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CORRECTIVE SURGERIES ON PERSONS BORN WITH INTERSEX-VARIATIONS IN INDIA

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Abstract: In the absence of any census, there is no exact number to figure out the population of the intersex persons in India. The Register of Births, a statutory register maintained to record all births in India under the Registration of Births and Deaths Act, 1969 classifies all births under the binary of male and female. In the absence of any legal definition of what constitutes as 'male' and 'female', this paper attempts to understand the methods deployed by the medical practices in constructing the socio-legal category of 'sex' only in terms of male / female. This evaluation is based on a critical analysis of five academic papers wherein, they discuss a total of 561 cases of corrective-surgeries operated on persons born with intersex variations between 1989 and 2007. The paper raises ethical and policy concerns over the continued pathologisation of the persons born with intersex variations that categorise them as a disorder. Based upon its critical analysis, this paper challenges the Indian socio-legal understanding of 'sex' and argues a case for completely dismantling the existing identities that define 'sex' as male / female.

Keywords: Gender-Binary, Intersex, Intersex-Variations, Medicalisation of Sex, Queer Theory, Sex Reassignment Surgery.

1. Introduction

Generally, when a child is born, the first thing that is asked is it a boy or a girl—which means, a certain 'sex' within the binary of male / female becomes an identity for that child. This general

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practice of attributing 'sex' at birth is mainly based upon a physical examination of the external genital organs.[1] Who has the authority to decide one's sex?[2] Such general examinations are essentially rooted in the socio-medical systems of knowledge as the authority to decide lies mainly with the physicians and/or the members of the society.[3] The medical knowledge has further enhanced the domain of its share in this authority, by developing certain additional yardsticks. First, to have the body examined of the presence of any internal genitalia (i.e., to determine whether anatomically one's gonads could be categorised as ovaries or testes).[4] The presence of a testes and the absence of ovaries makes a body 'male'; whereas, its opposite is called 'female'. Second, to genetically determine whether one's chromosomal pattern is distributed across the body as XX or XY; as it is suggested that a combination of two X chromosomes are needed for one to be medically categorised as a 'normal female', and a pairing of one X and one Y chromosomes are needed for one to be called a 'normal male'.[5] Thirdly, by determining the proportion of hormones in a body, the assumption being that a dominant proportion of testosterone and a relatively lesser of estrogen and progesterone qualify a body to be categorised as 'male'; whereas, a higher value of estrogen and progesterone compared with a lower proportion of testosterone would make

[1]G. L. Foss, "Intersex States," *The British Medical Journal* 2, no. 5217 (1960): 1907-1909, 1907.

[2]Re-appropriated from Elizabeth Reis's questions: "What did it mean to be male or female? Who had authority to answer that question, and what were the criteria?" See Elizabeth Reis, "Hermaphrodites: Intersex in America, 1620-1960," *The Journal of American History* 92, no. 2 (2005):, 411-441, 412.

[3]Reis, "Hermaphrodites: Intersex in America," 412.

[4]Foss, "Intersex States," 1907.

[5]Foss, "Intersex States," 1907.

the body 'female'.[6] The predominant medical narrative that defines 'normal' over 'abnormal' is therefore those bodies in whom all these three yardsticks align.

When one is born with an anatomical make-up different from the "standard male or female bodies"[7] it is not clear whether they should be regarded as male or female—medically they categorised as persons born with 'intersex variations'.[8] Dr Minu Bajpai of the Department of Paediatric Surgery, All India Institute of Medical Sciences, New Delhi writes:

> Disorders of Sex Development (DSD) have been previously known as Intersex disorders. There are misunderstandings attached with these conditions, mostly because of ignorance. These conditions are caused by genetic and endocrine imbalances in foetal life and children are born with genital appearances which do not conform to clearly male or female genital appearances. The infant may be often rejected by the parents and generally discriminated by the society. Corrective surgery is offered to these children to keep the best interest of the child.[9]

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[6]Melina Constantine Bell, "Gender Essentialism and the American Law: why and how to sever the connection," *Duke Journal of Gender Law & Policy* 23, no. 163 (2016): 163-221, 174.

