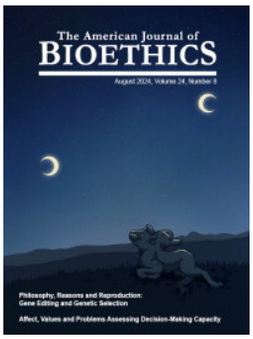

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The Brussels Collaboration on Bodily Integrity

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TARGET ARTICLE

Genital Modifications in Prepubescent Minors: When May Clinicians Ethically Proceed?

The Brussels Collaboration on Bodily Integrity*

ABSTRACT

When is it ethically permissible for clinicians to surgically intervene into the genitals of a legal minor? We distinguish between *voluntary* and *nonvoluntary* procedures and focus on *nonvoluntary* procedures, specifically in prepubescent minors ("children"). We do not address procedures in adolescence or adulthood. With respect to children categorized as female at birth who have no apparent differences of sex development (i.e., non-intersex or "endosex" females) there is a near-universal ethical consensus in the Global North. This consensus holds that clinicians may not perform *any* nonvoluntary genital cutting or surgery, from "cosmetic" labiaplasty to medicalized ritual "pricking" of the vulva, insofar as the procedure is not strictly necessary to protect the child's physical health. All other motivations, including possible psychosocial, cultural, subjective-aesthetic, or prophylactic benefits as judged by doctors or parents, are seen as categorically inappropriate grounds for a clinician to proceed with a *nonvoluntary* genital procedure in this population. We argue that the main ethical reasons capable of supporting this consensus turn not on empirically contestable benefit–risk calculations, but on a fundamental concern to respect the child's privacy, bodily integrity, developing sexual boundaries, and (future) genital autonomy. We show that these ethical reasons are sound. However, as we argue, they do not only apply to endosex female children, but rather to all children regardless of sex characteristics, including those with intersex traits and endosex males. We conclude, therefore, that as a matter of justice, inclusivity, and gender equality in medical-ethical policy (we do not take a position as to criminal law), clinicians should not be permitted to perform any nonvoluntary genital cutting or surgery in prepubescent minors, irrespective of the latter's sex traits or gender assignment, unless urgently necessary to protect their physical health. By contrast, we suggest that *voluntary* surgeries in older individuals might, under certain conditions, permissibly be performed for a wider range of reasons, including reasons of self-identity or psychosocial well-being, in keeping with the circumstances, values, and explicit needs and preferences of the persons so concerned. Note: Because our position is tied to clinicians' widely accepted role-specific duties as medical practitioners within regulated healthcare systems, we do not consider genital procedures performed outside of a healthcare context (e.g., for religious reasons) or by persons other than licensed healthcare providers working in their professional capacity.

KEYWORDS

Children and families; intersex; professional ethics; gender/sexuality; circumcision; ritual pricking; "FGM"

INTRODUCTION

When is it ethically permissible for a licensed healthcare provider to surgically intervene into the genital, sexual, or reproductive anatomy of a child, defined here as a prepubescent legal minor? This question has taken on greater urgency after two major U.S. hospitals pledged, in late 2020, to stop performing what they described as "medically unnecessary" genital surgeries on children born with variations of sex characteristics, also known as intersex traits, insofar as the children either fail to consent or assent to the surgeries or lack the capacity to do so (LCH 2020; Luthra 2020). We will call these *nonvoluntary* genital procedures, to be contrasted with *voluntary* procedures, the latter of which raise a different set of medical-ethical issues and will not be examined here. For example, we will not evaluate so-called gender-affirming procedures in transgender individuals, given that medicalized (as opposed to social) interventions for such purposes are virtually never initiated prior to the onset of puberty. This is especially true of genital surgeries in this population, the vast majority of which occur, if at all, at the request of the

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individual after an age of legal majority (Wright et al. 2023). They are thus neither nonvoluntary nor performed on children according to our definition.[1]

Meanwhile, scholarly discussions prompted by a recent U.S. federal court case (*United States vs. Nagarwala*) have raised significant doubts about the permissibility of clinicians performing any medically unnecessary genital operations on approximately half of all persons under the age of 18 years, irrespective of voluntariness: namely, those judged to have anatomically typical female genitalia (i.e., non-intersex or "endosex"[2] females) (see Duivenbode and Padela 2019a; Cohen et al. 2020; Earp 2020; Rosman 2022; Bootwala 2023; Shweder 2023; Bader 2023; Taher 2023; see also Buckler 2024).

Following the *Nagarwala* case, the STOP FGM Act of 2021 (H.R. 6100, enacted as Pub. L. 116–309) was passed by the U.S. Congress. While some scholars suggest this law could be vulnerable to constitutional challenge due to its sex-specific wording and lack of religious exemption (e.g., Rosman 2022; Shweder 2022a; for an earlier, related analysis, see Bond 1999), it currently clarifies that clinicians or others who perform genital cutting or surgery for "non-medical reasons [on] the external female genitalia" of a legal minor, however minimal—that is, including medicalized ritual "pricking" of the vulva, with or without removal of tissue—will be in breach of federal criminal law.

In this article, we will not be taking a position as to the appropriateness, or inappropriateness, of criminalizing ritual genital cutting of endosex female minors, including medicalized forms undertaken by a licensed physician, as was alleged in the *Nagarwala* case. In fact, we will not be advocating for or against any legal position in this article. Instead, we will be focused on moral arguments and on assessing their implications for clinical ethics and policy. Nevertheless, we mention the *Nagarwala* case at the outset to illustrate the seriousness with which at least some forms of medically unnecessary genital cutting of legal minors are treated in a Western context, even when the cutting is relatively superficial (e.g., "pricking"), is requested by the child's parents for explicitly religious reasons,[3] and is done with sterile instruments by a trained clinician.

Given this background, along with other rapidly evolving developments (see below for international context), it seems necessary to perform a critical analysis of *all* medically unnecessary, nonvoluntary genital cutting or surgery performed on children in regulated healthcare settings. This article represents one such analysis by a diverse group of stakeholders with a long-standing interest in the subject. The authors comprise a large informal network of physicians, nurses, and other healthcare professionals, along with philosophers, historians, bioethicists, psychologists, sociologists, anthropologists, law professors, gender scholars, feminists, sexologists, human rights advocates, and policy experts from more than two dozen countries and six continents (see Appendix A for more information).

[1]This is not to suggest that all *voluntary* genital cutting or surgery is automatically (i.e., simply by virtue of being voluntary) ethically sound. Nor does it suggest that there is a consensus as to when, if ever, decisions to undergo such procedures are in fact voluntary in the sense required for valid consent (Kiener 2023), even in the case of adults (Esho 2022). In the current discourse, there has been some discussion around the use of medical interventions such as hormones or surgery to modify the bodies of postpubescent minors ("adolescents") who identify as trans or nonbinary (Milrod 2014; Horowicz 2019; Mahfouda et al. 2019; Ashley 2019). Due to space constraints and our focus on prepubescent minors, we are not able to enter into—and do not take a position on—those debates in this article (for context, see Ghorayshi 2023; for analysis, see Grimstad et al. 2023). Nor do we attempt to spell out the conditions for giving morally valid consent to elective genital procedures such as cosmetic labiaplasty (increasingly performed on minors in the United States; see Luchristt, Sheyn, and Bretschneider 2022; for discussion, see Kalampalikis and Michala 2023). Instead, we are primarily concerned with interventions performed on younger children who have *not* personally requested them or whose inability to provide valid consent to them is not in question. Even so, we note that older minors with intersex traits often have undergone medically unnecessary surgeries or hormonal interventions against their will or without their (adequately informed) permission based upon the wishes of parents or physicians, sometimes under conditions of partial or total deception as to the real purpose of the procedure (Berger, Ansara, and Riggs 2023; see also Zieselman 2015). Even today, such minors remain vulnerable to coercion from adults seeking to alter their intersex traits (Human Rights Watch 2017; Rubashkyn and Savelev 2023). Arguably, such a situation is ethically different from that of older minors or adults, including but not limited to trans or intersex persons, who actively *request* certain body modifications: for example, to alleviate distress or dysphoria associated with their sexed anatomy, or to better align their embodiment with their sense of self (Kraus 2015; cf. Dembroff 2019). That being said, we also acknowledge the existence of concerns that some minors may face undue pressures to change their bodies, or may do so without being adequately informed about the scope or magnitude of the potential risks, many of which are the subject of ongoing research (e.g., Cass 2024; for critiques, see Grijseels 2024; Horton 2024; Noone et al. 2024; see also Robinson et al. 2023; Gorin 2024; Campo-Engelstein, Jackson, and Moses 2024).

[2]Endosex, in contrast to intersex, refers to "innate physical sex characteristics judged to fall within the broad range of what is considered normative or typical for 'binary' female or male bodies by the medical field, or to persons with such characteristics" (Carpenter, Dalke, and Earp 2023, 225). See also Catto (2020) and Monro et al. (2021).

[3]It is sometimes argued that medically unnecessary (i.e., ritual) female genital cutting is "not a religious practice" but is "merely cultural"—i.e., with the intended implication that it is less worthy of respect or consideration than other forms of ritual genital cutting, such as penile circumcision, or that parents or religious leaders who believe it is religiously required are simply mistaken. However, this view is untenable (Davis 2001; Myers 2015; Earp, Hendry, and Thomson 2017; Duivenbode and Padela 2019a; Dabbagh 2022; Shweder 2023). In at least some Muslim communities (e.g., the Dawoodi Bohra—involved in the *Nagarwala* case), both female and male genital cutting are regarded as obligatory based on locally authoritative interpretations of non-Qur'anic sources of Islamic jurisprudence, such as the Hadith (Bootwala 2019a, 2019b, 2019c; Duivenbode and Padela 2019b; see also Dawson and Wijewardene 2021; Dabbagh 2022).

Taking a large number of factors into consideration, our analysis concludes that clinicians, *qua* clinicians, should not be permitted to perform any nonvoluntary genital cutting or surgery on any child, regardless of the child's sex traits or socially assigned gender, unless doing so is urgently necessary to protect the child's physical health. For *voluntary* procedures, whether in older minors or adults, a different ethical standard might reasonably apply: for example, one that takes into consideration the known or expressed, rather than merely feared or anticipated, psychosocial concerns or identity-based needs of the individual. However, we do not explore that possibility in any great depth, given our focus on nonvoluntary procedures.

The article proceeds as follows. In the next section, we provide historical and medical background on the current treatment of children with intersex traits. We then introduce the contemporary movement for gender-equal "genital autonomy"[4] and further qualify the scope of this article's arguments. Following that, we outline the mainstream ethical consensus regarding genital operations on endosex female children, before returning to the aforementioned hospital pledges to similarly protect children born with intersex traits.

After noting certain gaps and ambiguities in these statements, we highlight their use of the terms "medical necessity" and "physical health" to establish clear ethical benchmarks for proceeding with nonvoluntary genital procedures in this population. We conceptually unpack these benchmarks and argue they are justified. As a part of this, we discuss at length the ethical relevance of human genitalia being considered as "private" or "intimate" anatomy in many cultures.

We then explain why the same ethical standards now widely applied to endosex females, and increasingly to some children with differences of sex development resulting in intersex traits, should ultimately be applied to all children irrespective of sex characteristics. Over the course of the article, we consider and respond to several prominent or likely objections to our proposal, including objections based on presumed parental decision-making authority over children's bodies, claims of harm or benefit in relation to different types of genital modification, and reportedly high rates of retrospective endorsement of childhood genital surgeries in personally affected individuals.

A word about context and scope: Although we believe our arguments are applicable to a wide range of cultural settings, we will limit our analysis in this article to so-called Western countries of the Global North—primarily those in North America, Australasia (viz., Australia and New Zealand), and Europe—insofar as they have relevantly similar healthcare systems, legal traditions, and medical-ethical norms.[5] We also limit our discussion to procedures performed by licensed clinicians in their role as medical providers within regulated healthcare systems. Accordingly, we will not be making any policy suggestions in relation to child genital procedures performed outside of a healthcare context, or by persons other than licensed clinicians operating in that capacity.

Thus, for example, we do not take a position on policies regarding (a) ritual penile circumcision of infants or newborns as carried out by an authorized community member within the context of a religious ceremony (e.g., a *brit milah* in the case of Judaism) (see, e.g., Silverman 2006; for an alternative perspective, see Goodman 1999), or (b) relevantly similar male or female genital cutting practices considered to be religiously required within some sects of Islam (e.g., male or female *khatna*, practiced in some South and Southeast Asian Muslim communities; see note 3 for details) (Rizvi et al. 1999; Merli 2008, 2010, 2012; Johari 2017; Taher 2017; Bootwala 2019a, 2019b, 2019c; Rashid, Iguchi, and Afiqah 2020; Jawher 2021; Shweder 2023; Taher 2023; Subramanian 2023). Although many of the ethical arguments in this article may have relevance for such procedures, our substantive policy proposals are focused exclusively on *nonreligious* procedures, given the distinctive moral and legal concerns that are raised by practices performed in accordance with perceived religious obligations (Rosman 2022). Note that we do, however, briefly discuss so-called "routine" penile circumcision as performed in the United States, as this is widely carried out by licensed clinicians in that country for entirely nonreligious reasons while also being medically unnecessary (for details, see Appendix B).[6]

[4]As Svoboda (2013) explains: "All forms of genital cutting—female genital cutting (FGC), intersex genital cutting (IGC), male genital cutting (MGC), and even cosmetic forms of FGC (CFGC)—are performed in a belief that they will improve the subject's life. Genital autonomy is a unified principle that children should be protected from [nonvoluntary] genital cutting that is not medically necessary" (237).

[5]We acknowledge that the similarity of some of these norms across contexts is due in large part to European colonialism. For a recent discussion of the implications of colonialism for bioethics, see Arguedas-Ramírez (2021).

[6]We note that, in the United States, the overwhelming majority of nonvoluntary penile circumcisions are not, in fact, performed for religious reasons, either by Muslims or Jews; rather, they are performed on a routine basis—i.e., in a "secular" context—by healthcare providers, due to the medicalized, nonreligious majority birth custom unique to that country (see Appendix B). Moreover, these so-called "routine" circumcisions are not generally considered ritually valid, and therefore do not meet traditional religious requirements, at least among ultra-Orthodox Jews, and among many observant Jews more generally (Reis 2021b). As

BACKGROUND ON INTERSEX

To frame our analysis, we will be focusing on the aforementioned hospital-level policy changes regarding genital surgeries in children born with intersex traits (see "Two Recent Pledges" below). Also known as congenital variations in sex characteristics (Carpenter 2018a), intersex traits may be associated with a number of conditions such as congenital adrenal hyperplasia (CAH), partial or complete androgen insensitivity, or mixed gonadal dysgenesis. These variations, in turn, may be caused by a range of factors including interactions among genes or gene expression, enzyme activity, hormone exposure, and hormone receptor function (Liao 2022; Conway 2023). Although intersex conditions may be detected throughout life and are not always recognized at birth, it has been estimated that 1 or 2 out of every 1,000 infants is born with noticeable intersex traits (Blackless et al. 2000; for critical discussion see Sax 2002; see also the exchange between Hull and Fausto-Sterling 2003).[7]

Since the 1950s, influenced by postwar cultural trends and political debates surrounding the nature and mutability of gender (see Eder 2022), U.S. physicians began regularly performing "early" (i.e., infant) genital surgeries in this population. At the time, it was widely believed that a person's sense of themselves as being female or male was more a matter of "nurture" (roughly, gendered socialization) than "nature" (roughly, intrinsic biological factors) (Lee, Mazur, and Houk 2023; for a critical discussion of such distinctions, see Fillod 2014). It was therefore hypothesized that it would be easier to ensure the eventual acceptance of one's medically designated status as a boy or girl if nonnormative sex traits or signs of sexual ambiguity were surgically hidden or removed before the child became aware of them (Gonzalez-Polledo 2017; Catto 2020).

