19-1952

IN THE

United States Court of Appeals

FOR THE FOURTH CIRCUIT

GAVIN GRIMM,

Plaintiff-Appellee,

—v.—

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant-Appellant.

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

BRIEF FOR *AMICUS CURIAE* interACT: ADVOCATES FOR INTERSEX YOUTH IN SUPPORT OF PLAINTIFF-APPELLEE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Civil Procedure, *amicus curiae* states as follows:

interACT: Advocates for Intersex Youth is a nonprofit organization. It has no parent corporation and no corporation or publicly held entity owns 10% or more of its stock.

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INTEREST OF *AMICUS CURIAE*

Amicus interACT: Advocates for Intersex Youth files this brief in support of Plaintiff-Appellee Gavin Grimm.[1]

interACT is a nonprofit organization that employs legal and policy advocacy to protect the rights of children born with variations in their sex characteristics, often called intersex. It is the first and only organization in the country exclusively dedicated to this purpose. Founded in 2006 as Advocates for Informed Choice, its mission initially focused on ending harmful, nonconsensual medical interventions on intersex children. Since then, interACT has expanded its mission to include awareness-raising to end the shame and stigma faced by intersex youth and overseeing the largest cohort of intersex young people advocating on their own behalf, interACT Youth.

The intersex youth for whom *amicus* advocates are a living refutation of Defendant-Appellant's argument that "sex" is a binary notion

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[1] *Amicus* certifies that no counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus*, its employees, or its counsel made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this brief.

and that a definition of "sex" based strictly on genitalia or other "physiological" factors is coherent and workable. *Amicus* has a strong interest in ensuring that this Court interprets "sex" in a way that respects all students, including those born with intersex variations.

SUMMARY OF ARGUMENT

Defendant-Appellant Gloucester County School Board (the "Board") argues that the word "sex" in Title IX and under Equal Protection Clause precedent must be construed to refer only to a student's "physiological" sex, and therefore permits educational institutions to disregard gender identity. Underlying the argument is the assumption that gender identity is an artificial and ethereal concept, whereas all students have a binary "physiological" sex—either male or female—that is unambiguous, indisputable, and always feasible for school personnel to determine.

That assumption is wrong. Each year thousands of intersex infants are born with variations in their sex characteristics, who could not be easily classified as "male" or "female" under the Board's "physiological" test. Intersex is an umbrella term describing a wide range of natural bodily variations—in external genitals, internal sex organs, chromo-

somes, and hormones—that do not fit typical binary notions of male or female bodies. These variations in physical characteristics have been known for millennia and their existence is universally acknowledged by the scientific and medical communities.

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

First, as *amicus* and others who work with intersex people well know, "physiological" sex is not an objective, clear-cut classification for all people. There are various ways that "physiological" sex could be defined—*e.g.*, on the basis of external genitalia, internal sex organs, hormones, or chromosomes. And where these criteria do not align, determining a child's "physiological" sex (however defined) is a necessarily subjective exercise.

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

quire forcing schoolchildren to submit to examinations of their genitals, internal sex organs, or DNA in order to use the restroom. Such a regime would be offensive, traumatic, and likely unconstitutional.

Third, the existence of intersex students belies the Board's assumption that construing "sex" solely on a "physiological" basis would prevent students from sharing a restroom with others whose sex characteristics differ from their own. As *amicus* explains, some children are assigned male sex at birth even though they have certain female-typical sex characteristics, and vice versa. Thus, even under the Board's regime, students could not be sure that the person in the next stall has genitals, gonads, or sex chromosomes identical to theirs.

ARGUMENT

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

The Board contends that "sex" is a "binary term encompassing [only] the physiological distinctions between men and women." Board Br. 20, 31.[2] However, thousands of children are born each year with

[2] References to "Board Br." refer to the Brief of Defendant-Appellant (Dkt. No. 19, filed Oct. 22, 2019). References to "Grimm Br." refer to the Brief of Plaintiff-Appellee (Dkt. No. 23, filed Nov. 18, 2019).

anatomy that is neither typically "male" nor typically "female." This has been true for millennia and was well known long before Title IX was enacted. The longstanding facts of human biology refute the Board's argument that a "physiological" understanding of sex eliminates the need to consider gender identity in determining what constitutes sex discrimination.