[7]Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex*, Cambridge: Harvard University Press, 2009, 4.

[8]Generally, the medical practice is to refer to intersex persons as 'persons born with intersex conditions'. Since, the usage of the word 'condition' quite pathologises the person and marks them with an identity that is considered abnormal (by putting them under the category of a medical disorder), hence, I would prefer using the term 'variations' instead of 'conditions'. See Chayanika Shah, Raj Merchant, *et al.*, *No Outlaws in the Gender Galaxy*, Delhi: Zubaan, 2016, 245.

[9]Minu Bajpai, "Disorders of Sex Development: The Quintessence of Perennial Controversies," *Journal of Indian Association of Pediatric Surgeons,* 19, no. 1 (2014): 3-4 <http://medind.nic.in/jan/t14/i1/jant14i1p3.htm> (31 May, 2018). See, Ellen K. Feder, *Making Sense of Intersex: Changing Ethical Perspectives in Biomedicine*, Bloomington: Indiana University Press, 2014.

Since, all human bodies are not identifiable under the neat and coherent biological categories of male/female, these bodies are labelled as 'disordered' within the existing medical epistemology. As Bell explains, "sometimes that is because the person's genitals are ambiguous (such as when the penis is very small, or the clitoris is very large). Other times, the person's genitals seem to indicate that they are one sex, while their chromosomes and/or hormones indicate that they are the other sex."[10] Congenital Adrenal Hypoplasia (CAH) is the condition typically found in genetic females with XX chromosomes, who are commonly born with external signs of male genitalia. According to Jordon-Young, the diagnosis of this condition generally takes place during infancy, and it is medically advised that such children be socially raised in the female gender, but with the caveat that they may turn masculine or tomboyish.[11] Androgen Insensitivity Syndrome (AIS) is a condition typical to genetic males with XY chromosomes, who internally have testosterone producing male genitals but externally they manifest female genitals. As the name of this condition suggests, this condition makes the body insensitive to the testosterone produced by the male genitals. For these reasons such persons are generally raised in the female gender until adolescence, when their failure to menstruate calls for pathological diagnosis.[12] There are some genetic males with normal androgen responsiveness who are reassigned females "only in extremely rare cases."[13] These are children who suffer an irreparable damage/loss of their male genital organs due to reasons such as circumcision, accidents, or at birth. According to Jordon-Young, rearing such children in the female gender is generally experienced as a cultural challenge for the parents.[14] Additionally, there is one more category of chromosomal

[10]Bell, "Gender Essentialism and the American Law," 175.

[11]Rebecca M. Jordan-Young, *Brain Storm: the Flaws in the Science of Sex Differences* Cambridge: Harvard University Press, 2011, 259.

[12]Jordan-Young, *Brain Storm*, 74, 258.

[13]Jordon-Young, *Brain Storm*, 259.

[14]Jordon-Young, *Brain Storm*, 259.

variations outside the typical XX or XY make-up.[15] It is seen in some rare cases for persons to have genotypic pairings such as XYY, XXY, or XXYY (considered male); or XO, XXX (considered female).[16] As these conditions occur typically from birth and sex-assignment in the male/female binary becomes problematic.

In the absence of any census, there is no exact number to figure out the population of the intersex persons in India. Also, in the absence of any medical or statutory registry for the number of intersex births in India, it is technically impossible to determine the number of such births across different hospitals. The Registration of Births and Deaths Act, 1969 classifies all births under the binary of male and female.[17] So if a child is born with intersex variations, generally the medical practice is to operate on the child to bring them in-line with the binary sexes. In a patriarchal society like India, where the rate of female infanticide is very high and the official sex-ratio figure as per the census of 2011 was 933 females per 1000 males,[18] it is highly possible that many so called 'sex-correction surgeries' are carried over children across India to either kill such infants or to correct them to become males.