Accordingly, it became standard practice to use surgeries as well as hormonal interventions to try to conform these children's inborn sexual anatomies to prevailing sociomedical ideals for binary or "absolutely dimorphic" male or female embodiment (Blackless et al. 2000). Subsequently, parents were commonly instructed to deliberately conceal, or even lie about, the existence or purpose of these procedures over the course of the child's upbringing, in part to avoid confusing the child (Dreger 1999). The decision about sex (and thus gender) designation for these children was shaped by multiple factors. Historically, these factors have included explicit efforts to prevent or discourage nonnormative ways of being, such as growing up to be gay or lesbian (see Reis 2021a).

A prominent assumption among healthcare providers then, as in the decades since, has been that these early medical procedures would thus promote "normal" psychosocial development: for example, by fostering a more coherent sense of self-identity in relation to dominant norms around sex, sexuality, and gender. It was hoped that this would in turn lead to greater self-esteem and self-acceptance by the child, or at least reduce (anticipated) distress and discomfort experienced by others in response to the child's bodily difference (Reis 2021b). However, the main empirical premises behind this approach, namely, that significant psychosocial benefits would in fact accrue to the child because of early surgery and that these benefits would, moreover, reliably outweigh the associated risks of physical and mental harm, were never subjected to rigorous testing (Creighton and Liao 2004; Liao et al. 2019). Rather, standard practice in this area became entrenched and institutionalized long before the advent of modern evidence-based medicine (Diamond and Beh 2008; Garland and Travis 2020a; Dalke, Baratz, and Greenberg 2020) as well as key developments in bioethics and children's rights (Brennan 2003; Reis 2019; Alderson 2023; Gheaus 2024).

Before proceeding further, it is important to note that the presence of certain intersex traits can, in some cases, signal the likely existence of an underlying physical health problem requiring urgent medical attention, including by means of hormones or surgery: for example, to prevent death or long-term physical impairment (see Feder 2014). A salient example of such a condition is salt-wasting congenital adrenal hyperplasia (CAH), for which hormone replacement therapy may be indicated.[8] So-called "gender

a reviewer points out, it is true that some licensed healthcare professionals do (also) perform ritual circumcisions; however this would not constitute operating *qua* clinician in a professional capacity in our view—rather, it would be acting as a religious official—so these procedures fall outside the scope of our analysis. Whether some form of clinician involvement in a religious ceremony that features child genital cutting or surgery might be consistent with their role-specific duties (e.g., being on standby for harm reduction purposes while a religious official performs the procedure) is an open question. For a discussion of ritual alternatives to penile circumcision in a Jewish religious context, see DuBoff and Davis (2023); for related arguments in a Muslim context, see Dabbagh (2017, 2022).

[7]Drawing on various sources, Abualsaud et al. (2021) give a wider range of estimates: "1 in 4,500–5,500 for strictly defined 'ambiguous genitalia' to 1 in 300 or higher when a broader definition is implemented" (2789).

[8]This so-called "classic" form of CAH can affect both 46,XX and 46,XY individuals. We note that what requires urgent medical attention in such cases is not the possible physical difference in genital morphology, which can range from female-typical to male-typical in appearance, but rather the salt-wasting condition that is life-threatening if left untreated: i.e., by steroid substitution (Lang, Quinkler, and Kienitz 2023), not genital-normalizing surgery.

normalization"[9] procedures, by contrast, which we take as our focus here, do not primarily serve such ethically uncontroversial purposes. Instead, they are done for what are sometimes characterized as "nonmedical" cultural or cosmetic reasons, or, as noted, for intended but unproven psychosocial gains that may or may not materialize (Earp, Abdulcadir, and Liao 2023, 1, paraphrased).

Thus, as critics argue, and as we will discuss further below, there is still today no compelling evidence that *nonvoluntary* genital "normalization" procedures actually cause, or even tend to cause, net positive outcomes in affected individuals, whether in terms of social adjustment, identity formation, self-acceptance, family dynamics, sexual satisfaction, romantic success, or any other facet of individual or relational well-being (for discussions, see Cabral Grinspan and Carpenter 2018; Dalke, Baratz, and Greenberg 2020). More specifically, there is no evidence of causal effectiveness of early surgery in these domains relative to, or controlling for,

a. less risky or invasive interventions such as psychosocial counseling,
b. *voluntary* surgery later chosen by oneself, if desired, under conditions of informed consent, or
c. a combination of both.

Meanwhile, evidence of harm accumulates. With respect to self-acceptance or self-esteem, for instance, many intersex individuals report feeling that the historical standard of care (i.e., nonvoluntary surgeries, as well as repeated hormonal interventions, frequent medical visits, invasive genital examinations, being deceived by doctors and parents, and so on) had the opposite of the intended effect. It made them feel they could *not* be loved or accepted by others unless or until they were medically "fixed" or "made normal"—no matter how physically damaging or emotionally painful the means (for examples and discussion, see Chase 1998a; Dreger 1999; Davis 2015; Wall 2015; Zieselman 2015; Pagonis 2017; Cabral Grinspan and Carpenter 2018; Sosin 2020; Hart and Shakespeare-Finch 2021; Pagonis 2023; Haghighat et al. 2023).

In addition, and most importantly for our purposes, the recent hospital pledges resulted from years of advocacy, protest, and attempts at consciousness-raising by intersex adults who did not only regard themselves as having been physically or psychosexually *harmed* by the genital surgeries to which they were subjected as children, but who also felt, more fundamentally, that they ought to have been given a free and informed *choice* about whether to undergo such surgeries when they were older and capable of understanding the stakes (see previous references).[10]

A MOVEMENT FOR GENITAL AUTONOMY—AND QUALIFYING THE SCOPE OF THE ARGUMENT

The focus on personal choice in relation to (decisions about) one's so-called "intimate" anatomy (see Box 1 for a discussion of this terminology and its ethical relevance) is not unique to advocates for intersex rights. Rather, it has been at the heart of a now-worldwide movement for genital autonomy whose contemporary origins stretch back until at least the 1980s or 1990s.[11] This movement has been, and continues to be, spearheaded by persons of all sex characteristics and gender identities who object passionately to having been subjected to nonvoluntary genital procedures in early childhood for contestable sociocultural reasons (e.g., conformity to gendered body aesthetics or heteronormative sexual expectations) rather than out of a universally recognized physical health need.

Of course, individuals who resent having had their genitals modified before they could give or withhold consent may not be representative of all who experienced such surgeries, many of whom report feeling undisturbed by, or even appreciative of, the changes made to their bodies earlier in life. Indeed, in some surveys of individuals who underwent such surgeries,

[9]Some in the medical community use the term "reconstructive" to describe these surgeries (e.g., Buyukunal et al. 2021); however, such language might be taken to imply that something is being constructed "again" (i.e., restored to a former structure), whereas that is not accurate in the cases under consideration. Instead, genitalia that have only ever existed postnatally in one configuration are being surgically fashioned into a novel configuration, albeit one that attempts to approximate an abstract perceived ideal for binary gendered bodies. See, for example, Kraus (2013). For an analysis of the importance and ethical implications of word choice in medicine, see Somerville (2006, 76).

[10]Against this view, it is sometimes argued that certain nonvoluntary genital procedures carry a lower risk of surgical complications or have other medical advantages in comparison to their voluntary analogues, and thus that the procedures are not directly comparable. We address this argument in Box 3 and in Appendix B. However, even if such disputable empirical claims were simply granted for the sake of argument, this would not defeat the view that individuals have a right against clinicians performing medically unnecessary surgical procedures on their sexual anatomy that they (the individuals) did not choose.

[11]For illustrative contributions or analysis, see these references (Somerville 1980; Wallerstein 1980; Romberg 1985; Denniston and Milos 1997; Van Howe and Cold 1997; Chase 1998a; Toubia 1999; Junos 1998; Lightfoot-Klein et al. 2000; Frisch 2002; Androus 2004; Dekkers, Hoffer, and Wils 2005; Fox and Thomson 2005; Glick 2005; Ehrenreich and Barr 2005; Darby and Svoboda 2007; Dreger and Herndon 2009; Swarr, Gross, and Theron 2009; Fox and Thomson 2009; Denniston, Hodges, and Milos 2010; DeLaet 2012; Mason 2013; Svoboda 2013; Johnson and O'Branski 2013; Carpenter 2016; Ammaturo 2016; Meddings and Wisdom 2017; Meoded Danon 2018; Bauer, Truffer, and Crocetti 2020; Behrensen 2021; Chambers 2022; Remennick 2022; Meoded Danon, Schweizer, and Thies 2023; Fusaschi 2023; Chapin and Garrett 2024; Allan 2024).

it is a minority of respondents who report opposing them, albeit with considerable variance in opinion depending on the questions asked and the respondent's diagnosed condition (e.g., Bennecke et al. 2021; for a recent review of such findings, see Meyer-Bahlburg 2022). As we will discuss, such surveys tend to have low response rates and may be subject to confirmation bias, sampling bias, or selection bias, among other forms of bias affecting representativeness, meaning that the true distribution of attitudes and experiences in the relevant population is unknown. However, even if it is "only" a sizable minority of affected persons who feel harmed or violated by early genital surgery, this would not thereby vindicate the status quo. As Bennecke and colleagues note, "the justification of elective genital surgery in childhood is fundamentally an *ethical* problem; solutions for ethical problems should not simply be based on the attitude of majorities" (920, emphasis added).

It is therefore necessary to evaluate the specific arguments raised by proponents of genital autonomy, as well as those raised by their critics, to reach an informed conclusion. This is why we have come together as a group of interdisciplinary scholars, subject-area experts, and other stakeholders—with a range of attitudes and experiences among us—to formulate and defend a coherent medical-ethical standard in this area: that is, a standard for when it is permissible, or impermissible, for a licensed healthcare provider to "prick," cut, excise tissue from, or (otherwise) surgically operate on the genitals of a child who cannot consent on their own behalf.

We reiterate that we consider *ethical* permissibility only. Although we refer to laws that criminalize all forms of medically unnecessary genital cutting or surgery on endosex females, we acknowledge that what is unethical or professionally unacceptable and what should be criminal are different questions.[12] As noted previously, therefore, we do not take a position on whether it is justified to apply criminal penalties to those who perform such procedures, be it on endosex females, endosex males, or children born with intersex traits (whether categorized as female or male). Instead, we are concerned solely with the ethical obligations of healthcare providers acting in that professional capacity who are therefore bound by established principles of healthcare ethics and role-specific duties and standards.

On the patient side, again, we are concerned *only* with legal minors who have not yet entered puberty (Euling et al. 2008). We will assume, for the sake of argument, that all such minors are insufficiently autonomous with respect to medically unnecessary genital cutting or surgery to provide their own ethically valid consent. In any case, our recommendations apply exclusively to prepubescent minors who are insufficiently autonomous with respect to such procedures (for a theoretical discussion, see Zagouras, Ellick, and Aulisio 2022). To avoid ambiguity, we will use the word "child" in a specialized sense to refer to such minors, and only such minors, going forward. Our question, then, has to do with the "zone of parental discretion" for authorizing medically unnecessary genital cutting or surgery on behalf of a child so defined (Alderson 2017; Gillam 2016). Medical necessity is defined later in the article.

LIMITS ON PARENTAL AUTHORITY: FROM STATUS QUO TO PARADIGM SHIFT

In the countries with which we are exclusively concerned (see above), it is uncontroversial that parents[13] are not entitled, whether legally or morally, to authorize simply whatever incursions into their child's body they may choose, even if they have benevolent intentions (Taylor-Sands and Bowman-Smart 2022). Nor are clinicians permitted to perform whatever surgical procedures a child's parents might request. Instead, there is a spectrum of potential surgeries or (other) body modifications a clinician might be asked to perform, ranging from the clearly permissible (e.g., life-saving heart surgery) to the clearly impermissible (e.g., facial scarification, ritual tooth extraction), with a number of less obvious examples in between (e.g., ear-pinning, surgery for polydactyly) (Council on Ethical and Judicial Affairs 2019; Hodges, Svoboda, and Van Howe 2002; Sarajlic 2020).

However, a lack of professional consensus regarding some cases does not entail that a policy of default deference to parental requests for surgery would necessarily be justified (Godwin 2015; Odhiambo Oduor 2022). Instead, due to children's heightened dependence, vulnerability, and (relative) inability to decline or adequately defend themselves against unnecessary or nonvoluntary interventions into their bodies, it is widely agreed that clear ethical standards as well as appropriate practical measures to protect their bodily

[12]There are various conflicting legal arguments in this space, and there is no consensus among the present authors as to which set of arguments is most compelling (e.g., Van Howe et al. 1999; Davis 2001; Schüklenk 2012; Merkel and Putzke 2013; Johnson 2013; Ben-Yami 2013; Savulescu 2013; Berer 2015; Munzer 2015; 2017; Berer 2019; Ammaturo 2016; Jacobs and Arora 2017; Ahmadu 2017; Balashinsky 2018; Chambers 2018; Cohen-Almagor 2020; Möller 2020; Jacobs 2021; Gruenbaum and Ahmed 2022; Duivenbode 2023).

[13]Or legal guardians; we will use "parents" throughout for simplicity.

integrity and (future) bodily autonomy are required (Van Howe 2013a; Hill 2015; Möller 2017; Gheaus 2018, 2021; Godwin 2011; Council on Ethical and Judicial Affairs 2019; Taylor-Sands and Bowman-Smart 2022).

This special concern for children's rights and welfare can be seen, for example, in the development of enhanced healthcare ethics guidelines for dealing with pediatric populations, or more generally in laws defining child-specific abuse or maltreatment. Irreversible, or hard-to-reverse, skin-breaking procedures that alter external body morphology, yet are not clearly medically indicated, come in for heightened scrutiny in this regard. For example, cosmetic body piercing or tattooing of young children is prohibited in many jurisdictions, including multiple U.S. states, notwithstanding parental permission (NCSL 2019; Breuner et al. 2017; Chegwidden 2009; Loue 2020). Even spanking or hitting a child "for their own good" has been banned as a form of discipline in more than 50 countries,[14] despite typically leaving no lasting physical mark (Gershoff and Durrant 2020).

In line with these measures, we think it is necessary to clarify the circumstances under which a physician, nurse, or other healthcare provider ("clinician" for short) may permissibly cut or surgically alter a child's genitalia. Such clarification is necessary both for the sake of the child, to protect them from needless injury or unwarranted intrusions into their genital anatomy, and for the sake of the clinician, so that there is no confusion about when potential interventions into a child's genitalia would violate professional ethical standards. Of course, clinicians must act with due discretion and sensitivity toward their child-patients in all aspects of their embodied personhood. But when dealing with a child's genital, sexual, or reproductive anatomy, extra care and caution are required (Fish, McCartney, and Earp 2023).

Consistent with this perspective, there is already a wide consensus as to the precise ethical limits of actions clinicians may take in relation to the genital or sexual anatomy of at least some children. This consensus holds that it is never ethically permissible—indeed, it is a serious criminal offense in the United States and elsewhere—for a clinician to cut into, remove healthy tissue from, or otherwise surgically alter the genitals of any child whose sex characteristics are deemed to be biologically normative for girls: that is, endosex females. Accordingly, with just one exception to be discussed shortly, *any* cutting or surgery, no matter how superficial, is considered to fall outside the zone of parental discretion.[15] This means that clinicians are not permitted to perform such a procedure even if they judge it is unlikely to cause serious, or indeed any, long-term physical harm; even if the parents believe the cutting is a cultural or religious obligation; and even if a plausible case could be made that performing the operation would leave the child better off in certain respects: for example, due to anticipated psychosocial benefits, or in terms of harm reduction through medicalization (AAP 2020; UN 2016; STOP FGM Act of 2021; for recent critical discussions, see Kimani, Barrett, and Muteshi-Stranchan 2023; Shell-Duncan 2023; Van Eekert et al. 2024).