A. There Is A Broad Spectrum Of Intersex Variations

"Intersex" is an umbrella term describing a wide range of natural variations in physical traits—including external genitals, internal sex organs, chromosomes, and hormones—that do not fit typical binary notions of male and female bodies. Each year, as many as 2% of all babies are born with these variations.[3]

Intersex traits originate from variations in the embryonic sexual development process. A fertilized egg usually has two sex chromosomes: XX or XY. For the first few weeks of gestation, XX and XY embryos look the same, but they later develop in different ways depending

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

on genetic and hormonal factors. In male-typical sexual development, the gonads become testes; the genital tubercle becomes a penis; and the labioscrotal folds fuse and form a scrotum. In female-typical sexual development, the gonads become ovaries; the genital tubercle becomes a clitoris; and the labioscrotal folds develop into the outer labia. Later, at puberty, hormones secreted by the testes or ovaries cause expression of male-typical or female-typical secondary sex characteristics, such as breast development, body hair, musculature, and depth of voice.[4]

There are many ways in which this "typical" process can vary.[5] Such variations may present at different ages. For example, external genitalia that look noticeably different may mean a child's intersex var-

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

[5] Hughes, *supra* note 4, at 488; Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics & The Law*, 11 Ann. Health L. 195, 204 (2002); Carla Murphy et al., *Ambiguous Genitalia in the Newborn: An Overview and Teaching Tool*, 24 J. Pediatric Adolescent Gynecology 236, 236–37 (2011).

iation is recognized at birth, but variations in internal organs or sex chromosomes may not become apparent until puberty or later.[6]

Intersex children are usually "assigned" a binary (male/female) sex at birth based on some combination of their genitalia, gonads and other internal organs, and chromosomes.[7] This is a largely subjective process, and experts may disagree on the "correct" sex to assign to an intersex child.[8] Often, children discovered to be intersex in infancy may be subjected to nonconsensual, harmful, and irreversible "normalizing" surgical procedures in an attempt to erase their intersex differences—

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

[7] Hughes, *supra* note 4, at 491. The emphasis on which characteristic should prevail in determining a person's sex has changed over time. For a history of intersex management, *see generally* Elizabeth Reis, BODIES IN DOUBT: AN AMERICAN HISTORY OF INTERSEX (2009).

[8] *See, e.g.*, Tamar-Mattis, *infra* note 38, at 5 ("There is still controversy and uncertainty about gender assignment in [cases of partial AIS], and it can go either way, depending largely on the doctor's judgment."); David A. Diamond et al., *Gender Assignment for Newborns with 46XY Cloacal Exstrophy: A 6-Year Followup Survey of Pediatric Urologists*, 186 J. Urol. 1642, 1643 (2011) (reporting that only 79 percent of surveyed clinicians agreed on a male gender assignment in 46XY cloacal exstrophy).

interventions condemned by every human rights organization to have considered the issue.[9]

Some intersex people continue to identify with their originally assigned sex throughout their lives, but others do not.[10] For most major intersex diagnoses, 5–29% do not identify with their originally assigned sex.[11] In other cases, the rate of sex assignment rejection can reach higher than 60%.[12]

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[9] Jeremy Toler, Medical and Surgical Intervention of Patients with Differences in Sex Development 1, Gay & Lesbian Med. Ass'n (Oct. 3, 2016); Katrina Karkazis, *Fixing Sex: Intersex, Medical Authority, and Lived Experience* 57–58, 60–61 (2008); Martin Kaefer & Richard C. Rink, Treatment of the Enlarged Clitoris, Frontiers in Pediatrics (August 2017); Jennifer Yang, et al., Nerve Sparing Ventral Clitoroplasty: Analysis of Clitoral Sensitivity and Viability, J. Urol., Vol. 178, 1598–1601 (October 2007); Sarah Creighton, et al., Timing and Nature of Reconstructive Surgery for Disorders of Sex Development – Introduction, J. Pediatric Urol. (2012).

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

[11] Julie A. Greenberg, INTERSEXUALITY AND THE LAW 20 (2012); Hughes et al., *supra* note 4, at 491; P.S. Furtado et al., *Gender Dysphoria Associated with Disorders of Sex Development*, 9 Nat. Rev. Urol. 620 (Nov. 2012) (reporting average rates of gender dysphoria at 5% for Complete Androgen Insensitivity Syndrome, 10% for Congenital Adrenal Hyperplasia, 12.5% for Ovotesticular DSD, 20% for Partial Androgen Insensitivity Syndrome, and 29% for Mixed Gonadal Dysgenesis).