The central question addressed by this paper is a qualitative one: in what ways, have the medical practices reified the socio-legal construction of 'sex' in terms *only* of the male/female

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[15]Bell, "Gender Essentialism and the American Law," 176.

[16]M. Blackless, A. Charuvastra, *et al*., "How Sexually Dimorphic Are We? Review and Synthesis,"*American Journal Human Biology* 12, no. 2(2000): 151-166.

[17]For example, see Forms 1, 5, and 7 of Kerala Registration of Births and Deaths Rules, 1999; or, see Forms 1, 5, and 7 of the Goa Registration of Births and Deaths Rules, 1999. This is common across all state-government-framed-rules under the Section 30 of the Registration of Births and Deaths Act, 1969.

[18]See Census of India-2011, Office of the Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India, <http://censusindia.gov.in/Census_And_You/gender_composition.aspx> (3 May, 2017).

binary in contemporary India? Critically evaluating the role of medical practices that have led to the marginalisation of the intersexed persons, this paper challenges the binary construction of 'sex' as an identity-category and argues a case for completely dismantling the existing identities that define 'sex' as male / female.

2. Problems with the Indian Medical Practice

Here, I critically evaluate five academic papers published by members of the medical fraternity between 1995 and 2009. In total, they discuss 561 cases of corrective-surgeries operated on persons born with intersex variations between 1989 and 2007 in diverse urban-locations in India. They mainly cover tier-1 and tier-2 cities from the north (Delhi and Chandigarh), west (Mumbai), and south (Trivandrum and Belgaum) of India. Also, these studies depict practices at public and private hospitals.

Using queer theory[19] as a methodological lens for this paper, these five academic papers are chosen because their content, extent, location and function are found to be suitably addressing the central research question. In an all, these five academic papers depict the larger Indian medical discourse that keeps producing and reproducing the socio-legal binary

[19]On Queer Theory as a methodological practice, see Francisco Valdes, "Afterword—Beyond Sexual Orientation in Queer Legal Theory: Majoritarianism, Multidimentionality, and Responsibility in Social Justice Scholarship, or Legal Scholars as Cultural Warriors," *Denver University Law Review* 75 (1998): 1409-1464; Francisco Valdes, "Queers, Sissies, Dykes, and Tomboys: Deconstructing the Conflation of 'Sex,' 'Gender,' and 'Sexual Orientation' in Euro-American Law and Society," *California Law Review* 83, no. 1(1995): 1-377; J. Gamson, "Sexualities, Queer Theory and Qualitative Research", in *The Landscape of Qualitative Research: Theories and Issues*, N. Denzin, and Y. Lincoln, eds., London: Sage, 2003, 540-64; Martha A. Fineman, Jack E. Jackson *et.al.*, ed., *Feminist and Queer Legal Theory: Intimate Encounters, Uncomfortable Conversations*, London: Ashgate, 2009; Kath Browne and Catherine J. Nash, eds., *Queer Methods and Methodologies: Intersecting Queer Theories and Social Science Research*, London: Routledge, 2010.

categories of 'male/female' as against the 'intersex'; and in this process it uninterruptedly keeps reinforcing an unequal set of power relations between the insider/normal-sexed-body and the outsider/abnormal-sexed-body. The paper raises ethical and policy concerns over the continued pathologisation of persons born with intersex variations that categorise them as a disorder.

As per a clinical study on 356 cases of Male Genitoplasty conducted for intersex disorders, between 1989 to 2007 at the Department of Paediatric Surgery, All India Institute of Medical Sciences, New Delhi, all the cases were between the age of 2.5 to 22 years with a mean of 11.5 years and median of 5.6 years. All these cases had different forms of hypospadias (a birth-condition, where the opening of the urethra is on the underside of the penis). The study concluded that correction in this penile condition is needed early "to allow phallic growth," along with various surgical interventions "to achieve good cosmetic and functional results." The paper acknowledges that there is a need for managing such disorders through a more robust scheme of medical interventions that involves counselling, informed consent, and careful judgment while protecting the rights of the child.[20]