As noted, there is just one exception to this strict prohibition, not only legally, but also in terms of professional standards of care and contemporary codes of medical ethics: namely, when the genital operation is *medically necessary* and so cannot, by any reasonable standard, be delayed or deferred until the girl or woman (or trans or nonbinary individual)[16] can consent. If the cutting is not medically necessary, by contrast, it is widely agreed she must be given the opportunity to decide for herself, when she is sufficiently mature,[17] whether she accepts the following:

[14]This includes most of the countries of Central and South America, most of Europe (including Scotland and Wales in the United Kingdom), multiple countries in Africa and central Asia, and New Zealand. Although the United States and Canada have not explicitly banned all corporal punishment of children, the leading pediatric societies of those countries do oppose the practice (AAP 2018a; CPPCY 2004).

[15]There have been a small number of attempts to argue against this ethical consensus, or at least the punitive legal manifestation of it in the form of criminalization, in recent years. These authors suggest that clinicians in Western countries should, in fact, be allowed to perform (what they regard as) *de minimis* forms of nonvoluntary ritual female genital cutting of minors (e.g., AAP 2010; Arora and Jacobs 2016; Jacobs and Arora 2017; Duivenbode and Padela 2019a; Porat 2021; Shweder 2022b; Duivenbode 2023), including the cutting or removal of part or all of a child's healthy clitoral hood or labia, at the request of the parents (i.e., WHO FGM Types 1a, 2a, or 4). However, although debates about the merits and demerits of criminalization continue, arguments that such cutting is *ethically* permissible for clinicians to perform have had little uptake; moreover, they have been addressed at length in previous publications, including by some of the present authors (Earp 2016b, 2022a; Shahvisi 2016; Weisenberg 2023). Nevertheless, rather than treating the mainstream ethical consensus view as obvious, much of the present article can be read as an (additional) attempt to provide reasons and arguments in support of this view, while also extending it to other cases and drawing out practical policy implications.

[16]For an overview of relevant sex and gender distinctions, see Bauer (2023); see also Ziemińska (2022) and Cederroth et al. (2024).

[17]We note that judgments about "sufficient maturity" to undergo (female) genital cutting have, in many contexts, been heavily racialized, with women and girls of color deemed not to have sufficient agency or maturity in situations where white women and girls are simply assumed to have these qualities (Conroy 2006; Villani 2009; Dustin 2010; Bader 2016; Boddy 2016, 2020; Florquin and Richard 2020; Abdulcadir et al. 2020; Shahvisi 2023; Townsend 2023b). Although we do not take a stand on the specific criteria by which "sufficient maturity" (i.e., to decide about undergoing a medically unnecessary genital procedure) should be assessed, we do insist that, whatever the appropriate criteria are, they be applied without such invidious discrimination (see also Ahmadu 2017).

1. the risks, however slight, that would accompany the application of a sharp instrument to her genitalia or the removal of live tissues therefrom, in exchange for
2. anticipated benefits, whether aesthetic, prophylactic, psychosocial, sexual, cultural-symbolic, or spiritual-metaphysical that she herself endorses in light of her known or established (rather than merely predicted) beliefs, values, preferences, personal commitments, and sense of self or identity, and that
3. she seeks to attain *through genital cutting specifically* (as opposed to various other possible means of pursuing such purported or intended benefits).

Unless it is medically necessary, that is, *any* cutting or surgery carried out by a clinician on the external genitalia of a child deemed to have female-typical sex traits is regarded as categorically unethical.[18] Accordingly, there seems to be a powerful expectation in Western societies that endosex girls have a right not merely to be consulted about, or involved in, so intimate and irreversible a decision as to whether their sexual organs will be cut or altered, but also to be allowed—barring a relevant physical health emergency—to autonomously consider and accept or refuse such a personally significant procedure.

We argue this expectation is reasonable. Accordingly, we suggest, the corresponding strict prohibition on clinicians performing medically unnecessary genital cutting or surgery in this population is justified, particularly in terms of hospital policies and professional codes of conduct. However, we go further to suggest that this moral-cum-professional prohibition ought not be applied in a discriminatory manner, that is, only with respect to procedures performed on endosex females. Rather, it must equally cover children born with intersex traits, whether categorized as female or male at birth, as well as children born without such traits who are categorized as male.

To illuminate these points, we will now examine in detail the two aforementioned hospital-level policy changes regarding intersex surgeries in the United States. In doing so, we go beyond previous work to

[18]In the United States, as mentioned, it is also a federal crime and a felony irrespective of parental motivation or anticipated harm level (see STOP FGM Act of 2020), with comparable legal prohibitions in many other countries (see, e.g., Hatem-Gantzer 2023). As demonstrated by the recent U.S. case concerning a Muslim physician accused of ritual "pricking" (or similar) in a clinical setting for explicitly religious reasons (i.e., the *Nagarwala* case), physicians who engage in such interventions are liable to lose their licenses, and may be subject to arrest and criminal prosecution (Bootwala 2023).

Box 1. Why are some body parts but not others widely considered "intimate" or "private"?

Material in this box is adapted and expanded from Earp and Bruce (2023) and Buckler, Bruce, and Earp (2023).

As philosopher Talia Mae Bettcher argues, there are nonarbitrary reasons why grabbing someone's genitals without their consent, versus grabbing, for example, their hand or shoulder without their consent, is usually a more serious wrong. She argues there is a distinctive violation involved in the former that is not usually involved in the latter. This violation has to do with the relationship between (a) selective, voluntary exposure of our genitals (or other putatively "private" body parts, such as breasts or anus) under certain circumscribed conditions (usually based on a personal decision to "open ourselves up" to others' engagement with those normally hidden body parts), and (b) the very possibility of certain kinds of human intimacy (Bettcher 2023). As she writes:

> Intrinsic intimacy [is] made possible by the existence of [certain personal] boundaries. Without them, there would merely be unselective, unfettered sensory and informational access to one other. Further, intrinsic intimacy is made possible by the standard observation of boundaries. Without the default of interpersonal distance, intimacy could not be possible. Specifically, the capacity for [voluntary] self-display would be undermined, and with that, the capacity to exert intimate agency over closeness and distance would be undermined. (6)

Why it is that a "default interpersonal distance" has been socially constructed around the genitals, in particular, in many societies (i.e., more so than virtually all other body parts) is an important question to which we will turn in a later section. However, for present purposes, it is enough to note that, for whatever reason, the genitals are so constructed—and this imbues them with special social significance. And yet, "medical practice cannot abstract itself from the culture in which it operates; thus we have [for example] the practice of requiring chaperones when male doctors perform pelvic exams [and] other ways in which the medical establishment acknowledges the special status and concerns that attach to the [sexual or] reproductive parts of our bodies" (Davis 2003b, 194).

As Bettcher concedes, when clinicians gain intimate access to our bodies for medical purposes, "the pursuit of intimacy is not the aim." Rather, "health is, and the traversal of sensory boundaries may be *necessary* for medical purposes" (Bettcher 2023, 6, emphasis added). If it is not necessary, however—and we also have not consented—the background conditions for appropriate traversal have not been met: our boundaries have been violated. This is to say that the very boundaries that make certain forms of intimacy possible in our lives, including sexual intimacy with chosen partners, are disrespected by such unconsented traversals.

Thus, as Marit van der Pijl and colleagues have recently argued, "the social meaning of these body parts leaves a very small margin for error [in a medical context] because invasion of these body parts without consent is an, unfortunately, relatively widespread and well-known social phenomenon with [a] degrading, humiliating and dehumanizing meaning. The medical setting cannot fully escape this connotation [which] means that extra care is needed to ensure one only touches and invades these body parts with consent [outside of medical emergencies]" (van der Pijl et al. 2023, 614).

Of course, very young children, including infants, do not (yet) have the capacity to voluntarily "open themselves up" to others' engagement with their sexual organs, whether in a medical context or otherwise; nor do they (yet) have a sense of their genitalia as "intimate" anatomy: that is, anatomy with respect to which they will one day have, or be able to exercise, an especially strong right to set and maintain certain personal boundaries. However, with time and socialization, most will come to acquire such a capacity and sense. If they learn, therefore, that prior to their ability to exercise this essential boundary-setting right, their "intimate" anatomy was *already* cut or altered for reasons other than medical necessity, they may reasonably come to conclude that (what should have been) an exceptionally personal choice about their sexual embodiment has been usurped. See the section "Private Anatomy, Personal Choice" for further discussion.

highlight significant problems not only with the status quo, but also with morally incoherent attempts at reform. Given these problems, and what we see as the most ethically principled way of resolving them, we argue for a paradigm shift in the medical treatment of children's bodies, particularly with respect to cutting or surgery into their genital, sexual, or reproductive organs (i.e., "intimate" anatomy; see Box 1).

The paradigm shift, briefly stated, is this: Instead of drawing lines of moral permissibility or impermissibility around (a) subjective, vague, contestable, and often culturally biased[19] third-party assessments of expected levels of net harm or benefit (i.e., utility calculations), or around (b) the assigned or assumed sex- or gender-class membership of an infant or child based on their congenital bodily features, the medical ethics of *nonvoluntary* genital cutting or surgery in prepubescent minors should, we suggest, turn exclusively on considerations of medical necessity as defined and elaborated below (see "Physical Versus Mental Health and Medical Necessity").

Simply put, if the proposed cutting or surgery is medically necessary, it may permissibly be performed by a licensed clinician on a child who lacks decision-making capacity if there is valid parental permission (Council on Ethical and Judicial Affairs 2019).[20] If the same surgery is medically unnecessary, however, it is not permissible for clinicians to perform it, even if it is requested in good faith by the child's parents with the belief it will improve the child's life (e.g., by potentially reducing the likelihood of future teasing or other possible social mistreatment).

See Figure 1 for a schematic representation of our proposal. Note that this proposal concerns specifically genital-related cutting or surgery by healthcare providers operating within their professional capacity; it is not intended to apply to all possible interventions into a person's body that might take place in a healthcare context (or elsewhere). We justify this special focus below, drawing in part on considerations we have already spelled out in Box 1.

In the next section, we zoom in to describe the two aforementioned hospital pledges to stop performing some intersex surgeries and try to clarify the underlying moral reasons behind the pledges. We argue that these reasons have more to do with preserving certain intimate personal choices or (future) sexual boundary-setting abilities than with medical or nonmedical benefit–risk assessments carried out prospectively by third parties such as clinicians or parents. We argue that these reasons are sound.

We then explain why this reasoning should not be applied in a selective or discriminatory manner only to some children—that is, those with certain specific genital anatomies—but rather to all children, representing the full diversity of human genital anatomies. In addition to the children characterized as "intersex" by the hospital pledges, we include children with conditions such as hypospadias who are not explicitly covered by the pledges, as well as children who, at birth, do not appear to have any sex-developmental differences, whether they are categorized as female or male.[21]

TWO RECENT PLEDGES

In July 2020, following a three-year campaign against the hospital led by intersex activists Pidgeon Pagonis and Sean Saifa Wall,[22] Lurie Children's Hospital of Chicago announced that it had voluntarily stopped performing some—but not all—"medically unnecessary" surgeries on children born with intersex traits (Neus 2020). There is disagreement about which specific bodily configurations should fall under the "intersex" umbrella (Liao and Baratz 2022), and some may choose to avoid this term altogether due to its complex political associations. However, whatever they are called, the traits in question are unified by their perceived incongruity with one or more normative criteria for classifying persons, based on their inborn sex characteristics (e.g., chromosomes, gonads, hormone receptors, or external genital morphology), as being exclusively or typically either female or male (Monro et al. 2021; Kraus 2015). According to the hospital statement, feedback and testimonials from members of the intersex community had caused them to reflect critically on historical standards of care, including the underlying sociocultural motivations for performing early genital surgeries on this population:

> We recognize the painful history and complex emotions associated with intersex surgery and how, for many years, the medical field has failed these children. Historically care for individuals with intersex traits included an emphasis on early genital surgery to make

[19]See, e.g., Davis (2003a); Van Howe (2011); Frisch et al. (2013); Earp and Shaw (2017). See also Godwin (2021).

[20]Determining the right set of requirements for a valid parental permission in these circumstances (sometimes called parental "proxy" consent, although this is controversial) is outside the scope of this article.

[21]Some children who are reflexively classified as either female or male at birth based on their external genital morphology nevertheless discover later in life, sometimes due to bodily changes associated with puberty, or as a result of seeking medical care for an unexplained health issue, that they do in fact have one or more differences of sex development or intersex traits, whether in terms of chromosomes, hormonal function, or internal reproductive characteristics (Cabral Grinspan and Carpenter 2018; Conway 2023).

[22]Co-founders of the Intersex Justice Project: https://www.intersexjusticeproject.org.

Status of Genital Intervention (i.e., cutting or surgery)	**Consensual** (competently authorized by the affected individual)	**"Gray Zone"** (agreement given by the affected individual; consent capacity/validity unclear)	**Non-consensual** (due to incapacity)	**Non-consensual** (due to competent refusal)
Medically Necessary (e.g., urgently required to prevent premature death or serious physical impairment)	Permissible	Potentially permissible, especially if valid "proxy" consent/permission (also) obtained	Permissible if valid "proxy" consent/permission obtained (where possible)	**Impermissible**
"Gray Zone" (medical necessity status unclear)	Permissible	Potentially permissible, especially if valid "proxy" consent/permission (also) obtained	Potentially permissible if valid "proxy" consent/permission obtained	**Impermissible**
Medically Unnecessary	Likely permissible (e.g., voluntary "cosmetic" surgeries)	Likely impermissible, especially without valid "proxy" consent/permission	**Impermissible**	**Impermissible**

Figure 1. An illustrative model for determining the permissibility of genital cutting or surgery in a medical context; adapted with permission, along with this figure description, from Earp, Abdulcadir, and Liao (2023). The model is based on widely accepted standards in contemporary medical, pediatric, and sexual ethics and codes of professional conduct, although it may not reflect a universal consensus. Interventions into nongenital (or sexual/reproductive) areas of the body may not fit this model. The gray section represents maximal uncertainty: cases in which neither medical necessity nor consent status is clear. Note: Moral permissibility or impermissibility does not necessarily entail legal permissibility or impermissibility.

> genitalia appear more typically male or female. As the medical field has advanced, and understanding has grown, we now know this approach was harmful and wrong. We empathize with intersex individuals who were harmed by the treatment that they received according to the historic standard of care and we apologize and are truly sorry. (LCH 2020, n.p.)

We expect that this statement will be seen as a watershed moment for intersex rights in the U.S. context, and to some extent around the world (see Box 2 for international developments). Public recognition by a major healthcare institution of its history of medicalized harm and wrongdoing is rare and takes extraordinary courage. This should not be understated. Now, the hospital website affirms that "irreversible genital procedures" in children with intersex traits "should not be performed until patients can participate meaningfully in making the decision for themselves, unless medically necessary" (LCH 2020).

