, identify all parent corporations, including all generations of parent corporations:

3. Is 10% or more of the stock of a party/amicus owned by a publicly held corporation or other publicly held entity? ☐ YES ☑ NO
If yes, identify all such owners:

4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation (Local Rule 26.1(a)(2)(B))? ☐ YES ☑ NO
If yes, identify entity and nature of interest:

5. Is party a trade association? (amici curiae do not complete this question) ☐ YES ☑ NO
If yes, identify any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding or whose claims the trade association is pursuing in a representative capacity, or state that there is no such member:

6. Does this case arise out of a bankruptcy proceeding? ☐ YES ☑ NO
If yes, identify any trustee and the members of any creditors' committee:

Signature: /s/ Aron Fischer Date: May 15, 2017

Counsel for: interACT

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INTEREST OF *AMICI CURIAE*

Amici file this brief in support of Plaintiff-Appellant G.G., i.e., Gavin Grimm.[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, non-consensual 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 ages 7–22 with gender dysphoria and/or differences of sex development.

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[1] *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.

- **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 International 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 community 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. Defendant-Appellee Gloucester County School Board (the "Board") maintains that the word "sex" in Title IX must refer only to an individual's "physiological" sex, and that under this interpretation the statute allows the Board to prohibit transgender students such as Mr. Grimm from using the restroom that is consistent with their gender identity. The intersex youth for whom *amici* advocate are a living refutation of the argument that "physiological" sex is dispositive here.

The Board's assumption that "physiological" sex is always clear-cut and binary is demonstrably inaccurate as a matter of human biology. Many people are born with intersex traits that cannot be unambiguously classified as "physiologically" male or female. As a result, 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 this Court does not accept the Board's misguided view of "physiological" sex, and in seeing the Court interpret Title IX in a way that respects all children.

SUMMARY OF ARGUMENT

The Board argues that the word "sex" in Title IX must be construed to refer only to a student's "physiological" sex, and therefore permits educational institutions to disregard students' gender identity. Underlying the argument is the assumption that gender identity is a novel and ethereal concept, whereas all schoolchildren have a binary "physiological" sex—either male or female—that is unambiguous, indisputable, and always 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 the Board's "physiological" test. Intersex is an umbrella term describing a wide range of natural bodily variations—in external genitals, internal sex organs, chromosomes, and hormones—that do not fit typical binary notions of male or female bodies. Intersex

traits have been known for millennia and their existence is universally acknowledged by the scientific and medical community.

The existence of intersex people disproves the Board's unsupported assumptions about "physiological" sex, thereby undercutting its 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 for all people. 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 necessarily subjective exercise. Focusing on "physiological" sex therefore does not eliminate the need to determine whether Title IX prohibits discrimination on the basis of gender identity.

Second, a restroom policy based on "physiological" sex is impossible to administer. The presence of intersex (and transgender) students in schools across America means that "physiological" sex cannot be determined from a child's clothed appearance or any other non-intrusive physical assessment. The Board'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.

Third, the existence of intersex students belies the Board'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 the Board'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

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

The Board contends that "sex" under Title IX is a "binary term encompassing the physiological distinctions between men and women." Board Br. at 28–29. However, thousands of children are born each year with anatomy that is neither typically "male" nor typically "female."

This has been true for millennia and was known at the time Title IX was enacted. The longstanding facts of human biology refute the Board's argument that a "physiological" understanding of sex eliminates the need to consider gender identity in determining what constitutes sex discrimination under Title IX.

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.[2]

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[3] of babies are born with intersex traits—similar to the number born with red hair.[4] And there is evidence that the incidence of intersex conditions is on the rise.[5]

As detailed below, intersex conditions vary widely. They may involve the external genitalia, gonads and other internal sex organs, sex

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[2] *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).

[3] *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).

[4] 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 3, at 51.

[5] Fausto-Sterling, *supra* note 3, at 54.

hormones, and/or sex chromosomes.[6] 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.[7]

Intersex children are generally assigned a sex at birth based on some combination of their genitalia, gonads and other internal organs, and chromosomes.[8,9] Some intersex people continue to identify with that assigned sex throughout their lives; others later identify differently.[10]

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[6] 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).