Another clinical study conducted by Joshi *et.al.* is based on the clinical and etiological profiles of 109 minor patients (age ranging between 5 days to 12 years) presenting with ambiguous genitalia over a period of 10 years (years 1995 to 2004) at Paediatric Endocrine Service of the B. J. Wadia Hospital for Children, Mumbai. This study reveals that 63 out of 109 patients (57.8% of total cases) were operated at a very young age ranging from five-days to one-year. The next-largest share of surgical interventions (around 20 cases) were found in toddlers ranging between one to three years of age. However, amongst all the 109 cases, the mean age of surgical intervention was 27.4 ± 38.4 months. Almost 60% of these minor patients

[20]Shilpa Sharma and Devendra K. Gupta, "Male Genitoplasty for Intersex Disorders" *Advances in Urology Volume* 2008 <http://dx.doi.org/10.1155/2008/685897> (25 May, 2017).

were reared as males, whereas, around 20% were raised in the female gender.[21] According to the paper, the rest of the patients were not assigned any gender at the time of their medical referral, which is quite possible given that most of these patients were referred upon for medical examination in the first few days/months of their birth. Like the previous one, this paper also emphasises the need for the paediatricians to "relieve psychological distress of families and patients."[22]

In a similar study conducted at the Department of Pediatrics Surgery, S.A.T. Hospital, Medical College, Thiruvananthapuram by Rajendran and S. Hariharan 35 cases were studied between 1986 to 1991. It was found that most of them presented between the age-range of one-month to two-years of age and only 2 presented in the new-born period. Sixteen were female pseudo-hermaphrodites. Eighteen out of 31 children were assigned female sex. One genetic female with congenital adrenal hyperplasia was assigned male sex.[23] The authors observe in their patient profile that the need for a neonatal assignment of sex is nearly "a social emergency," which indicates the growing influence of parental pressure in medical decisions of sex assignment. The authors of this paper conclude as a part of their study that "parents prefer the intersex children to be reared as male possibly because of the less social stigma attached to an impotent male than to sterile female, and because males are socially independent."[24] They report similar

[21]Rajesh R. Joshi, Sudha Rao, *etal.*, "Etiology and Clinical Profile of Ambigious Genitalia: An Overview of 10 years' Experience," *Indian Paediatrics* 43 (2006): 974-979, 975 <http://indianpediatrics.net/nov 2006/ nov-974-979.htm> (5 September, 2017).

[22]Joshi, Rao, *et al.*, "Etiology and Clinical Profile of Ambiguous Genitalia," 978.

[23]R. Rajendran and S. Hariharan, "Profile of Intersex Children in South India," *Indian Paediatrics* 32, no. 6 (1995): 666-671, 669 <https://www.ncbi.nlm.nih.gov/pubmed/8613335> (5 March, 2017).

[24]Rajendran and Hariharan, "Profile of Intersex Children," 670.

medical experiences in other Indian studies.[25] Although, they reckon that the medical judgment in assigning sex is generally a result of team-efforts from paediatric surgeons, endocrinologists, cytologists, radiologists and psychologists, in the case of one child with CAH they were forced to assign male sex "because of parental pressure".[26] They explain the basis of sex assignment in genetic males to be the size of the phallus—if it is less than 1.5 cm long and 0.7 cm wide, the child should be assigned female gender.[27] Whereas, all genetic females should be assigned female sex, they reckon.[28] They consider surgical interventions to be an imperative in such cases that must commence as early as three-months of infancy,[29] and that there must be no effort to change the child's sex after the second year.[30]

In another recent study[31] conducted by the Doctors at Postgraduate Institute of Medical Education and Research, Chandigarh, paediatric history of a total of 58 children were studied between the period of 2003 to 2007. The study found that all these 58 children were presented between the ages of 1 day to 144 months, with a majority (i.e., 87.9%) presented before 5 years. Out of this, almost 37% were presented in infancy; and, 12% were brought in the neonatal age-group (i.e., under 28 days of age).[32]A total of 43 children (i.e., 74.1%) were reared as males by their respective families, only 39 were

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[25]D. Maji, B Mukkopadhyay, *et.al.* "True Hermaphroditism: A Report of 2 Cases," *Journal of Associated Physicians India*, 38 (1990): 868- 870.