Boston Children's Hospital soon followed suit (Luthra 2020). In October 2020, a media spokesperson stated that clinicians associated with the hospital "will not perform clitoroplasty or vaginoplasty in patients who are too young to participate in a meaningful discussion of the implications of these surgeries, unless anatomical differences threaten the physical health of the child" (*ibid.,* n.p.). Finally, as of July 2021, it was reported that New York City Health & Hospitals, "the largest public healthcare system in the United States, has [also] instituted a policy to defer all medically unnecessary surgeries on intersex children" (Knight 2021, n.p.).[23]

We congratulate the medical staff and hospital administrators who authorized these important changes, in response to years of impassioned advocacy by intersex people and their allies. We also urge that parents be thoughtfully included in these change efforts by being provided with education and support. Clearly, it will not be enough simply to prohibit certain surgeries without putting substantial resources toward other modes of care, including individual and family-based psychological counseling, while also ensuring that these resources are equitably accessible and can effectively be used (Liao 2022). Even so, we suggest that, in order to fully appreciate the implications of this historical moment, further reflection and analysis are required.

For example, how the statements are being translated into practice is not clear. Both Lurie and Boston Children's hospitals invoke the notion of "meaningful participation" in discussions about potential genital surgeries by the persons whose bodies would be affected. However, it is one thing for an individual to "participate meaningfully" in a decision about whether to undergo a surgery; it is another for that individual actually to agree or assent to—much less validly consent to—the permanent alteration of their own genitals. Which of these levels of participation do the hospitals mean to invoke (Waligora, Dranseika, and Piasecki 2014)?

There are also some hedges and omissions in the pledges. For example, the Lurie statement singles out children with congenital adrenal hyperplasia (CAH) as a "potentially separate patient population,"[24] and none of the hospital statements mentions children with hypospadias. CAH is an adrenal condition that can affect the size and shape of the genital shaft or glans (Dalke and Baratz 2021), and hypospadias is an anatomical variation in which the urethra opens below the tip of the glans along the ventral side of the organ (when it opens on the top or dorsal side, this is known as epispadias) (Wood and Wilcox 2022; CDC 2019). Together, hypospadias and CAH make up the vast majority of sex-development variations for which the surgeries in question are currently pursued: namely, surgeries whose primary aim is to render the child's body more "typically" male or female in function or appearance, even when there are no urgent physical health concerns that require such surgical treatment (Blackless et al. 2000; Klöppel 2016). Moreover, it is not clear whether the hospitals have only external genitalia in mind, or whether internal genital organs such as gonads are also to be covered by the updated policies (for discussion, see Pagonis 2017).

These uncertainties and ambiguities, we suggest, leave room for ethically questionable genital modification procedures on children to continue. Such procedures may include "feminizing" surgeries (e.g., clitoral reduction) on children with CAH raised as girls, surgeries to release chordee or reposition the urethral opening in children with hypospadias (including in rare cases, 46,XX children with CAH raised as boys; Lee and Houk 2010; Kraus 2017), surgeries to remove nonmalignant internal genital parts from children whose bodily differences do not pose a serious or time-sensitive threat to their "physical health" (as per the language of the Boston statement) (Cools et al. 2018; Peard et al. 2023; O'Connell et al. 2023; Ho et al. 2024), and surgeries to remove the healthy genital prepuce (i.e., through routine, nonreligious penile circumcision) from children who may or may not have any recognized differences of sex development.

To address these actual and potential loopholes, it is necessary to get a firmer grip on what is normatively at

[23]According to the intersex advocacy group interACT, the updated policy of New York City Health & Hospitals (NYC H+H) states: "All medically unnecessary surgery on Intersex [children] should be delayed until the child is of an age to assent/consent (adolescence). If parents are requesting such surgery, the rights of the child to be protected from harm should take precedence over the demands of parents for intervention. … Therefore, NYC H+H hospitals should respect the child's increasing decision-making authority and moral understanding and not perform any medically premature procedures" (Brown-King 2021, n.p.).

[24]The statement reads: "For patients with CAH, many of whom do not consider themselves under the intersex umbrella, the question of early surgery requires immediate and critical evaluation, as there remain unanswered questions about best practices, ethics and how to optimize medical outcomes. For the overwhelming majority of these CAH patients, surgery plays no role in the management of their medical condition. When it comes to surgery, we are committed to reexamining our approach. [However, until our] practices [are thoroughly] re-evaluated, we will not perform any surgical procedures on children with CAH outside of those deemed medically necessary" (LCH 2020, n.p.). Given this stance, we hope that our article can contribute constructively to the process of reevaluation.

stake across all such cases. In particular, as noted, we need to understand exactly *when* and *why* it is (in)consistent with medical ethics for a healthcare provider to operate on a child's genitals, whatever the child's sex characteristics may be. We flesh out this account in the following sections. As a part of this, we elucidate the concepts of "physical health" (mentioned in the Boston statement) and "medical necessity" (mentioned in the Lurie statement) and explain their role in furthering children's bodily integrity interests, while also leaving certain "personal decisions" to the individual to make when they have the relevant capacities (Fox and Thomson 2017).

Box 2. Recent developments in the United States and beyond: an international overview.

Within the United States, the Council on Ethical and Judicial Affairs of the American Medical Association produced a measured analysis in 2019 that raised various relevant ethical considerations, for example, "To what extent would the proposed intervention (or lack of intervention) foreclose important life choices for the adolescent and adult the child will become? Are there reasonable alternatives that would address immediate clinical needs while preserving opportunity to make important future choices?" (6). The Council stopped short of making a blanket policy recommendation against medically unnecessary intersex surgeries in children. However, in a press release coinciding with Intersex Awareness Day (Miller 2023), the U.S. Department of State under President Biden has taken a clear stand against such procedures:

> Intersex persons often [are] subjected to medically unnecessary surgeries. These harmful practices, which can cause lifelong negative physical and emotional consequences, are a medical form of so-called conversion therapy practices in that they seek to physically "convert" Intersex children into non-Intersex children. We applaud all activists, organizations and governments working to raise visibility and protect Intersex persons' rights to bodily integrity and to ensure equal protection and recognition before the law.

Meanwhile, outside the United States, national senates, bioethics committees, and human rights institutions have conducted numerous inquiries into intersex-related medical practices, considering evidence from community, clinical, legal, and human rights stakeholders and releasing various reports and statements (Swiss National Advisory Commission on Biomedical Ethics 2012; German Ethics Council 2012; Senate of Australia Community Affairs References Committee 2013; Council of Europe 2015; Centro de Derechos Humanos UDP 2016; Sénat—France 2017; Kenya National Commission on Human Rights 2018; Danisi, Dustin, and Ferreira 2019; Australian Human Rights Commission 2021; Delhi Commission for Protection of Child Rights 2021). For the most part, these statements have adopted positions more in line with the U.S. State Department position quoted earlier.

Since 2009, multiple United Nations Treaty Bodies, including the Committee on the Rights of the Child, the Committee on the Rights of Persons with Disabilities, the Human Rights Committee, and the Committee Against Torture, have likewise issued recommendations against medically unnecessary, nonvoluntary intersex genital surgeries (Intersex Rights 2022). Moreover, the African Commission on Human and Peoples' Rights (2023), the Parliamentary Assembly of the Council of Europe (PACE 2017), and the European Parliament (European Parliament 2019) have passed resolutions calling on their member states to prohibit "sex-normalizing" surgeries and other medical treatments on children with intersex traits, and to respect rights to "bodily integrity, physical autonomy and self-determination" (African Commission on Human and Peoples' Rights, 2023). Finally, on April 4, 2024, the United Nations General Assembly passed a historic resolution expressing "grave concern" about "medically unnecessary or deferrable interventions, which may be irreversible, with respect to sex characteristics, performed without the full, free and informed consent of the person, and in the case of children without complying with the provisions of the Convention on the Rights of the Child" (Human Rights Council 2024).

In 2015, Malta became the first country to partially outlaw intersex normalizing surgeries (Maltese Parliament 2015). As of January 2024, Portugal, Germany, Iceland, Greece, Spain, and a first jurisdiction in Australia have passed similar laws (Intersex Greece 2022; Anarte 2021; ILGA-Europe 2018; Jefatura del Estado 2023; ACT Government 2024). Meanwhile, comparable legislation is under consideration in other jurisdictions, including in Australia (Victoria Department of Health 2023) and India (Delhi Commission for Protection of Child Rights 2021). However, despite these developments, some advocates for intersex rights have stressed that the new laws are not being fully enforced: Medically unnecessary, nonvoluntary intersex genital surgeries have remained pervasive despite the prohibition in Malta (Costa 2020), and Portugal has been reprimanded twice by the UN Committee on Civil and Political Rights for allowing such surgeries to continue (Pereira 2022).

Others have stressed that certain weaknesses, loopholes, and exceptions (e.g., for hypospadias surgery) remain in the laws that have so far passed or are currently being considered, and have called for more thoroughgoing provisions to protect the bodily integrity rights of persons with intersex traits (Garland and Travis 2018; Bauer, Truffer, and Crocetti 2020; Garland et al. 2021; Meoded Danon, Schweizer, and Thies 2022; Ní Mhuirthile et al. 2022; Garland and Travis 2023; Rubashkyn and Savelev 2023; DeLaet, Earp, and Miller 2024).

PRIVATE ANATOMY, PERSONAL CHOICE

Our position regarding healthcare settings is that all medically unnecessary, nonvoluntary genital cutting or surgery, as such, infringes the right of individuals to set and maintain certain important personal boundaries having to do with their sexual or reproductive anatomy (see Box 1 for background). They are therefore wronged by any such cutting or surgery, *regardless of the anticipated level of harm or benefit as judged by an outside party* (i.e., someone other than themselves). We will begin by expanding on the "personal boundaries" aspect of this argument, before unpacking the concepts of physical health and medical necessity.

According to the statement from Lurie Children's Hospital, quoted above, "Decisions about if and when surgery is performed [to alter] the appearance of the genitalia, are some of the most personal decisions an individual can make" (LCH 2020, n.p.). We agree with this—but elaboration is required. This is because the special status of the genitals in relation to personal autonomy and sexual boundary-setting is often elided in debates about child genital cutting or surgery.

For example, defenders of medically unnecessary genital operations in childhood will sometimes raise analogies with other interventions (or activities) that

parents routinely authorize without much controversy: ones that expose the child's body to some amount of risk of harm despite not being medically necessary, which nevertheless are widely seen as permissible in Western and other countries. For example, they may mention infant ear-piercing, removal of digits (fingers) that exceed the expected number per hand, pinning back of ears that are perceived to "stick out" more than usual, cosmetic orthodontia, and even certain contact sports such as ice hockey or American football (Holm 2004; Bester 2015; Jacobs and Arora 2015). However, whatever one thinks of the permissibility of these various interventions or activities,[25] one thing they do not do is concentrate surgical risk on, nor deliberately remove living tissue from, the genital, sexual, or reproductive anatomy of a nonconsenting person.

As mentioned previously in Box 1, in many (perhaps most or all) cultures, the genitals, whether internal or external, are imbued with a special significance: They are implicated to a high degree in people's sense of privacy, dignity, sexuality, bodily integrity, and bodily autonomy—that is, their ability to decide how others may or may not interact with their embodied selves, irrespective of others' preferences or desires (or even others' judgments about what would be best for them). This can be seen, for example, in the way that bodily assault involving the genitals is widely seen as a far greater violation than a comparable assault involving other body parts, and all the more so if the one transgressed upon is a child (Reis, Lopes, and Osis 2017; Kumar 2017).

Indeed, setting aside acts that are necessary to preserve the physical health of someone who lacks relevant capacities (e.g., diaper changing or help with washing within certain care-based relationships), even touching someone's genitals without their consent may be humiliating and abusive; depending on the details, it may constitute the crime of sexual battery. This includes cases in which the affected individual was not aware of the touching at the time and only learns about it later, as well as cases in which the touching was not necessarily intended to be sexual in nature.[26]

One way to understand this concern is in terms of *moral risk*:

> When it comes to engaging with the sexual anatomy of someone who is temporarily non-autonomous—because they are intoxicated, asleep, or a child—there are two types of error one can make. In the first type of error, one fails to engage with the person's sexual anatomy when, in fact, the person would have consented to, and even benefitted from, the engagement with their genitalia if they had been able to consent at the time. There is some loss here—a "missed opportunity" to benefit the person—but in most situations, the harm done, if any, is relatively small. In the second type of error, one engages with a non-autonomous person's sexual anatomy, perhaps believing that this is what the person would consent to (or benefit the most from), when in fact the person would not have consented to the engagement had they been able to do so. In contrast to the first type of error, the potential harms to the individual associated with the second type of error—for example, a feeling of having been sexually violated, or of having had one's most important boundaries not respected—are enormous. Thus, it is [typically] much worse, from a moral perspective, to commit the second type of error compared to the first. (Earp 2022b, 307–8)

How might we make sense of these common perspectives or attitudes? In contemporary Western societies, among others, one's genitalia, along with other sexual or reproductive features, are regarded as exceptionally "personal" in at least two senses. Firstly, the shape, constitution, and classification of one's genitalia, and how one comes to relate to these factors over the course of development, may be central to one's identification in terms of sex, gender, and sexual orientation, all of which may powerfully shape a person's sense of self (Ashley 2022). One cannot know, in early childhood, how a person will later conceive of themselves in terms of these key categories.

Second, in these same Western societies, among many others, the genitals are culturally associated with particular environments, activities, and relationships that are considered to be especially intimate or private, and therefore most appropriately governed by powerful norms of willing participation, personal discretion, and free choice (Sörensdotter and Siwe 2016;

[25]It is not at all clear to us that these interventions should all be considered permissible. Indeed, several of them seem decidedly problematic. However, we do not have space to give a separate analysis of each one. Our point is only that even if one sees these practices as permissible, there would still be an ethically relevant disanalogy between them and medically unnecessary genital cutting of a nonconsenting individual. Regarding another analogy that is often raised in this context—i.e., vaccination—see the discussions by Darby and Van Howe (2011) and Lyons (2013).

[26]Whether or not touching of the genitals is intended to be sexual in nature, insofar as it is both nonconsensual and medically unnecessary—as has been illustrated by recent decisions of the European Court of Human Rights—it may also be against the law. See the following decisions of the European Court of Human Rights: Wainwright v UK (2007) 44 EHRR 40 prison search: touching of minor's penis (breach of Art 8 ECHR); YF v Turkey (2004) 39 EHRR 34: nonconsensual gynecological examination (breach of Art 8 ECHR); Valasinas v Lithuania (2001) 12 BHRC 266—prison search: handling of adult's genitals (breach of Art 3 ECHR).

Archard 2007, 2022). So, for example, from a young age, children are taught to regard their genitals as their "private parts"[27]—not to be seen or touched by others except in certain limited situations—unless and until they are in a position to decide for themselves when and how this may happen (Edelman 2013; Sanders 2021; Emote 2023; see also, in relation to adults, Sörensdotter and Siwe 2016). The same rule, they are told, applies to others (i.e., they must also respect others' bodily and sexual boundaries) (Babatsikos and Miles 2015).

What about infants and newborns, however? They will not learn about such "grown up" matters until later; in the meantime, up to a certain age, they will not form any consciously retrievable memories of their experiences,[28] including with respect to potential surgeries that may be carried out on their bodies. Being entirely reliant on adult caretakers to make decisions on their behalf, infants and newborns do not yet have "bodily autonomy" in any meaningful sense; they cannot set or maintain almost any boundaries with respect to their physical embodiment (Godwin 2020). So, perhaps it does not make sense to impose a categorical limit on the kinds of actions that clinicians may permissibly take toward children's genitals at such a young age.