[7] 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").

[8] Hughes, *supra* note 2, at 491.

[9] 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).

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

As many as 25% of intersex people (and for some intersex conditions, as high as 40%) do not identify with their originally assigned sex.[11] 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.[12]

The Intersex Society of North America ("ISNA") recognizes approximately 20 different intersex conditions,[13] including the following:

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

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[11] Julie A. Greenberg, INTERSEXUALITY AND THE LAW 20 (2012); Hughes et al., *supra* note 2, at 491; P.S. Furtado et al., *Gender Dysphoria Associated with Disorders of Sex Development*, 9 Nat. Rev. Urol. 620 (Nov. 2012).

[12] Hughes, *supra* note 2, at 491; Katrina Karkazis, FIXING SEX: INTERSEX, MEDICAL AUTHORITY, AND LIVED EXPERIENCE 95, 100–02 (2008).

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

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.[14]

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), 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

[14] 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 3, at 154–55; ISNA, *Congenital Adrenal Hyperplasia (CAH)*, https://goo.gl/8Ki1FH; Fausto-Sterling, *supra* note 3, at 51–53 & Tbl. 3.2; Clinical Guidelines, *supra* note 7, at 6.

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.[15]

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 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 nei-

[15] Hermer, *supra* note 6, at 207.

ther 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.[16]

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 develop most secondary sex characteristics without hormone replacement.[17]

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[16] Blackless et al., *supra* note 3, at 153; Fausto-Sterling, *supra* note 3, at 52; Hughes, *supra* note 2, at 491; ISNA, *Androgen Insensitivity Syndrome*, https://goo.gl/GJziJL.

[17] 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 33, at 52 & Tbl. 3.1; Julie A. Greenberg, *De-*

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 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. Kline-

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fining Male and Female: Intersexuality and the Collision Between Law and Biology, 41 Ariz. L. Rev. 265, 284 (1999).

felter syndrome has a prevalence of about 1 in 500 children raised as boys, and is not ordinarily diagnosed before puberty.[18]

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.[19]

h. ***Persistent Müllerian Duct Syndrome (PMDS)*****:** Persons with PMDS have an XY chromosomal pattern and typical male re-

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[18] Blackless et al., *supra* note 3, at 152; Greenberg, *supra* note 17, 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).

[19] 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 3, at 152; Greenberg, *supra* note 17, at 284.

productive 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.[20]

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.[21]

j. ***Mosaicism*:** As a result of atypical cell division in early embryonic development, some people are born with a mosaic karyotype, meaning that their chromosome pattern varies from cell to

[20] Greenberg, *supra* note 17, at 285.

[21] Hughes, *supra* note 2, at 492; Fausto-Sterling, *supra* note 3, at 21.

cell. A person with mosaicism may have an XX chromosomal pattern in some bodily cells, and an XY pattern in others.[22]

Other conditions may or may not result in an intersex diagnosis, depending on the subjective approach of the attending physician.[23] 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.[24] Historically, however, babies born with aphallia were assigned a female sex and raised as girls.[25]

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[22] Wilson & Reiner, *supra* note 2, at 122; Clinical Guidelines, *supra* note 7, at 7; L. Sax, *How Common is Intersex? A Response to Anne Fausto-Sterling*, 39 J. Sex. Res. 174, 175 (2002).

[23] *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).

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

[25] 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.[26] 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.[27]

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

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[26] *See, e.g.*, Karkazis, *supra* note 12, 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").

[27] *See* Fausto-Sterling, *supra* note 3, 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).

whose genitalia are obscured); *aylonit* (a person designated 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.[28] According to some traditions, Adam, the first human, was *androgynos*, and Abraham and Sarah, the progenitors of the Jewish people, were both *tumtum*.[29]

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."[30] Pliny's Natural History refers to "those who belong to both sexes, [whom] we call by the name of her-

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[28] 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).