[26]Rajendran and Hariharan, "Profile of Intersex Children," 668.

[27]Rajendran and Hariharan, "Profile of Intersex Children," 670.

[28]Rajendran and Hariharan, "Profile of Intersex Children," 669.

[29]Rajendran and Hariharan, "Profile of Intersex Children," 666, 670.

[30]Rajendran and Hariharan, "Profile of Intersex Children," 669.

[31]Ketan Prasad Kulkarni, Inusha Panigrahi, *et al.*, "Paediatric Disorders of Sex Development," *Indian Journal of Paediatrics*, 76, no. 9 (2009): 956-958 <http://medind.nic.in/icb/t09/i9/icbt09i9p956.pdf> (6 May, 2017).

[32]Kulkarni, Panigrahi, *et al*., "Paediatric Disorders," 956.

genetic males, whereas, the rest were genetic females.[33] Based on the unbalanced gender division in the dataset (i.e., 43 of the 58 intersex children referred between 2003 to 2007 having been reared as males), the authors speculate that the absence of an equal number of females show the general neglect and the typical aversion of Indian parents for having female babies / foetuses.[34]

In another case-study based research, Nerli *et.al.*, at KLES Hospital, Belgaum studied three cases of genetically male children who were reassigned to male gender. They were assigned female at birth due to "severe hypospadias and micropenis." The age of these children was 6, 11 and 13-years respectively, when they were medically referred. All of them came from lower-middle class backgrounds, but both parents and children were involved in the decision-making where they were facilitated by "psychiatrists, urologists, paediatricians and family physicians."[35] The authors find the parents consistently keen on changing their children's gender to male, during the discussions; and, in two of these cases the child is also said to have effectively consented to male reassignment. Based on their post-surgery follow-up of fifteen-months, the authors reported that the children appear to have synced well in their new gender (e.g., the older ones have started having erections, and have started playing with other boys, whereas, the youngest one has reportedly overcome his shyness, but feels awkward in a boy's dresses). All the three children had been put through rounds of counselling at various phases during the whole process.

As in majority of the cases, the subjects are not just minors but are also very young to have understood the ramifications of

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[33]Kulkarni, Panigrahi, *et al*., "Paediatric Disorders," 957.

[34]Kulkarni, Panigrahi, *et al*., "Paediatric Disorders," 958.

[35]R. B. Nerli, S. M. Kamath, *et. al*., "Female-Assigned Genetic Males with Severe Hypospadias: Psychosocial Changes and Psychosexual treatment," *Indian Journal of Urology* 22, no. 1 (2006): 42-45 <http://www.indianjurol.com/article.asp?issn=09701591;year=2006;volume=22;issue=1;spage=42;epage=45;aulast=Nerli#ref1> (6 May, 2017).

such a surgery. Minu Bajpai asks, "who is the best person to take a decision regarding nature of surgery: parents or patients? Is the decision part of the parents' desire duly fulfilled by doctors? What is the best age of such surgeries?"[36] To which, I add: Are most of such sex-corrective surgeries directed to reassign male-sex to the child? And most basic, what is the need for such corrective surgeries? These aforesaid studies conducted by medical professionals indicate and thus, facilitate my understanding to arrive at a few observations that are common to all these studies.

i. Pathologisation of the intersexed body: On the part of the medical/psychiatric fraternity, and the social workers, there is a constant attempt to pathologise persons born with intersex variations by categorising them as disorder/ problem—an abnormality that must be fixed on an urgent basis. A congenial or non-congenial sex variation is always seen more as a social problem than a medical urgency. Much of this problem stems from the common knowledge of gender understood as a binary of male/female, shared by members of the medical/psychiatric fraternity and the society.