It is true that newborns and infants do not yet have a conception of their genitals as being private anatomy (see Box 1). However, as they are socialized into early childhood and beyond, they will inevitably come to associate this part of their body (but not, for instance, their earlobes) with the aforementioned concepts: privacy, intimacy, sexuality, personal identity, and a powerful presumption of individual discretion or choice. If, therefore, they come to reflect on the fact that their genitals were *already* subject to a nonvoluntary yet medically unnecessary surgery, they may feel, as many affected persons do feel, that a significant violation has occurred (for examples and discussion, see Morland 2008, 2009; Watson 2014; Davis 2015; Hammond and Carmack 2017; Berg et al. 2017; Earp and Darby 2017; Jordal, Griffin, and Sigurjonsson 2019; Bastien-Charlebois 2020; Pagonis 2023; Uberoi et al. 2023).

In their memoir, Pidgeon Pagonis, one of the intersex campaigners who challenged Lurie Children's Hospital to change its policy, connects such feelings to a subsequent aversion toward certain forms of intimacy. When a partner tried to touch Pagonis sexually, "I wanted to cry and scream and run away, but instead I froze. I'd learned early on, in the days after surgery, [that] my body was not my own. It didn't belong to me. It belonged to everyone else. It belonged to the people who could 'fix' it, to the people who wanted to study it, to the people who would use it" (Pagonis 2023, 87). Similarly, Janik Bastien-Charlebois, an intersex woman and professor of sociology, writes of her own experiences with early-childhood medical interventions:

> I did not have a word for that kind of sexual [violation], nor could I ever envision it applying to such a context, having been raised to see doctors as benevolent professionals whom I must trust, and who have a right of access to my body. This dispossession process is insidious. We are told our bodies belong to ourselves in some awareness-raising classes at school or by parents, except experience often imprints another message … that our bodies belong to medicine, and that doctors have the final authority to judge of its worth. (Bastien-Charlebois 2020, n.p.)

In response to this or similar testimony, those who defend the performance of nonvoluntary genital surgeries even in the absence of a serious and time-sensitive physical health need are likely to grant that an unknown proportion of affected persons could, like Pagonis and Bastien-Charlebois, go on to feel harmed, or even sexually violated (for background, see Buckler 2024), by what was done to their bodies before they could consent. However, this does not typically lead such defenders to concede that the surgeries should therefore be discontinued. Instead, they may suggest that any negative feelings associated with the performance of such surgeries must be balanced against the possibility that negative feelings could also result from a lack of surgery in certain cases. For example, as a peer reviewer on an earlier version of this article suggested, "if one accepts that the genitalia are 'involved to a high degree in people's sense of privacy and sexuality,' then *withholding* surgery may also be considered an involuntarily imposed decision associated with harm" (emphasis added).

This argument, however, has several weaknesses. First, it seems to imply a moral or practical equivalency between the two types of harm alluded to earlier: that is, the harms associated with the two types of "error"—namely, of omission or commission—one can

[27] However see, for example, Burrows et al. (2017) on the need for children to learn anatomically correct terms for their sexual anatomy (e.g., for purposes of reporting sexual abuse).

[28] Note that early experiences of pain and trauma are nevertheless registered by the brain, even if not in the form of consciously retrievable memories, risking long-term adverse implications for neurodevelopment as well as psychological health and well-being, possibly into adulthood (Taddio and Katz 2005; Grunau, Holsti, and Peters 2006; AAP 2016; Walker 2019; for a general discussion, see Tye and Sardi 2023).

make in relation to another's intimate anatomy. However, the harms are not equivalent. On the one hand, there are the harms of having had one's sexual embodiment nonvoluntarily intruded upon while in a highly vulnerable state, exposed to surgical risk and pain, and permanently altered without one's consent. These are, on most accounts, paradigmatic harms, and ones that are widely considered to be especially serious. On the other hand, there is the hypothetical harm of being left to grow up with one's genitals intact; being thus spared surgical risk and pain (unless one personally judges these are "worth" a desired end, having considered all relevant alternatives); being offered noninvasive psychosocial support if necessary (e.g., in response to possible mistreatment by others); and, if all else fails, *still having the option of surgery left open to one* to pursue on a voluntary basis (see Grimstad et al. 2023). As it seems to us, there is no comparison.

Second, however, even if the harms could be meaningfully compared, there is no empirical evidence to support the claim that net harm actually is caused by "withholding" nonvoluntary genital surgeries in the absence of a physical health emergency while preserving the choice to undergo a similar surgery later in life. By contrast, there is abundant evidence that nonvoluntary surgeries have themselves caused harm to many people, both intersex and endosex: not only physically (e.g., due to surgical complications), but also to self and sexuality, often with the nonvoluntary status of such procedures playing a significant role in shaping these experiences of harm (see "Most Don't Complain," below).

Finally, even if a person did feel harmed by a lack of medically unnecessary genital surgery in early childhood (i.e., an error of omission), that person would, as noted, still have voluntary surgery available to them as an option. Although it is true that such a person could not go back in time to undergo the desired surgery while still in childhood (see Box 3 for details), their primary concern about the unmodified state of their body could at least potentially be remedied. By contrast, if a person felt harmed by having had such a surgery imposed on them without their consent (i.e., an error of commission), that person would have no comparable remedy for their complaint. Thus, the two situations are not equivalent: either in terms of the type or magnitude of the potential harms that might be caused by withholding versus performing a nonconsensual genital surgery, or in terms of the potential means of addressing those harms (or associated moral complaints) should they occur.

Accordingly, we believe the concept of a "right in trust" should be given significant weight here: Clinicians, parents, and others with caretaking responsibilities toward infants and children have an obligation to hold certain rights in trust for the child to exercise when they have reached a certain stage of maturity, rather than undermine those rights in advance (Feinberg 2014; Lotz 2006; Darby 2013). We propose that the right to make certain intimate decisions about one's own genitalia, sexed embodiment, or sexual or reproductive anatomy—especially in the case of irreversible surgical interventions that are not strictly medically necessary—is among the most important rights a person has. In the case of children, therefore, this right to genital autonomy must be held in trust until they can exercise it themselves (Meddings and Wisdom 2017; Munzer 2018; Earp and Steinfeld 2018; Garland and Travis 2020b).[29]

The implications of this claim for healthcare ethics should be clear. In a previous article by members of this group (BCBI 2019), we observed that any medical professional who even handles the genitals of a child or other nonconsenting person when doing so is not strictly required for adequately evidence-based screening, diagnosis, or treatment thereby crosses a boundary and behaves unethically, irrespective of stated intentions (on the related issue of "unconsented intimate exams," see, Friesen 2018; Bruce 2020; Hendricks and Seybold 2022; Tillman 2018, 2023; Friesen et al. 2022). For the same reasons, it is likewise unethical—if not more so—to actually cut into, remove tissue from, or otherwise permanently alter a child's genitals when doing so is not similarly medically required.

Box 3. Apples to oranges?

Responding to the argument that "early" versus "delayed" genital surgeries are not medically equivalent options. Some phrases in this box are adapted from Earp (2022b, 306). See also Meyers and Earp (2020).

Proponents of genital autonomy argue that unless there is a relevant medical emergency (i.e., a serious physical health condition requiring surgical intervention into a person's genital, sexual, or reproductive anatomy while they are incapable of personally authorizing this), the decision about whether to undergo any form of genital cutting or surgery should be preserved for individuals to make for themselves when they are capable of doing so.

[29]For an alternative argument based around the right to bodily *integrity*—which is not an autonomy-based right and is therefore applicable to persons while they are still in childhood—see the following references: Fox and Thomson (2017), Townsend (2020, 2023a, 2023b), and Chambers (2022). This is relevant to the case of children or other persons who are unlikely ever to be sufficiently autonomous to be able to provide informed consent to the permanent alteration of their own genitals: for example, because of a long-lasting, autonomy-undermining cognitive difference.

However, critics of this view might respond that "early" (i.e., nonvoluntary) genital surgery and "delayed" (i.e., voluntary) surgery are not necessarily medically equivalent. For example, it could be the case that a nonvoluntary genital operation performed in childhood, compared to a similar, albeit voluntary, operation performed later (e.g., in adolescence or adulthood), is technically simpler for the surgeon to perform, or has a lower risk of complications, a faster healing time, or the like. In such a case, "delaying" genital cutting or surgery until it could be voluntary would not, on this view, amount to offering the same operation, only at a later time, but rather, it would amount to offering a different (e.g., physically riskier) operation. Thus, it might not be as simple as allowing individuals (who are not facing a relevant medical emergency as indicated above) to decide for themselves whether to undergo a given genital operation.

This argument should be carefully examined. First, it assumes the procedure will happen either way (i.e., either "now" or "later"), whereas in reality many adults with surgically unmodified genitalia may choose to keep them that way; and no surgery, compared to early surgery, is even less medically risky (etc.). Second, any number of potential surgeries—for example, earlobe removal or cosmetic labiaplasty—might be less medically risky in infancy compared to later in life, but it must first be established that it is ethical to perform the surgery without the affected person's own permission. As the examples just given suggest, however, it is normally not permissible to surgically remove healthy body parts from someone who does not, or cannot, authorize this, irrespective of the relative risk profile that may be associated with performing the surgery at various different times of life. Third, even if it is the case that the *relative* risk of some (but perhaps not other) problems is increased by some amount in voluntary, compared to nonvoluntary, genital operations, the difference in *absolute* risk between these options is unlikely to be big enough to deserve decisive ethical weight, whereas the inability of the person to consent to the latter, compared to the former, operation is a 100% risk (i.e., it is a certainty) that would be seen as ethically decisive in most analogous situations. See Appendix B for further discussion.

PHYSICAL VERSUS MENTAL HEALTH AND MEDICAL NECESSITY

We have so far refrained from giving a precise account of what we mean by "medical necessity" or specifying the conditions under which a nonvoluntary genital operation would fit this description. In this section, we tackle these issues directly. We will start with a general definition of medical necessity recently proposed by the physician-ethicist Dominic Wilkinson (2023):

> *Medical Necessity:* Treatment X is "medically necessary" just if, in the absence of X, patient P will suffer from, or has a high chance of suffering from, a significant deterioration in health-related wellbeing, or continuation of a significantly lower than normal state of health-related wellbeing. (285)

According to Wilkinson, there are two main elements to this concept. The first is the emphasis on *need*.[30] We interpret "need" here as referring to situations in which it is highly likely that a patient will fall or remain below a minimally acceptable threshold of health-related well-being if they do not receive the intervention in question, *accounting for all relevant alternatives* (i.e., there are no other comparably effective options that are less risky, more respectful of autonomy, and so on; see Van Howe and Svoboda 2008; Cocanour 2017). The second feature is the *medical* nature of the need: that is, the anticipated decrement in well-being must be "related to a state of poor health" (285) (but see Davies 2023).

One reason to keep the latter constraint is that clinicians receive specialized training and develop expertise in health-related well-being (paradigmatically, in relation to diseases of the body), whereas they do not have expertise in "overall" well-being: for example, in relation to contested sociocultural practices. It is true that some clinicians have developed expertise in *mental* health, which can include concerns beyond the treatment of physical diseases. However, clinicians with mental health expertise are generally not among the ones responsible for performing, or deciding to perform, *nonvoluntary* genital operations on children. Nor is there any evidence, in any case, of a mental health-related need for such surgeries, as we will soon explain.

Equipped with Wilkinson's definition, we can now ask when, or under what conditions, a *nonvoluntary* genital procedure would plausibly fulfill the concept's normative requirements. To do this, we unpack the concept of "physical health" as invoked in the statement from Boston Children's Hospital (as this will feature in our set of relevant conditions).

As a reminder, the hospital stated that it will no longer perform certain genital surgeries without the input of the affected child "unless anatomical differences threaten the physical health of the child." We agree with this condition but add the following caveats in light of Wilkinson's proposed definition of medical necessity and the "intimate" nature of the anatomy in question (from Box 1):

1. the threat to physical health is both *serious* and *time-sensitive*, such that it must be resolved, prior to the possibility of obtaining personal consent, through genital surgery specifically (i.e.,

[30] As opposed to talk of medical "benefit," for example. Strikingly, to illustrate this point, Wilkinson uses the example of a contested genital surgery, and one that, moreover, is often performed on a nonvoluntary basis—namely, nonreligious penile circumcision: "For example, circumcision might be regarded as medically necessary in cases of severe phimosis with recurrent balanitis (narrowing of the foreskin and repeated inflammation/infection) that is unlikely to resolve without surgery. However, circumcision would not be medically necessary in order to reduce the risk of future acquisition of HIV (since this may be prevented in other ways), or cancer of the foreskin (since the risk of this occurring is low)" (285).

it is not possible to delay the intervention—or to substitute a more conservative alternative—until the individual could consent without putting them at an even greater risk of "significant deterioration in health-related well-being");
2. the surgery in question is among the least risky, invasive, or harmful of the available treatment options for which there is evidence of comparable effectiveness (i.e., "accounting for all relevant alternatives" per our earlier clarification); and
3. the surgery is among the options that will preserve, as far as possible (given the other criteria), the individual's future ability to make any personal, preference-sensitive decisions about their own sexual or reproductive anatomy (i.e., given the special considerations laid out in Box 1 and the section "Private Anatomy, Personal Choice").

In other words, if a child's anatomical difference posed only a weak or distant threat to their health, such that it would be reasonable to delay any proposed surgical interventions until they could decide for themselves; or if there were other effective options for addressing the health threat that were less risky or harmful than genital surgery; or if there were options that would better preserve the child's future ability to make certain decisions about their body as described earlier, then nonvoluntary genital surgery would still not be permissible according to the criteria we have adopted, notwithstanding the posited threat to physical health.

How, then, should we understand the term "physical health"? The term is not defined in the Boston statement. However, it seems to have been intended as a contrast with something like "psychological" or "psychosocial" health—we'll say "mental health" for simplicity—insofar as nonvoluntary surgeries on children with intersex traits have traditionally been defended on such a basis: that is, with the belief that they will causally improve the child's *future* mental health, given certain assumptions about their long-term psychosocial environment, notwithstanding any risks to physical (or indeed mental) health introduced by the surgery itself.

Such a defense, however, is problematic, as we elucidate in Box 4. Analogous arguments regarding potential future benefits to *physical* health, albeit ones that do not rise to the level of medical necessity, such as a reduction in the risk of certain treatable infections, are addressed separately in Appendix B in relation to nonreligious penile circumcision.

Box 4. Problems with the "mental health" defense of nonvoluntary genital surgery.

It is uncontroversial that genital surgery, like any surgery, poses physical risks to a patient's health (and, we would add, also to their mental health). Given this, it generally understood that surgery typically should not be performed, especially on a nonconsenting individual such as a child, unless the patient's own body is posing an even greater physical health risk for which the surgery in question is among the least harmful of the adequately effective treatment options available (Hutson 2004).

However, proponents of "early" genital surgeries might argue as follows: Suppose that performing a genital surgery on a child whose body is not, in the relevant cases, posing any such physical health risk, nevertheless served to bolster the child's eventual *mental* health. For example, suppose it increased their genital self-image or sexual self-confidence, or reduced the likelihood that they will be bullied, teased, or sexually rejected for having culturally or anatomically nonnormative genitalia. If so, the surgery could still be justified, on this view, on grounds of "total" health (i.e., physical plus mental health).

The assumption, then, is that a child whose genitalia are surgically altered (that is, in an attempt to make them look or function more like those of a "typical" member of their sex or gender class—an attempt that is not always successful) will in fact be better off in terms of mental health than a similarly situated child with identical genital anatomy who does not undergo such a surgery.

A further, implicit, assumption is that the postulated increase in mental health will be sufficiently great so as to reliably offset, and indeed outweigh, any combined decreases in physical and mental health that may be caused by the surgery itself (e.g., due to pain, bleeding, pigmentary changes, recurrent infection, scarring, keloid formation, skin bridges, fistulas; numbness or hypersensitivity due to nerve damage; possible loss or diminishment of sexual feeling; unhappiness about the scarred appearance of one's genitalia; frustration about often needing multiple follow-up surgeries and repairs; persistent shame due to being perceived as unacceptable and in need of "fixing"; resentment about being deprived of an important personal choice; feelings of violation about having had one's sexual anatomy surgically operated on without one's consent; and so on).

