

Q&A: SB 201 (Wiener)

What does SB 201 do?

SB 201 preserves options for children born with natural variations in their sex characteristics (often called intersex traits) and their families.

The bill protects this group of children by delaying medically unnecessary, irreversible, and often high-risk surgeries that are now typically performed on infants to conform their bodies to gender expectations. SB 201 simply defers any such procedures until patients can participate in these personal decisions and determine what, if any, interventions are appropriate for them. SB 201 will still allow doctors to provide medically necessary care to patients when they need it.

What conditions qualify as a variation in sex characteristics?

There are dozens of traits that may cause someone's sex characteristics – including chromosomes, genitals, or organs like testes or ovaries – not to fit traditional ideas of male or female. SB 201 covers any such variation that might be surgically altered to match social gender norms. Some people use the word “intersex” to refer to these variations, while others use terms like Disorder (or Difference) of Sex Development (DSD). Others use the name of the specific diagnosis or trait (such as Congenital Adrenal Hyperplasia (CAH), a hormonal variation that may cause an enlarged clitoris, or hypospadias, where the urethra opens on the underside of the penis rather than the tip). Regardless of terminology, SB 201 aims to protect kids from the life-long harms of “correcting” healthy differences.

What kinds of surgical procedures are performed?

These medically unnecessary and high-risk procedures include reducing the size of a clitoris, creating a vagina, removing internal testes, and relocating the urethra so that it opens on the tip of the penis.

If these procedures aren't medically necessary, why do doctors perform them?

Many of these surgeries are driven by the well-intentioned but misguided assumption that conforming sex traits to gender norms is necessary for psychosocial development or is what children would want as adults. Others are historically rooted in sexism, homophobia, and a fear of bodily difference. An original motivation for surgeries like clitoral reduction and vaginoplasty was to ensure children raised as girls would not become lesbians and would be penetrable by their presumed future husbands. These same surgeries are still done, but now with the stated goals of achieving a “feminine” appearance (for infants) and normal sexual development (though patients describe the surgery itself as sexually traumatic). Surgery to move the urethral opening is done to “normalize” appearance and to allow children raised as boys to urinate standing up (yet urinary continence and function are often damaged in the process). Performing these procedures on young children prioritizes gendered assumptions over physical health and patient autonomy. SB 201 protects children with variations in sex characteristics by delaying these invasive, elective “normalizing” surgeries until the patient can consent. . . . ➔

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What are the risks associated with these elective surgeries on infants?

There is medical evidence that early surgeries can cause a wide range of serious and irreversible consequences. Clitoral reductions and vaginoplasties, commonly performed on infants with CAH, carry documented risks of scarring, incontinence, inability to orgasm, and urinary tract infections. Removing hormone-producing gonads creates a need for hormone replacement therapy and can be sterilizing. Hypospadias surgeries can damage sexual and urinary function and often require repeated surgeries as the child grows (when no surgery was necessary in the first place). Any of these procedures can lead to PTSD, depression, and problems with intimacy later in life. Surgery that aims to reinforce gendered appearance or behavior carries extra risks when the child may later identify with a different gender instead (as is the case for 5-15% of CAH patients, and up to 60% for some other intersex traits). Finally, the risk of permanent brain damage related to anesthesia in infants and young children has led the FDA to recommend that surgery on children under 3 be delayed unless urgently necessary.

Is it safe to delay these surgeries until patients can make their own decisions?

There are no proven risks in delaying these elective surgeries until patients can decide for themselves whether the surgery is right for them. Assumptions that children who do not undergo surgery will be bullied or feel uncomfortable with their bodies have not been supported by medical studies or by the vast majority of personal stories from the intersex community. Patients interviewed by Human Rights Watch for a 2017 report overwhelmingly indicated that non-consensual surgery **caused** trauma and shame instead of preventing them. Studies of children who did not have surgery show they are healthy and well-adjusted. In rare cases, some children with intersex traits need immediate surgery, such as when no urinary opening exists. SB 201 will still allow them to receive this needed care.

In what circumstances are other medical procedures delayed or banned for minors?

California prohibits certain practices with high risks of irreversible harm from taking place in childhood, only allowing them to be carried out once the patient can give informed consent. LGBTQ conversion therapy, female genital mutilation, sterilization, psychosurgery, and electroconvulsive (“shock”)

therapy are all against the law to perform on minors because the risk that they may cause lifelong damage must be weighed by patients for themselves. Most of these procedures, like elective surgeries on intersex children, have no demonstrated benefits. Even in cases where they may benefit some patients, state law does not allow them to be performed on children because their high risks require individual consent.

What percent of the population is intersex, and how common is surgery on intersex infants?

About one in two thousand babies is born with genitals that are visibly different from what we think of as typical for male or female infants. Many more – up to 1.7% – have variations in sex characteristics, including chromosomes and gonads, that might not be visible at birth. We do not know how many intersex people received surgery in the past because many were never told about their intersex status or childhood surgeries. Today, these surgeries remain common practice in California and around the U.S., with most carried out under the age of two. In several recent medical studies, over 90 percent of the young intersex patients enrolled at participating hospitals underwent surgery, and public records show that surgical rates are increasing, with over 1,000 being covered by Medi-Cal alone each year.

Shouldn't parents get to decide what surgery their children should have?

SB 201 is about centering care on the needs of patients themselves. If a surgery is urgently necessary for the young patient's health, their parents and doctors will still be able to make sure they receive it. Elective surgeries that make irreversible changes to the genital appearance and function of children with variations in their sex characteristics, however, are highly personal decisions that impact gender, reproduction, and sexual life. Trying to predict what a child will choose before they are able to actively participate in these decisions can do more harm than good in the end. Waiting until they can understand their options and give their own consent has no medical or psychological downsides, while prematurely performing these medically unnecessary, elective, irreversible, and often high-risk surgeries does.