ii. Androcentric parental pressures over medical decision making: Looking at the quality of the aforesaid clinical experiences of the medical/psychiatric staff dealing with such cases, one cannot dismiss the recurrent parental desire to see a male child post-surgery. Given that, the medical fraternity is dependent on parental consent to go ahead with such sex-assignment procedures, there is always a possibility for medical decision-making to be controlled by parental interests. If medical judgments are a product of patriarchal values, then certainly the genuineness of such life-changing surgical decisions must need a rethink.

iii. Issues of age and consent in medical decision-making: It is a long-standing medical practice to undertake corrective

[36]Bajpai, "Disorders of Sex Development."

procedures/surgeries while the child is either young or an infant. Such practices are controversial as they severely undermine the agency of the child. The medical knowledge very-well understands that such practices are problematic but, seldom plays any active role in positively changing it. Because such practices are deeply institutionalised in the socio-medical knowledge, it has had (and, continues to have) a significant impact in shaping the intersex lives. Given that, the intersexed body has no effective role in choosing such futures, the liability of any damage caused to such lives lies solely on the real decision-makers, i.e., the parents and medical professionals. The issues of age and consent of the intersex persons raise serious ethical and policy issues concerning public health—thus, making it an apt case for legal intervention.

Although this qualitative study cannot be used to draw generalisations about the overall state of corrective surgeries, or its impact over the intersex community as a whole, it shows how socio-medical knowledge has the potential to shape intersex experiences. This discussion demonstrates the ways in which the powers of 'the medical' and 'the social' work together control the mind and body of the intersex persons. The apparatuses of this socio-medical power-structure construct what is worth normalising, and what is not—thus, subjecting the intersex lives to their will and domination, constructing new meanings and realities for them. This also shows how the socio-medical actors (i.e., the members of the medical/psychiatric fraternity, and the parents and family of the intersex child) can abuse their position by taking granted the agency of intersex children.

3. Law's Purported Role in Invisibilising the Intersex

The medical discourse above indicates at the politics and economy of the management, regulation and administration of sexes, which is an important public policy of our times. While explaining his thesis of biopolitics, Foucault quotes Claude-Jacques Herbert, the French Economist who wrote during the enlightenment years of the eighteenth century:

> States are not populated in accordance with the natural progression or propagation, but by virtue of their industry, their products, their different institutions. ... Men multiply like the yields from the ground and in proportion to the advantages and resources they find in their labours.[37]

It looks as if the story fits squarely well in our contemporary times; the production of the human is managed by the institutions of our times, the hospital and the family act like the farmer who cultivates and very meticulously cuts out the unproductive plants from his fields to enhance the quality of his yield. The metaphor quite fits as human births have taken the status of human production. Since, there is a structural interdependency between patriarchy and the modes of production,[38] much of the factors that influence this selective (re)production of the 'normal bodies' is related to the way patriarchy has historically defined the economics of the Indian society. The medical literature discussed, clearly indicates the possible ways of patriarchy's operation in medical decision-making through the parental demands for a virile male child. This way, 'maleness' of the body is not just defined biologically (e.g., by the presence of certain genotype, or hormonal proportions), but also through surgical procedures, such as penile-construction (phalloplasty), or fixing hypospadias. A particular shape, size, length, and depth of the penis/vagina therefore is relied upon uninterruptedly by 'the medicine' to determine whether the body is worthy of being categorized as 'male'. This way, the biology of the body solely determines the destiny of a person.

But, how does law sustain this biopolitics? After all, law lays down the norm just like any social code that regulates behaviour in the society. Often, law empowers some in order to

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[37]Claude-Jacques Herbert, *Essai sur la police générale des grains* 320-321 (1753) cited in Michel Foucault, *The History of Sexuality: An Introduction-I*, New York: Pantheon, 1990, 25.