However, there is not any credible evidence to support the just-stated assumptions: namely, that such positive mental health outcomes reliably occur; that if they do occur, they can be causally attributed to "early" (as opposed to delayed, or no) genital surgeries; and that, even if so, they are of such a great magnitude that they can be said to outweigh the various risks, harms, and other disadvantages of the surgeries, many of which have been amply documented. Moreover, at least some of these harms, in contrast to almost all of the postulated benefits, can be directly causally linked to the surgeries themselves.

This is not to suggest that the ethics of nonvoluntary genital cutting or surgery might one day be determined by simple appeals to empirical studies attempting, however well or poorly, to measure or assign weights to long-term physical or psychological benefits versus harms (Reis-Dennis and Reis 2021). After all, many of the key moral factors we raise, such as the value of personal choice, are not susceptible to being measured with scientific instruments. Instead, it is to note that, even if one believes that postulated mental health benefits could somehow render such operations permissible, such a view lacks empirical support.

Given the concerns spelled out in Box 4, we suggest that for a *nonvoluntary* genital surgery on a child to be ethically permissible, it must be necessary to prevent or alleviate a significant and pressing threat to physical health (rather than a potential future threat to physical or mental health). In other

words, to fulfill Wilkinson's (and our) criteria for being medically necessary, an individual would need to be suffering from (a) a physical-functional impairment in a relevant biomechanical structure or process, where (b) this impairment poses a serious, time-sensitive threat to the person's life or long-term health or well-being (e.g., an anatomical difference that blocks the passage of urine; recurrent infections that cannot be more conservatively managed or prevented than by nonvoluntary surgery; a malignant genital tumor, or the like).

By contrast, in the case of *voluntary* genital modifications in adolescence or adulthood (i.e., a personally requested operation whose all-things-considered desirability to the individual is not a matter of speculation), the appropriate ethical standard might well be more expansive. For example, it might include considerations of potential benefits to mental health, since the particular psychosocial or identity-related concerns of the individual will, in such cases, be much more meaningfully ascertainable, as will the particular risks or trade-offs the individual is willing to accept in attempting to address those concerns by whatever chosen means.

Even so, in the case of *nonvoluntary* modifications, it might still be asked why we have focused so narrowly on serious physical impairments, rather than mere anatomical differences (i.e., deviations from population-level statistical norms for various genital traits or features), or even perceived deviations from widely endorsed heteronormative standards for genital function or appearance. The reason for this is that such serious impairments, but not the other conditions, constitute a subset of bodily states or configurations for which immediate surgical intervention *without the prior consent of the affected individual* is almost universally recognized as being all-things-considered justified, even though it concentrates risk on a nonconsenting person's "intimate" anatomy (see Box 1). As such, the individual would have no reasonable basis for subsequently raising a moral complaint against those who authorized or performed such a surgery on them without their permission (i.e., under those special conditions).[31]

Notably, medically unnecessary genital surgeries are characterized by a different set of features, making subsequent moral complaints much more reasonable and justified. In particular, the norms, beliefs, and values that motivate such surgeries (e.g., contested gender norms, cultural attitudes, or metaphysical beliefs) are much more susceptible to being changed upon reflection, following exposure to alternative points of view. In other words, "assuming a multicultural context with sufficient access to contrary perspectives, there will typically be greater opportunity for someone who was pre-autonomously exposed to a medically *unnecessary* genital operation to (re)construe the operation as having been harmful or inappropriate, than for someone who was exposed to a medically *necessary* genital operation, all else being equal" (Earp 2021, 4).

So, for example, we reject claims of "functional impairment" that are premised on heterosexist (or other oppressive or discriminatory) social norms, such as the notion that a male should be able to "pee standing up" in order to be a "real man," or that a female should be capable of being vaginally penetrated by a penis in order to be a "real woman" (Kraus et al. 2008; Behrensen 2013; Orr 2019; Dalke, Baratz, and Greenberg 2020; Walsh and Einstein 2020; Cannoot 2021; Carpenter 2024). Insofar as a person grows up to endorse such contested norms, they may, if genital surgery would be required to achieve them, weigh the risks and benefits of proceeding in light of their own values, aesthetic or sexual preferences, tolerance for different kinds or degrees of risk, and so on, and decide for themselves.

This ability to decide for oneself is key. As some of us stated in our previous contribution: "If someone is capable of consenting to genital cutting but declines to do so, no type or degree of expected benefit," whether physical or psychosocial, "can ethically justify the imposition of such cutting. If, by contrast, a person is not even capable of consenting due to a temporary lack of sufficient autonomy (e.g., an incapacitated adult or a young child), there are strong moral reasons in the absence of a relevant medical emergency to wait

[31]In other words, medical necessity constitutes a kind of justification for intervening in such cases to which all reasonable people can agree; it therefore provides sufficient "public reason" for treatment (Van Howe 2013b; Chambers 2018). Under such conditions, the future adult can, on some views, provide retrospective consent to the intervention (Clayton 2012; for a related analysis in terms of "anticipated" consent, see Somerville 2006, 214). An alternative account holds that one can justify the performance of the surgery by appealing to the strength of the future autonomy-based interest which the surgery is necessary to protect. In the case of medically necessary surgeries, to wait until the child is able to authoritatively waive their own right to bodily integrity is to postpone treatment in a manner that will itself substantially restrict their future set of valuable personal choices. As such, providing the intervention may be necessary for affording the individual a sufficient degree of autonomy in the future, while failing to provide the intervention may not be. In the case of a medically unnecessary surgery, by contrast, it is much less plausible that such an irreversible intervention would better protect the child's future interest in genital autonomy than would the failure to provide it. See Pugh (2020, 2023). For a response to Pugh, see Mazor (2024).

until the person acquires the capacity to make their own decision" (BCBI, 2019, 18).

Accordingly, we maintain that certain sensitive, permanent choices about one's own sexual embodiment, including how one's genitals should look or function, ought to be left to the individual to make on a voluntary basis: that is, when they have—among other things—a more stable sense of their long-term preferences, values, or sociocultural environment, which may be very different from the one(s) into which they were born or with which they were raised. We argue that, at least in societies whose ethical and legal traditions position bodily integrity, personal autonomy, consent, respect for sexual boundaries, and nondiscrimination on the basis of sex as foundational values, nonvoluntary genital cutting that is not medically necessary is wrong for clinicians to perform as a matter of principle (Möller 2020; BCBI 2019; Alston et al. 2017; Carpenter 2021; Frisch 2002; Buckler 2022; Catalan and Emilova 2023).

WHO DESERVES PROTECTION?

The preceding arguments against medically unnecessary, nonvoluntary genital cutting or surgery apply to children irrespective of their sex characteristics or gender. As is increasingly recognized, children with intersex traits due to diverse sexual development (Lampalzer, Briken, and Schweizer 2020) have a powerful interest in having decisions about such modifications preserved for them to make when they are older (Feder 2014). This principle is clearly articulated in the statements from Lurie and Boston Children's hospitals quoted earlier. Likewise, children who are not intersex, that is, children whose features are deemed to fall more clearly within normative standards for "binary" female or male bodies—namely, endosex females or males (Carpenter, Dalke, and Earp 2023)—also have such a powerful interest.

In prior sections, we noted that when it comes to endosex female children, it is hospital policy—not only in the United States, but in many hospitals worldwide—that *no* cutting of a person's vulva should occur, however slight, unless it is (at least) voluntary or medically necessary. Failure to comply with this rule is, as noted, also unlawful in many countries. Special statutes in numerous jurisdictions explicitly ban such cutting as "female genital mutilation" whether or not it is done by a specialist surgeon (Garcia et al. 2022). According to a 2017 statement from the American College of Obstetricians and Gynecologists, surgery of the vulva, including labiaplasty, in girls younger than 18 years should be restricted to situations in which serious or persistent symptoms are caused "directly" by vulval anatomy. Otherwise,

> Physicians should be aware that surgical alteration of the labia *that is not necessary to the health of the adolescent*, who is younger than 18 years, is a violation of federal criminal law [i.e., the law prohibiting "FGM"]. At least half of the states also have laws criminalizing labiaplasty under certain circumstances, and some of these laws apply to minors and adults. (ACOG 2017, 2, emphasis added)

Moreover, in some legal contexts, medically unnecessary cutting of the vulva may also be interpreted as constituting criminal assault, even if no tissue is removed, the clitoral glans is not affected, and the procedure is performed, as noted, for explicitly religious reasons at the request of the child's parents (Hayter 1984; Bronitt 1998; Atkinson and Geisler 2019; Earp 2022a; see also Sheldon and Wilkinson 1998).[32]

These striking considerations about endosex female genital cutting were the focus of our previous article (BCBI 2019). In the present context, what they help to reveal is a significant inconsistency in the updated policies of Lurie and Boston Children's hospitals. Although both hospitals now recognize that children with certain intersex traits, alongside those with anatomically normative vulvas, should not have their genitals operated on in healthcare settings for social, cultural, religious, aesthetic, or any other reasons apart from strict medical necessity, their respective websites reveal that these same hospitals continue to perform both routine (i.e., nonreligious) penile circumcisions (LCH 2022b; BCH 2022a) and medically unnecessary surgeries for hypospadias[33] (LCH 2022a; BCH 2022b) on a nonvoluntary basis. Moreover, neither hospital explicitly rules out the performance of medically unnecessary "internal" genital surgeries (e.g., prophylactic gonadectomies in

[32]As for endosex male children, it should be noted that legal scholars have argued since the 1980s (Somerville 1980; Brigman 1984; Price 1997; Van Howe et al. 1999; Boyle et al. 2000), and with increasing force in recent years (Somerville 2000; Adler 2012; Merkel and Putzke 2013; Svoboda, Adler, and Van Howe 2016; 2019; Lenta and Poltera 2020; Adler et al. 2020), that medically unnecessary, nonvoluntary cutting of the penis—including its prepuce or foreskin as in the case of circumcision; see Appendix B—is likewise interpretable as criminal assault, with parental "proxy" consent or permission argued to be legally invalid (see, e.g., Svoboda, Van Howe, and Dwyer 2000). Yet such cutting is not currently treated as illegal in virtually any jurisdiction (Geisheker 2013; Sandland 2019). For a recent analysis, see Brown (2023).

[33]For further discussion of hypospadias and the lack of medical need (according to the conception employed in this article) for nonvoluntary surgery in many cases, see Kessler (1998); Kraus (2013); Carmack, Notini, and Earp (2016); see also Roen and Hegarty (2018). For a contrary perspective, see Wirmer et al. (2023); see also the replies.

situations where retention of the gonads is unlikely to seriously endanger the child's health before they can meaningfully participate in any associated decisions; see Cools et al., 2018; O'Connell et al. 2023; Peard et al. 2023; Ho et al., 2024).

To see the inconsistencies here, consider the hypothetical case of a child born with a genital morphology that might plausibly be regarded either as an unusually small penis or an unusually large clitoris, due to a difference of sex development (Kessler 1990; Lee and Houk 2010; Lee, Houk, and Husmann 2010; Kraus 2017). Under the new Lurie Children's Hospital policy, if the child is deemed "intersex," it seems they should be *protected* from medically unnecessary surgical operations, including the needless repositioning of their urethral opening, or the excision of their healthy genital prepuce (foreskin). As the policy states, "irreversible genital procedures [on intersex individuals] should not be performed until patients can participate meaningfully in making the decision for themselves, unless medically necessary."

But now suppose the child is deemed to be a boy, albeit one with a smaller-than-average penis. Does he suddenly become *eligible*, under the hospital's new policy, for the very same medically unnecessary procedures, that is, "cosmetic" surgery for hypospadias or nontherapeutic penile circumcision? At present, it would seem so. But this is problematic: Simply being recategorized in this way should not cause him to lose his interest, explicitly recognized under the new hospital policy, in "participating meaningfully" in so personal a decision as to whether his own genitals should be cut, much less permanently modified.

The same, of course, would be true if the child were deemed to be a girl, whether or not she has CAH. To put it differently: The shape of one's genitalia, or how one is socially or legally categorized on that basis, is *morally irrelevant* to whether one deserves to be protected from medically unnecessary, nonvoluntary genital cutting or surgery. Rather, all children, irrespective of their sex characteristics, have a powerful right-in-trust to *at least participate* in such intimate decisions when they are able to verbalize their preferences and advocate on their own behalf.

To reiterate, this powerful interest does not primarily depend on the precise degree of anticipated physical risk (e.g., of surgical complications) associated with any particular procedure. Both ethically and for purposes of health policy, it is possible and often desirable to position certain kinds of interventions as being entirely "off the table"—even if they could in principle be done relatively safely or in a *de minimis* fashion.[34] We suggest that nonvoluntary genital cutting or surgery that is not medically necessary should likewise be "off the table" for healthcare providers, irrespective of their patient's sexual anatomy (Bewley, Creighton, and Momoh 2010; for a related discussion, see Chambers 2004).

"MOST DON'T COMPLAIN"

Some have argued that, insofar as most individuals who have undergone medically unnecessary genital cutting or surgery in childhood do not seem strongly opposed to what happened, there is insufficient reason to change the status quo. For example, Meyer-Bahlburg (2022) has recently reported (based on a review of 10 different patient surveys)[35] that "a clear majority of patients with somatic intersexuality favors genital surgery before the age of consent, particularly in infancy or early childhood … these patients have personally experienced the psychosocial consequences of living with somatic intersexuality, and most of the survey participants had undergone one or more genital surgeries" (16). From these empirical results, Meyer-Bahlburg draws the following normative conclusion:

> [This majority] preference for early surgery constitutes a striking contrast to the human rights-based demands for surgery delay by ethicists and politicians who usually do not have that lived experience … Thus, the preference of the majority of patients is *incompatible with* a legal ban of such surgery before the age of consent and does also not support a general moratorium of early surgery. (16–17, emphasis added)

There are several problems with this line of reasoning. First, even if one accepts the empirical premise

[34] As Behnke (2006) argues, "Licensing boards and ethics committees—unlike courts in a malpractice action—do not need to find harm in order to find a violation, and thereby 'de-link' the ethical and the empirical in relation to specific cases. Such 'de-linkage' allows a committee or board to find a violation apart from finding harm and thereby provides considerably greater discretion in finding a violation … such discretion [is] an essential and valuable feature of the ways boards and committees work, [and] an absolute prohibition [on certain practices] should not depend upon finding harm in every specific case" (86).

[35] Per the author, "all were published in the English language: three from the USA; four from European countries; and one each from Brazil, China, and Malaysia. All 10 surveys were based on samples of clinic patients, most of whom had previously undergone genital surgery … Total sample sizes of participants answering questions regarding the timing of genital surgery ranged from n = 21 to n = 415. Five surveys were limited to women with XX CAH. One survey included XX women with CAH and XY women with androgen insensitivity, one other focused on men and women with various categories of XY intersexuality, two covered males and females with diverse XX and XY intersex syndromes, and one dealt with male-raised patients with diverse 46,XY, 46,XY/45,X, and 46,XX syndromes" (Meyer-Bahlburg 2022, 16).