[29] O'Brien, *supra* note 28, at 313.

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

maphrodites … [or] Androgyni."[31] And the Roman emperor Justinian permitted children with ambiguous genitalia to choose their own sex prior to marriage.[32]

In medieval and Renaissance Europe, "hermaphrodites" were often regarded as a third sex and recognized by law or custom.[33] 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.[34] De Bracton's thirteenth-century treatise on English law classified people as "male, female, or hermaphrodite."[35] And, in a treatise regarded as a founding document of English

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

[32] 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).

[33] 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).

[34] Preves, *supra* note 33, at 536–37.

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

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 heire, either as male or female, according to that kind of sexe which doth prevaile."[36]

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.[37] Sigmund Freud discussed "hermaphroditism" in his writings,[38] as did pioneering sexologist Richard von Krafft-Ebing.[39]

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[36] Sir Edward Coke, 1 INSTITUTES OF THE LAWS OF ENGLAND 8.a; Greenberg, *supra* note 17, at 277–78.

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

[38] Sigmund Freud, THREE CONTRIBUTIONS TO THE THEORY OF SEX 7 (A.A. Brill trans., 1910); Reis, *supra* note 9, at 55–81.

[39] Richard von Krafft-Ebing, PSYCHOPATHIA SEXUALIS 304 (Charles Gilbert Chaddock trans., 1894); Reis, *supra* note 9, at 55–81.

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/secondary sex characteristics, internal reproductive structures, external genitalia, and sex of rearing—and that these factors do not always align.[40] 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.[41]

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

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[40] 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).

[41] *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).

anatomy alone. Congress could not have believed otherwise without ignoring millennia of Western history, science, and law.

B. INTERSEX CONDITIONS UNDERMINE THE BOARD'S RELIANCE ON "PHYSIOLOGICAL" SEX

The existence of intersex traits illuminates at least three fundamental flaws in the Board's arguments.

First, "physiological" sex is nowhere near as clear-cut as the Board assumes. The term has no single meaning, and experts can disagree on a given child's "physiological" sex. A "physiological" understanding of sex therefore would not eliminate the need to consider gender identity in assessing discrimination under Title IX.

Second, determining a child's "physiological" sex (however that term is defined) would require intrusive examinations of their anatomy and genome in some cases. Such examinations would be traumatizing, impracticable, and likely unconstitutional. Nobody would defend inflicting these examinations on students for the purpose of deciding which restrooms they should use.

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. As-

suming sharing a restroom with people with different bodily characteristics implicated a privacy interest, even under the Board's preferred regime students will frequently have to share restrooms with intersex peers whose sex characteristics do not align with their own.

A. Because "Physiological" Sex Is Not Always Clear Cut, "Physiology" Cannot Answer the Question Presented Here

The underlying premise of the Board's argument is that if "sex" in Title IX is "physiological," then educational institutions may prohibit transgender students from using the restrooms corresponding to their gender identities. Indeed, the Board goes so far as to argue that if Title IX's understanding of sex even "includes" physiology, the Board's policy is lawful. Board Br. at 23–27. But as the above discussion makes clear, that argument is unfounded.

Despite its extensive reliance on the concept, the Board fails to specify the supposedly "binary . . . physiological distinctions" that it contends justify disregarding an individual's gender identity. Board Br. at 28–29. To the contrary, the Board effectively concedes that "physiological" conceptions of sex contain "ambiguities." Board Br. at 25; *accord* Board Br. at 23–25. The Board's argument is that these ambiguities do

not matter because "physiology is at least a critical factor in the term 'sex' as deployed in Title IX." Board Br. at 26. This argument makes no sense. The existence of physiological ambiguities as to sex defeats the Board's argument that educational institutions may disregard gender identity and assign students to restrooms according to a purely "physiological" understanding of sex.

What "physiological" criteria does the Board contend it is permitted to rely on in barring students from using the restrooms corresponding to their gender identity? Is the Board 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 the Board suggesting a *holistic* test that balances all of these factors? If so, what is the weighting to be assigned to each factor, and whose task is it to weigh them?