[38]Val Burris, "The Dialectic of Women's Oppression: Notes on the Relation between Capitalism and Patriarchy," *Berkley Journal of Sociology* 27 (1982): 51-74, 53.

disempower *the other* and this is how the 'queer' is produced.[39] Since, the law sustains the medico-social (re)production of the male/female binary, it has to regularly act to ensure that this production follows a flawlessly uniform pattern. This is how the intersex body is corrected at all costs, to prevent it from becoming *the other*—the queer. As David Halperin marks, "queer is by definition whatever is at odds with the normal, the legitimate, the dominant. There is nothing in particular to which it necessarily refers."[40] In this case, the intersex is positioned as the queer.

Being queer doesn't necessarily restrict its location to be always situated outside (or, in opposition to) the law. It doesn't also mean that it is futile to have contestations within or without the law. After all, the language that the constitution provides makes law a site of democratic contestations. But, all law is not the constitution, neither all of it is constitutional. Traditionally, law has just been recognising the rights of male/female, because of which, the intersex was always located outside of the law. This piece of research thus, attempts to problematize the legal theory of binary sexual identities, and its conflation with gender roles.

Butler asks, "Can we refer to a 'given' sex or a 'given' gender without first inquiring into how sex and/or gender is given, and, through what means? And what is 'sex' anyway? Is it natural, anatomical, chromosomal, hormonal?"[41] Invoking Foucault, she asks:

> ... does sex have a history? Does each sex have a different history or histories? Is there a history of how the duality of sexes was established, a genealogy that might expose the binary options as a variable construction? Are the ostensibly natural facts of sex discursively produced by various

[39]Carl F. Stychin, *Law's Desire: Sexuality and the Limits of Justice*, New York: Routledge, 1995.

[40]D. Halperin, *Saint Foucault: Towards a Gay Hagiography*, New York: Oxford University Press, 1995, 62.

[41]Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity*, New York: Routledge, 1990, 6.

> scientific discourses in the service of other political and social interests?[42]

Law is concerned about 'sex' because there is an entire structure of economy that thrives on this materiality. All this in turn produce some essentialist relations and certain functional roles for this bodily materiality (that we call sex)—which is thus, used to serve this structure of economy. For example, the heterosexual family (a constituting institution in the economy of the heteronormative structure) demands from a father, a mother, a son and a daughter, certain specific roles as per their sex. As 'sex' is defined by the materiality of the biology of one's body, the male members of the family always get a privileged position in a hetero-patriarchal social-order and, in order to provide the males that space to dominate, the dominated-role is played by the male's *other*, *i.e.* the female (as a part of that binarised hetero-patriarchal structure). This is how the heteronormative structure conflates the biology of the body (i.e., sex) with that of the assigned social role of that biological body (*i.e.*, gender). To sustain the economy of this binarised hetero-patriarchal structure, of course, any other form of body, other than the male and female has no space and role; the other forms of non-male-non-female bodies are seen as obstructions in the re-production of this hetero-patriarchal economy. This makes all the non-binary bodily forms unproductive in this structure and hence, invisible. Since, the sex/gender-based binarised hegemony of male/female bodies signify production, heterosexuality acquires the status of 'the norm', whose compulsory reinforcement on the bodies (and the body's incessant response in terms of its uninterrupted performance to those assigned roles) further naturalises this 'norm' as a monolithic social order—result, the entire social order gets imbued into heteronormative settings.

Of course, these givens are very powerful in their mere existence as they enable an entire structure of power and oppression to come alive. Queer theorists attempt to

[42]Butler, *Gender Trouble*, 7.

deconstruct the power displayed by essentialist arguments that link the purported gender roles with that of the materiality of the body or simply the biological differences based on the category of 'sex'.[43] Butler argues, that "sex is therefore not a simple fact or a static condition of the body which is based only on some material/biological differences; but it is a process whereby regulatory norms compulsorily demand a certain performance of the body based on the category called 'sex'."[44] Why is this relation between materiality of the body problematic, thus, untenable and unstable *vis-à-vis* performativity of gender? The production of certain prescriptive and ideal gender roles takes place through a process of iteration and compulsory reiteration of a normative frame. What if, there is a break in the production and reproduction of these normative pressures on the body? Or, what if the body refuses to follow or practice or perform these normative roles anymore? Butler, contemplates that because of such possibilities of subversion by the bodies, such norms need to be enforced and re-enforced so that the compliance to such norms acquire the status of an absolute compulsion, something that gets etched in the psyche of the bodies as their naturalised destiny.