(notwithstanding serious methodological shortcomings in the surveys purporting to show it, as discussed below), the conclusion is a non sequitur. This can be seen by drawing an analogy. Suppose a "clear majority" of British women prior to suffrage had a real or apparent preference not to be enfranchised, or were indifferent to the question, as historians argue is plausible.[36] As John Stuart Mill (1869) argued more than a century ago, this would not entail that the women did not have a justice-based moral right to vote, nor that the laws that prevented them from doing so (based on socially reinforced beliefs among those with more political power about what was in their best interests) should not be overturned.[37]

Second, with respect to the empirical premise of the argument, it must be noted that the "majority" in question are the majority of those who *chose to participate in the surveys*: that is, a subset of affected persons who, as Meyer-Bahlburg goes on to acknowledge, often represented "only a fraction of the eligible patients seen in a clinic [raising] the question of representativeness and potential selection biases" (Meyer-Bahlburg 2022, 19). For example, it is possible that survey nonrespondents harbor more negative attitudes than respondents, while also being more reluctant to reengage with healthcare professionals (i.e., those they may feel have harmed them), which would also explain their nonresponse (Carpenter, Kraus, and Earp 2024a).

Third, there is no appropriate comparison group in the surveys (i.e., similarly situated persons who did not undergo early surgery but who instead had access to psychosocial support or other nonsurgical medical care), which undermines the drawing of causal inferences (Liao 2022; see also Carpenter et al. 2024a, 2024b).

Fourth, at least some of the surveys included leading questions and did not make clear to participants that "no surgery" was even an option. As Baratz and Feder noted in response to an earlier, similar analysis by Meyer-Bahlburg, "the significance of the responses to the questions asked … should be assessed with respect also to relevant questions that were not asked as well as to potential lack of information provided to those questioned" (Baratz and Feder 2015, 1761) (cf. Meyer-Bahlburg 2015).

Fifth—to return now to the attempted normative inference—it is obviously possible for someone to be wronged by a nonvoluntary genital practice even if they do not consciously wish it hadn't occurred (much less actively resent it). There are several reasons for this. They might not realize they have been harmed or wronged (e.g., because they have not considered, or have no experience of, the alternative;[38] or they may not have explicitly reflected on the matter, perhaps because it is too psychologically fraught to do so) (for discussion, see Goldman 1999); they might have formed an adaptive preference[39] for an (otherwise) undesirable situation they cannot change (Lewis 2021b; see also Mackenzie 2008; Walsh 2015; Jacobson et al. 2018); or the practice may be sufficiently widespread, long-standing, or culturally embedded that it does not intuitively *seem* wrong (Waldeck 2003a, 2003b; Bear and Knobe 2017; Martín et al. 2023), even though it is inconsistent with well-established moral principles that are generally accepted within the same society (Chambers 2018; Baker 2019; Chambers 2022). See Box 5 for an elaboration of these points, drawing on the analogous case of ritual endosex female genital cutting.

Sixth, even when someone is distressed that their genitals were altered without consent, they might not feel comfortable sharing this with others, whether publicly or as part of a research project (see also the "Prevalence Paradox" as described in Uberoi et al. 2023). For example, it can be embarrassing and is contrary to social norms to talk openly about one's

[36] As Julia Bush argues in *Women Against the Vote: Female Anti-Suffragism in Britain* (Oxford University Press, 2007), "British women who resisted their own enfranchisement … together with the millions whose indifference reinforced the opposition case, claimed to form a *majority of the female public* on the eve of the First World War [and by] 1914 the organised 'antis' rivalled the suffragists in numbers, though not in terms of publicity-seeking activism" (Bush 2007, 1, emphasis added). Indeed, she argues, from the 1870s "up to the moment of enfranchisement, both male and female anti-suffragists claimed emphatically that the *majority of British women* did not want the parliamentary vote. *This claim has considerable plausibility*" (3, emphasis added).

[37] According to Mill (1869), it might seem that women's disenfranchisement was "accepted voluntarily, that women don't complain, and are consenting parties to it" (24). "Well," he continues, "the first point to make is that a great number of women do not accept it. Ever since there have been women able to make their sentiments known … increasingly many of them have protested against their present social condition [and we] can't possibly know how many more women there are who silently have such hopes, but there are plenty of signs of how many *would* have them if they weren't so strenuously taught to repress them as improper for their sex" (*ibid.*). We make analogous points in relation to people who, based on their sex characteristics, are presently afforded different rights to genital autonomy, in the following.

[38] Indeed, as exemplified by the case of intersex genital modifications, the procedures themselves may reinforce the very psychosocial risks they are claimed to reduce, namely, by systematically eliminating, or seeking to eliminate, "alternative" types of embodiment (i.e., reifying an endosex binary body as natural and normal). A similar logic applies to endosex genital modifications in cultures with sufficiently high rates of cutting: i.e., the risk of a person with intact genitalia being mistreated for being perceived as "different" is reinforced by surgically upholding the genital modification norm.

[39] Roughly, a real or apparent preference (often unconsciously formed) for a given state of affairs due to (unjustly) limited access to or awareness of better alternatives. For formal definitions and analysis, see Khader (2011).

genitals, especially when one feels they were damaged or diminished (Earp and Darby 2017). It can be prohibitively difficult to put into words certain emotions related to experiences one interprets as traumatic (Boyle et al. 2002; Goldman 1997; Behrendt and Moritz 2005; Hart and Shakespeare-Finch 2021; Remennick 2022; for conceptual and methodological critiques of how trauma is understood in cross-cultural contexts, see Theisen-Womersley 2021). There is also a power imbalance between the individual and the medical profession, which may prevent individuals from openly complaining about something a clinician authorized or performed. Moreover, individuals may worry or feel guilty about upsetting their parents, who might be devastated (or defensive) to learn that their child feels harmed by a medically unnecessary genital procedure for which they gave their permission. And, in the case of cultural cutting that is widely accepted within one's group, it can be threatening to one's standing within the group to challenge the dominant norm, or one may be socially ostracized, which can be a significant further harm (Gleichen 2020; Meoded Danon 2021).[40] Hence, a lack of explicit or public complaining does not necessarily entail a lack of resentment or harm.

Seventh, despite all those barriers, there has in fact been substantial public complaining by persons of all sex characteristics and gender identities, suggesting that increasing numbers of adolescents and adults who had medically unnecessary genital cutting imposed on them as children are overcoming their fears and speaking out. As Lurie Children's Hospital acknowledged, this certainly includes intersex individuals who have spent decades fighting for change (Kessler 1998; Chase 1998a; Dreger 1999; Karkazis 2008; Davis 2015; Wall 2015; Carpenter 2016; Viloria 2017; Pagonis 2017; Human Rights Watch 2017; Reis 2021a). Indeed, there is now a global intersex movement, active on all permanently inhabited continents, reflecting the scale and scope of the medical practices to which the movement objects.

Research also reveals that a large proportion of women subjected to ritual endosex female genital cutting in their home countries when they were children, although they did not initially regard the cutting as detrimental, came to see it as such post migration (often upon learning it is condemned in Western countries or otherwise gaining a new perspective, for example, through a challenging healthcare encounter or acquiring greater health literacy) (Catania et al. 2007; Merli 2010; Vissandjée et al. 2014; Johnsdotter and Essén 2016; Berg et al. 2017; Vissandjée, Short, and Bates 2017; Wahlberg, Essén, and Johnsdotter 2019; Koukoui 2019; Johnsdotter 2020; Hanberger, Essén, and Wahlberg 2021; Ziyada and Johansen 2021; Abdulcadir 2021; Gutiérrez-García et al. 2022; Besera et al. 2023; Nur 2023). Some such women have been at the forefront of public conversations about the need to protect *all* nonconsenting people from medically unnecessary genital cutting.[41]

Box 5. Rates of adult resentment regarding nonvoluntary genital cutting or surgery in childhood and ethical implications: the analogy of ritual endosex female genital cutting.

Some advocates of medically unnecessary, nonvoluntary (i.e., early childhood) genital cutting or surgery point to surveys (often with low response rates) finding that a majority of respondents do not report resenting—or even report preferring—having undergone the cutting or surgery before they could consent. From this, advocates conclude that nonvoluntary surgery is morally permissible (e.g., Meyer-Bahlburg 2022). In this context, however, one must remember that in many societies where ritual genital cutting of endosex girls—even highly invasive forms—is culturally normative, many, and in some cases the majority, of surveyed women report that they prefer having been "cut" as children, regard the procedure as necessary for psychosocial or cultural reasons, and do not feel, on balance, seriously harmed by what happened to them (Shell-Duncan and Hernlund 2000; Ahmadu and Shweder 2009; UNICEF and Innocenti Research Centre 2010; Abdulcadir et al. 2012; Obiora, Maree, and Nkosi-Mafutha 2020; O'Neill and Pallitto 2021; Omigbodun et al. 2022).

It does not follow from this, however, that it is ethically permissible to cut or remove parts of young girls' healthy genitalia before they are capable of providing their own consent, nor that a ban or "general moratorium" on such cutting should automatically be ruled out.

In any case, the alleged minority of persons who do feel harmed by such surgeries, or who would have preferred to have had a choice in the matter, ought not be dismissed simply because they do not seem to share the majority opinion of persons who (a) underwent such surgeries and (b) subsequently agreed to participate in a survey. Instead, we suggest that the views of the 'aggrieved minority' (if that is what they are; i.e., simply granting the empirical premise of those who argue for the status quo) should be given significant moral weight.

Among other reasons, they arguably have a much stronger moral complaint (and fewer available remedies, insofar as their genital modification status cannot be reversed) compared to persons in the relevant comparison class: that is, those who were *not* genitally modified in childhood, wish they had been, and yet still have the option of genital modification open to them (see main text).

It is therefore the concerns of the alleged minority who do feel harmed or wronged by virtue of having been subjected to early genital cutting or surgery, rather than those of the (purported) majority who do not report such feelings, that should be given priority for ethical analysis in this area.

[40]In the course of our work, we have received numerous private messages from individuals thanking us for raising critical concerns about nonvoluntary genital cutting. These individuals have shared that they did not feel they could express their objections within their own families or communities for fear of creating conflict, being ostracized, or facing various forms of reprisal.

[41]Soraya Mire, a well-known human rights advocate and survivor of endosex female genital cutting, originally from Somalia, has stated: "The thing that really shocked me when I came to America was the reaction I got when people find out what was happening in Somalia, Sudan, Ethiopia, those parts of the world … about female genital mutilations, and people were horrified, they were shocked, they were angered: it was not even a feminist standpoint, but it was the rights of

Finally, a great number of endosex boys and men (and also some transgender women; see, e.g., Tao 2024) have been vocal about being "routinely" circumcised without their consent, although we have found that their concerns are often ridiculed or dismissed (this is consistent with patriarchal cultural norms according to which those expected to fill a male gender role are required to be stoical, tough, and strong) (Thomson 2008; Young 2009; Fox and Thomson 2009; Steinfeld and Lyssarides 2015). Recent demographically diverse surveys in the United States suggest that around 10–16% of adults who underwent a nonvoluntary penile circumcision in childhood wish that they had not been circumcised despite the practice remaining a dominant social custom in that context (Moore 2015; Earp, Sardi, and Jellison 2018; Serody 2021). Given the large U.S. population and the high rate of routine infant circumcision—well above 80%—until recent decades (WHO 2008), this likely amounts to several million resentfully circumcised men, plus an unknown number of transgender women and nonbinary people born with penises. Moreover, sales of a popular "foreskin restoration" device suggest, conservatively based on 2016 company records (reviewed in Earp 2016a), that many thousands of circumcised men in the English-speaking world are actively attempting to create a pseudo-prepuce by stretching remaining shaft skin over the penile head in an arduous and uncertain process that may take several years (Timmermans et al. 2021; Özer and Timmermans 2020), indicating a high level of dissatisfaction with having been circumcised without consent (Hammond et al. 2023; Mokken, Özer, and Timmermans 2023; see also Fox, Thomson, and Warburton 2019).[42]

In relation to such articulated grievances, defenders of nonvoluntary genital cutting or surgery have sometimes responded that methods are always improving (see Chase 1998b; Buyukunal et al. 2021; Lee, Mazur, and Houk 2023). By this, they seem to imply that the expressed dissatisfaction is primarily due to unfortunate accidents or "botches" that are less common now than in the past (e.g., Meyer-Bahlburg 2022; for critiques of this view, see Carpenter 2018b; Karkazis 2008). However, this response fails to account for at least two considerations. First, it fails to account for the common ethico-legal perspective, described as "self-evident" by a California Appeals Court judge, that "even if a surgery is executed flawlessly [i.e., with no complications], if the surgery were unnecessary, the surgery in and of itself constitutes harm" (Tortorella v. Castro 2006).[43] And second, it fails to account for the abundant testimonial literature of adults subjected to medically unnecessary genital cutting or surgery as children, many of whom express a sense of violation or betrayal simply by virtue of having had such cutting imposed on them without their consent when they were at their most vulnerable.[44]

Again, we do not claim that these experiences are necessarily representative, nor do we suggest that the studies or surveys documenting such complaints are free of methodological shortcomings of their own (e.g., selection bias, potentially leading questions, and so on). However, for the reasons already given—for example, in Box 5—the moral arguments in favor of delaying medically unnecessary genital cutting or surgery until the affected individual can meaningfully participate in the decision do not depend, for their validity, on the representativeness, proportion, or absolute number of affected persons who consciously feel harmed by such cutting or surgery (and who also manage, despite the above-described barriers, to publicly report this in some format or another).

By contrast, to be successful, arguments in favor of the status quo must, effectively, "prove a negative"—they must positively demonstrate, among other things, that the proportion and/or absolute number of people harmed or violated by these procedures is trivially low. In other words, from a moral point of view, the epistemological burden of proof is on those who claim

the child, taking her humanity and integrity. But behind closed doors, they were mutilating their own young boys, sons—and it's [an everyday] ritual here, but people don't see it as a ritual. But to me I would see it as a ritual, because it's the same thing to me: mutilation is mutilation. I feel this is really wrong, when it comes to child rights: this is a human rights issue, and I think all of us need to protect young children's bodily integrity" (Mire 2011, n.p.).

[42]Public demonstrations against medically unnecessary penile circumcision by affected persons have taken place since the early 1990s (SFW 1993; MIJ 1995). In recent years, an organized network of such individuals and their allies have conducted regional tours across the United States and internationally to raise awareness about their objections to nonconsensual penile circumcision and its human rights implications (BSM 2020; MDC 2020; see also Droit au Corps 2019). There is also a growing African movement objecting to U.S. government- and WHO-sponsored circumcisions, increasingly targeting adolescents or even younger males, and performed in many cases without parental knowledge or permission (Gilbertson et al. 2019; Luseno, Rennie, and Gilbertson 2023; Rennie et al. 2021a, 2021b; see also Sidler et al. 2017; VMMC Experience Project 2019; Gwaambuka 2019; Fish et al. 2021; Reporter 2023). See Appendix B for further information.

[43]The case concerned an adult who underwent a medically unnecessary sinus surgery, not a nonvoluntary genital surgery. However, as noted by the judge who wrote the decision, "*any* unnecessary surgery is inherently injurious in that the patient needlessly has gone under the knife and has been subjected to pain and suffering" (n.p., emphasis added).

[44]Strikingly similar stories of pain and resentment about having had one's "intimate" anatomy interfered with before one was capable of "participating meaningfully" in the decision—often on account of reasons one does not endorse or even rejects upon later reflection—have been expressed by individuals of all sex characteristics (Morland 2008; 2009; Watson 2014; Davis 2015; Hammond and Carmack 2017; Berg et al. 2017; Earp and Darby 2017; Bossio and Pukall 2018; Jordal, Griffin, and Sigurjonsson 2019; Garland and Travis 2020b; Uberoi et al. 2023; Pagonis 2023).

a *lack* of harm or wrongfulness pursuant to nonvoluntary genital cutting or surgery, not on those who claim to have been harmed or wronged. And yet, as Box 4 elucidates, many serious harms (e.g., surgical complications) can be directly causally attributed to the surgeries themselves, whereas most of the postulated benefits (e.g., potential psychosocial gains) cannot be so attributed with any great certainty, since, among other limitations, studies in this area have so far failed to feature a relevant control group.[45] In any case, the largely subjective and value-laden nature of most of the intended benefits (that is, their dependence on individually or culturally variable preferences regarding, e.g., bodily esthetics or conformity to gender norms) suggests that the person to decide whether they are worth the particular risks of genital surgery should be the person who would have to live with the consequences.