Koomah, an interACT-affiliated individual born with a form of mosaicism (*see* p. 16–17, *supra*), summarizes the problem clearly:

> I have 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.
>
> 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?[42]

Kat Caldwell, another interACT-affiliated intersex individual, 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

[42] Telephone interview with Koomah, Feb. 8, 2017. "Koomah" is this individual's adopted stage name.

and my chromosomes don't match up. So essentially [the rule] leaves no place for people like me."[43]

The existence of intersex individuals like Koomah and Kat belies the Board's premise that physiology necessarily provides an "objective" basis for determining which restrooms students are to use. Board Br. at 26, 33–34. An intersex student's "physiological" sex may depend entirely on which physiological trait one chooses to privilege. There is no inherently objective basis on which to make that choice. Indeed, because of the diversity of medical perspectives, trained experts can and do disagree on the "correct" sex to assign to an intersex child.[44] When intersex individuals are stigmatized based on other people's beliefs about their

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

[44] *See, e.g.*, 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 5 (March 2013) ("There is still controversy and uncertainty about gender assignment in [cases of partial AIS], and it can go either way, depending largely on the doctor's judgment."), https://goo.gl/Nf7Xt7; 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).

sex, they suffer discrimination on the basis of sex. The same is true of transgender individuals.

Because even "physiological" sex is (and always has been) ambiguous in some cases, a "physiological" understanding of sex cannot answer the question presented here. As Mr. Grimm explains, discrimination on the basis of transgender status is sex discrimination for many reasons. G.G. Br. at 21–33. The Board's simplistic appeal to "physiology" does nothing to refute Mr. Grimm's arguments.

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

The Board contends that allowing students to use restrooms that match their gender identity would place schools in the difficult and perilous position of evaluating how a student "'presents' his or her gender identity." Board Br. at 44. By contrast, the Board suggests, a regime assigning students to restrooms based on "physiological" sex would be easy and straightforward to administer.

As the above discussion makes clear, that is completely backward. Setting aside the definitional question just discussed, determining a child's "physiological" sex in doubtful cases would be far more difficult than evaluating whether a student is falsely claiming a particular gen-

der identity. Assessing physiological sex would require inspections of students' 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 American schoolchildren.[45]

Evaluating questionable cases of "physiological" sex would be far more perilous than assessing whether a student's gender identity is genuinely held. The Supreme Court has 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 stu-

[45] 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.

dents, who may already suffer from trauma, depression, and suicidality as a result of years of medical examinations of their genitals and worse.

Although the specter of school "sex testing" seems unlikely, it is no more far-fetched than the supposedly difficult assessments of gender identity posited by the Board. It is impossible to tell from an intersex student's clothed appearance what their sex organs look like or what their chromosomal patterns are. Indeed, intersex students often themselves 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."[46] Only a "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 gen-

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

der identity, you simply ask them their gender identity. That procedure was sufficient here—there is no dispute that Mr. Grimm is a transgender boy—and there is no real-world reason to doubt that it would work elsewhere. G.G. Br. at 40–43. Even if assessments of gender identity would occasionally have 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 sex examinations that the Board's rule would require.

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

Finally, the Board argues that students must be assigned to restrooms on the basis of "physiological" sex in order to protect the "privacy" of other students. Board Br. at 39–40.

As a threshold matter, the Board 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.

Beyond those issues, however, the presence of intersex youth in our nation's schools means that students will inevitably share restrooms with peers whose sexual anatomy differs from their own, *even if the Board'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. 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 the Board trumpets as its main redeeming feature.

* * *

In sum, the Board's arguments in support of its "physiological" reading of "sex" under Title IX do not withstand scrutiny. The Board'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.

CONCLUSION

Because Mr. Grimm is transgender, this case has been framed as a case about transgender students only. But the Court's decision will al-

so directly and profoundly affect the lives of many thousands of intersex youth. 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.

Respectfully submitted.

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(s) Aron Fischer

Party Name interACT, as amicus curiae

Dated: May 15, 2017

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Aron Fischer