5. Conclusion

The critical evaluation of these five academic papers explain the ideological affiliations of the medical discourse in India, exposing its firm commitment to heteronormativity. This study tells us the fate of all those 561 bodies (most of whom were infants, toddlers and children)— how 'the medicine', along with its protractors of 'the social' and 'the legal' had the power to change these lives forever. It explains why these 561 bodies had no control over their own lives; and how the forces of 'the normative' had an incessant power to control, dictate and

[43]*See* Judith Butler, *Undoing Gender*, New York: Routledge, 2004; Sara Salih and Judith Butler, eds., *The Judith Butler Reader*, Oxford: Wiley-Blackwell, 2003.

[44]Butler, *Gender Trouble*, viii.

manoeuvre their choices. The queer analysis of these medical practices enables us to understand how heteronormative values and ideals have been normalised and naturalised in our social order, culture and the law.

The politics and economy of the management, regulation and administration of sexes is an important public policy of our times. And, this is when the Supreme Court of India has held that "...no one shall be forced to undergo medical procedures, including SRS (Sex Reassignment Surgery), sterilization or hormonal therapy, as a requirement for legal recognition of their gender identity."[45] The deep-fissures between the *formality* and the *reality* of law are openly evident—fissures that need to be addressed soon if the former has to triumph over the latter.

Keeping in mind the liberal legal rights' framework of the Indian juridical structure, it is obvious that identity-categories (old and new) are needed for any rights-based framework to operate. Perhaps this is the inherent paradox of any liberal legal regime, that on the one hand, it aims for enabling the individuals towards having control over one's life, and on the other, it disciplines them to act according to certain pre-determined socio-legal scripts. This way, a body that fails to fit into these scripted forms / roles falls out of its cracks.[46]

This paper argues for completely dismantling the existing identities that define 'sex' as male / female or intersex. In other words, speaking from the queer political perspective, 'sex' as a category of identity (whether with old categories such as male / female, or with new ones, such as intersex, transgender, etc.) must be thrown out of the window (legal structure) completely. Which means the queer would seek to quite radically transform the existing rights-based juridical structure into an identity-neutral framework, which has its own inherent problems and contradictions—a discussion which is beyond the

[45]*NALSA v. Union of India*, (2014) 5 SCC 438 at para 20.

[46]Wendy Brown and Janet Halley, eds., *Left Legalism/Left Critique*, Durham: Duke University Press, 2002; Oishik Sircar, "Some Paradoxes of Human Rights: Fragmented Refractions in Neo-liberal Times," *Journal of Indian Law and Society*, 2, (2010): 182.

scope of this paper.[47] The understanding and practice of 'sex' (and the entire economy based on it) runs at the cost of a routine invisibilisation of *the other*—the queer body (in this case the body marked as 'intersex') therefore needs changes in the current state of the socio-legal norms.

[47]Michael Warner, *The Trouble with Normal: Sex, Politics, And the Ethics of Queer Life*, Cambridge: Harvard University Press, 2000; Kimberlé Crenshaw, Neil Gotanda, *et. al.*, eds., *Critical Race Theory: The Key Writings That Formed the Movement* New York: New Press, I995; Katherine Franke, "The Domesticated Liberty of *Lawrence v. Texas*" *Columbia Law Review* 104 (2004): 1399; Janet Halley, *Split Decisions: How and Why to Take a Break from Feminism?* Princeton: Princeton University Press, 2006.