CONCLUSION

As a matter of medical-ethical consistency, selectively excluding some children from equal respect for their bodily integrity and future genital and sexual autonomy risks undermining the force of those concepts as they apply to other cases (Van Howe and Cold 1997; Davis 2003a; Steinfeld and Earp 2017; O'Neill et al. 2020; Lewis 2021a). Consequently, the hard-won protections that have been put in place for girls with anatomically normative genitalia, and now increasingly for children with certain intersex traits, will not be secure against objections and countervailing pressures as long as nonvoluntary clitoral reduction surgeries on children with CAH, "cosmetic" hypospadias surgeries, medically unnecessary removal of internal gonads, and nontherapeutic, nonreligious penile circumcision of newborns continue in healthcare settings unrestricted.[46] The right of each person to decide for themselves whether they want to accept the risks, costs, and trade-offs associated with medically unnecessary genital cutting or surgery—and if so, toward what ends—is threatened by the denial of that right to any person.

We do not share a single opinion as to which legal measures, if any, should be pursued in order to ensure that persons of all sex characteristics are equally protected from medically unnecessary, nonvoluntary genital cutting or surgery performed by licensed healthcare providers in regulated medical contexts. However, we are united in a conviction that basic justice requires such equal protection.

To that end, we call for major policy change. We welcome the decisions of Lurie and Boston Children's hospitals to cease some intersex surgeries. It is laudable that they took action in response to grassroots intersex advocacy in the absence of a legislative mandate. We hope and expect that other hospitals will soon follow suit, as has already happened with New York City Health & Hospitals, as mentioned above. At the same time, we encourage Lurie and Boston Children's administrators to follow their own reasoning through. In other words, we call on them to publicly commit to stop performing—or allowing—any medically unnecessary, nonvoluntary genital cutting or surgery on children within their care, irrespective of the child's sex characteristics. We extend the same call to all hospitals, clinics, and medical associations throughout the Global North, and support similar efforts by local reformers worldwide.

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[45] As a reviewer notes, it might be possible to compare the experiences of persons with intersex traits whose parents were equally determined to authorize an "early" surgery for them, and yet were either successful or unsuccessful in achieving this aim (e.g., due to differences in access to a qualified surgeon). However, in practice, if two sets of parents were indeed equally motivated to have their children undergo an "early" genital surgery, and yet only one set of parents was able to bring this about, it is unlikely that the two sets of parents/families would be socioculturally comparable, making it difficult to rule out relevant confounds. Nevertheless, we agree with the reviewer that the existence of even great challenges in conducting high-quality, informative research in this area does not imply that it should not be attempted, assuming that this can be done ethically. Whether a clinician can ethically perform a nonvoluntary genital surgery on a child who is facing no urgent physical health need for such a surgery (or whether, instead, children have a right against such surgery irrespective of third-party judgments), however, is precisely what is under dispute.

[46] For example, some advocates of the permissibility of medicalized newborn penile circumcision who recognize the physical and symbolic overlaps between this custom and what they see as "minor" female genital cutting (e.g., ritual cutting of the labia or clitoral hood) increasingly argue that the latter should be permitted in Western societies even for nonconsenting girls (i.e., for the sake of parity) (Arora and Jacobs 2016; Cohen-Almagor 2020; Porat 2021; Shweder 2022b; for analysis, see Van Howe 2011). Nonvoluntary intersex surgeries have also in some cases been justified by appeals to the presumed acceptability of nonvoluntary penile circumcision (Fox and Thomson 2005; Meoded Danon 2018; see also Earp, Abdulcadir, and Shahvisi 2024).

Aged Care, the Australian Human Rights Commission and New South Wales Health. He is currently a member of the Australian Capital Territory's Variations in Sex Characteristics Restricted Medical Treatment Assessment Board. The views expressed within the context of this paper are solely his own. Ranit Mishori was, at the time the work was produced, Senior Medical Advisor at Physicians for Human Rights, and had received honoraria for speaking engagement, travel expenses, and consulting work from The American Academy of Family Physicians; World Organization Against Torture (OMCT); Legal Accountability Worldwide (LAW); and Society of Asylum Medicine. Eliana Rubashkyn is a member of ILGA World and Intersex Asia. Lauren Sardi has provided expert testimony to the New Hampshire State Legislature in support of bills that would require enhanced informed consent and that would limit state Medicare funding of medically unnecessary neonatal circumcision; Sardi has also written numerous articles on the ethics and human rights implications of genital cutting.

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APPENDIX A. ABOUT THE AUTHORS

This work grew out of informal discussions among participants in the G3 International Experts Meeting on FGM/C in Brussels, Belgium, May 20–22, 2019, along with other scholarly collaborators. A shorter statement by some members of our group was previously published in the *American Journal of Bioethics* (BCBI 2019). Our collaborative network has shifted and grown since then, including by way of additional workshops in Höör, Sweden, and Toronto, Canada, in 2023. The present article represents the views of the signing authors listed below. We are physicians, ethicists, nurse-midwives, public health professionals, legal scholars, human rights advocates, political scientists, anthropologists, psychologists, sexologists, sociologists, philosophers, and feminists from Africa, Asia, Australasia, Europe, the Middle East, and the Americas with interdisciplinary or experiential expertise in child genital cutting practices across a wide range of cultural contexts. Although we do not necessarily share a single policy perspective with respect to such practices, nor a uniform moral assessment of every feature of them, we are united in a concern about inconsistencies, double standards, and Western cultural bias in the prevailing discourses on genital cutting of children. Some of us have evolved in our thinking over the years in response to scholarship illuminating such problems. Indeed, several of the present authors have previously performed medically unnecessary genital surgeries on healthy children at the parents' request, whether for cultural, prophylactic, or psychosocial reasons—or as a part of their medical training—without realizing the ethical implications at the time. Some of the present authors, moreover, have authorized such surgeries for their own children (a decision for which they have sought to make amends). Those among us who were, ourselves, subjected to medically unnecessary genital cutting or surgery as children have a range of complex attitudes toward our parents and physicians; although we cannot change the past, we are committed to creating a better future. Together, we argue that no child—no person—who has not requested such an intervention and given their own "morally transformative" agreement or permission for it to occur should have a surgical or other cutting instrument applied to their genital anatomy except in cases of medical necessity. We argue for a more coherent, sex- and gender-inclusive approach that recognizes (1) the special vulnerability of young people—regardless of their sex characteristics—to medically unnecessary genital cutting or surgery and (2) the moral importance of bodily integrity, respect for bodily/sexual boundaries, and consent. The contributors are listed alphabetically.

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APPENDIX B. THE QUESTION OF POTENTIAL BENEFITS TO PHYSICAL HEALTH

Notwithstanding our analysis in the main text (including our critique of what we called the "mental health" argument for certain kinds of genital modifications; see Box 4), those who believe that clinicians should be allowed to perform at least some forms of medically unnecessary, nonvoluntary genital cutting or surgery on children might think to invoke the notion of *physical* health benefits to explain and defend their perspective. In particular, they might argue that if a proposed genital modification is reasonably expected to benefit the child's physical health at some future point, it is permissible to go ahead with the surgery on that basis, assuming parental permission.

For example, in the case of genital surgery for endosex males, an eight-member task force of the American Academy of Pediatrics (AAP) asserted in 2012 that the health-related benefits of nontherapeutic infant or newborn circumcision (removal of the penile prepuce)[47] "outweighed" the risks of surgery, a claim they felt was sufficient to justify "access [for] families who choose it" (AAP 2012a).[48] However, no recognized method of assigning weights to benefits or risks—for example, in light of nonsurgical alternatives—was used by the task force members (Svoboda and Van Howe 2013; Van Howe 2018), one of whom later acknowledged that "most circumcisions are done due to religious and cultural tradition [and] although parents may use the conflicting medical literature to buttress their own beliefs and desires, for the most part parents choose what they want for a wide variety of nonmedical reasons" (Freedman 2016, 2).

Accordingly, the claim about net health benefits has not been adopted, or has been explicitly rejected, by all other comparable health authorities (i.e., mainstream national-level medical bodies to have issued specific policies or guidance on the subject), including the Canadian Paediatric Society, the Royal Australasian College of Physicians, the British Medical Association, the Royal Dutch Medical Association, the Danish Medical Association, and the Finnish Medical Association (see Lempert et al. 2023 for a recent summary, with a focus on UK guidance).

Perhaps that is why the AAP policy has been allowed to expire, with no known plans to renew or reaffirm it (Klotz 2024). However, even if one simply grants all claims of potential future health benefits that have been statistically associated with a given genital modification, it does not follow that the modification—if nonvoluntary and medically unnecessary—is an ethically valid means of pursuing such benefits. To continue with the example of penile circumcision for purposes of illustration, consider that the only substantial health benefit that has been attributed to this procedure that applies in childhood, prior to sexual debut, is a reduced risk of urinary tract infection (UTI). According to the AAP (2012b), it would take approximately 100 penile circumcisions to prevent one UTI that, in the vast majority of cases, could successfully be treated without surgery (i.e., with antibiotics).

As a thought experiment, one can imagine that removing healthy tissue from a child's vulva (e.g., from the labia) similarly reduced the risk of acquiring a UTI, which girls are approximately 4 to 8 times more likely to contract than are boys by the age of 5 (AAP 2018b).[49] One can imagine, too, that

[47]The prepuce or foreskin is a "common anatomical structure of the male and female external genitalia of all human and non-human primates" (Cold and Taylor 1999, 34). In humans, the penile and clitoral prepuces are identical in early fetal development and remain indistinguishable in some intersex individuals (Grimstad et al. 2021). The prepuce is an "integral, normal part of the external genitalia that forms the anatomical covering of the glans penis and clitoris," thereby internalizing each and "decreasing external irritation and contamination" (Cold and Taylor 1999, 34). In the case of the penile prepuce (approximately 30–50 cm^2 in the adult organ, or about one-third of the motile skin system of the penis), an additional function, alongside its dynamic role in copulation, is to protect the urinary opening from abrasion, as this runs through the penile, but not through the clitoral, glans. In both cases, the prepuce is "a specialized, junctional mucocutaneous tissue which marks the boundary between mucosa and skin … similar to the eyelids, labia minora, anus, and lips … [the] unique innervation of the prepuce establishes its function as an erogenous tissue" (Cold and Taylor 1999, 34). Notably, under a new U.S. federal law signed in January 2021—the STOP FGM ACT—it is explicitly a crime even to "prick" the clitoral prepuce (including for religious reasons) unless it is medically necessary, whereas partially or totally removing the penile prepuce (even for nonreligious reasons) is not considered to be a crime within the same jurisdiction (a similar asymmetry exists in other Western countries, including England and Australia) (Rogers 2016). Whether medically unnecessary cutting of the prepuce in intersex cases is criminal under the new law is not clear. In any case, the Act may face constitutional challenges due to the equal protection clause of the Fourteenth Amendment to the U.S. Constitution, which requires equal treatment of persons, irrespective of sex—and parental religion—before the law (Rosman 2022). Note that some of the material in this note is adapted from Myers and Earp (2020). The penile prepuce size estimate is derived from Werker, Terng, and Kon (1998), Kigozi et al. (2009), and Taylor, Lockwood, and Taylor (1996). For additional information, see Sorrells et al. (2007); Bossio, Pukall, and Steele (2016) and the response by Van Howe et al. (2016); see also Fahmy (2020); and Cepeda-Emiliani et al. (2023).

[48]Note that an anonymous working group with the U.S. Centers for Disease Control and Prevention (CDC) subsequently advanced a similar claim (CDC 2018), drawing on the AAP analysis and attracting similar international criticism (see Frisch et al. 2013 for international criticism of the AAP analysis by a large group of authors, and Kupferschmid et al. 2015 for a similar critique of the original draft guidelines posted by the CDC; see also Van Howe 2015 for a critical CDC-requested peer review of the draft guidelines). Both organizations justified their stances by appealing to evidence from trials of *adult, voluntary* circumcision conducted in parts of sub-Saharan Africa experiencing epidemics of heterosexually transmitted HIV, while failing to demonstrate either the medical or ethical relevance of this evidence to the nonvoluntary circumcision of children in highly dissimilar epidemiological environments, such as the United States (Bundick 2009; Darby and Van Howe 2011; MacDonald 2011; Travis et al. 2011; Bossio, Pukall, and Steele 2014, 2015; Frisch and Earp 2018). Meanwhile, large population-based cohort studies in countries more similar to the United States in multiple relevant respects, including Canada (Ontario) and Denmark, show no protective effect of early childhood circumcision against HIV and other sexually transmitted infections (STIs) later in life (Frisch and Simonsen 2022a, 2022b; Nayan et al. 2022a, 2022b). Indeed, in the Danish study, "circumcised males had a 53% higher rate of STIs overall [and] rates were statistically significantly increased for anogenital warts [and] syphilis" (251).

[49]According to the AAP (2018b), "By age 5, about 8% of girls and 1–2% of boys have had at least one urinary tract infection (UTI). Most children who have one UTI will not have another." Even in the rarer case of children with recurrent UTIs, "there are many effective treatments available. Some simple things you can do to help prevent UTIs in your child include drinking lots of fluids, encouraging frequent

labial ablation is less expensive and less surgically risky, with a shorter healing time, and so on, if performed in childhood rather than later in life, as is often claimed for both penile circumcision and for various intersex operations (i.e., the claim that, medically speaking, there is a "window of opportunity" for early intervention that, if missed, will result in increased risks or decreased benefits; see Box 3 in the main text).

But if 100 childhood labial excisions, or even a small fraction thereof, were necessary to prevent a single, likely treatable, UTI, it is implausible that the AAP or any other Western organization would concede that girls no longer had a moral right to bodily or sexual integrity according to which such a surgery would seriously wrong them. In other words, it would not be considered morally or legally acceptable for a licensed medical professional to cut and remove living tissue from a child's healthy vulva to moderately reduce her future risk of acquiring a likely treatable (or otherwise avoidable) infection (note that this thought experiment, including the additional argumentation in the next paragraph, is adapted and paraphrased from Earp 2021).

Instead, the following points would be seen as uncontroversial: (a) healthy, sensitive genital tissue has an intrinsic value, so that damaging or removing it without a strict medical indication is harmful per se; (b) surgery on the genitals should not be employed until all more conservative means of treating or preventing potential infections—or other health problems—affecting that part of the body have been appropriately ruled out: that is, surgery should be an "extreme last resort" (Van Howe 2013b, 479), and (c) girls have a moral right against *any* interference with their sexual or reproductive anatomy to which they themselves do not consent (whether due to incapacity or competent refusal) unless medically necessary in the sense discussed in this article. Since preemptive genital modification is not justifiable to reduce the risk of a potential future health problem (whose prevention or treatment almost never requires cutting or surgery) in the case of a child with normatively female sexual anatomy, it is morally inconsistent to allow such modifications in the case of children with normatively male sexual anatomy, or indeed in children with nonnormative sexual anatomy (i.e., intersex traits), and for the same reasons.

urination, preventing constipation, keeping the genital area clean, wearing cotton underwear, and wiping from front to back after a bowel movement or urination." There is also evidence that at least some of the reported association between UTI rates and noncircumcision may be due to confounding (Van Howe 2005, 2009).