[12] P.S. Furtado et al., *Gender Dysphoria Associated with Disorders of Sex Development*, 9 Nat. Rev. Urol. 620 (Nov. 2012) (reporting average

The (now-defunct) Intersex Society of North America ("ISNA") recognized approximately 20 different intersex diagnoses,[13] including:

a. ***Congenital Adrenal Hyperplasia (CAH)*:** CAH can occur in babies with XX or XY chromosomes, but is only considered an intersex variation in XX babies. In CAH, a variant form of an enzyme leads to heightened production of androgenic hormones *in utero*. This can cause development to varying degrees of typically "male" physical characteristics. XX individuals with CAH may have female-typical internal organs and masculinized external genitalia, such as an enlarged clitoris and/or the lack of a vaginal opening. CAH can also cause development of male-typical secondary sex characteristics like body hair, deep voice, and prominent muscles. CAH occurs in about 1 in 14,500 births.[14]

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rates of gender dysphoria at 57% for 17-beta-HSD3 deficiency and 63% for 5-alpha-RD2 deficiency).

[13] Clinical Guidelines, *supra* note 6, at 5–7.

[14] Walter L. Miller & Selma Feldman Witchel, *Prenatal Treatment of Congenital Adrenal Hyperplasia: Risks Outweigh Benefits,* 208 Am. J. Obstetrics & Gynaecology 354, 354 (2013); Phyllis W. Speiser, et al., *Congenital Adrenal Hyperplasia Due to Steroid 21-Hydroxylase Deficiency: An Endocrine Society Clinical Practice Guideline*, 95 J. Clin. Endocrinology & Metabolism 4133–60 (2010); Blackless et al., *supra* note

b. ***5-Alpha Reductase (5-AR) Deficiency*:** People with 5-AR deficiency have an XY chromosomes and testes, but their bodies produce lower-than-typical levels of the hormone dihydrotestosterone (DHT), which impacts formation of the external genitalia. Many are born with external genitalia that appear typically female. In other cases, they are neither male- nor female-typical. Still other affected infants have genitalia that appear predominantly male, often with an unusually small penis (micropenis) and the urethral opening on the underside of the penis (hypospadias). During puberty, people with 5-AR deficiency develop some typically male secondary sex characteristics, such as increased muscle mass and a deep voice, but do not develop much facial or body hair. Children with 5-AR deficiency are often raised as girls. However, about half have a male gender identity and live as male beginning in adolescence or early adulthood.[15]

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

[15] Hermer, *supra* note 5, at 207.

c. ***Androgen Insensitivity Syndrome (AIS)*:** People with AIS have XY chromosomes, but their cells have a reduced or absent response to testosterone or other androgens. As a result, they do not form typically male genitalia. In "complete" AIS, babies are usually born with a vaginal opening and clitoris indistinguishable from those seen in typical female babies. The diagnosis is ordinarily not suspected until puberty, when menstruation does not occur. Investigation then reveals that these individuals are XY, that they have undescended testicles, and that neither a uterus nor ovaries are present. However, because their bodies naturally convert the testosterone they produce into estrogen, they will usually develop female-typical secondary sex characteristics at puberty so long as their gonads are not removed. In "partial" AIS, the body's cells have some (albeit limited) response to androgens, and as a result, the external genitalia fall somewhere between typically male and typically female. While individuals with complete AIS often have a female gender identity, individuals with partial AIS are divided approximately evenly

between female and male gender identity. AIS occurs in approximately 1 in 20,000 individuals.[16]

d. ***Swyer Syndrome*:** In this variation, an XY child is born with "gonadal streaks" (minimally developed gonadal tissue) instead of testes or ovaries. Externally, a child with Swyer Syndrome usually appears female-typical; however, because streak gonads do not produce the sex hormones that bring about puberty, the child will not develop most secondary sex characteristics without hormone treatment.[17]

e. ***Kallman Syndrome*:** This variation occurs in both XX and XY children, characterized by delayed or absent puberty and an impaired sense of smell. It is a form of hypogonadotropic hypogonadism, or absence of certain hormones that direct sexual

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

[17] L. Michala, et al., *Swyer syndrome: presentation and outcomes*, 115 BJOG: An Int'l J. of Obstetrics & Gynaecology 737–41 (2008); Georgiann Davis, CONTESTING INTERSEX: THE DUBIOUS DIAGNOSIS 2 (2015); Fausto-Sterling, *supra* note 3, at 52 & tbl. 3.1; Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 Ariz. L. Rev. 265, 284 (1999).

development. XY children with Kallman syndrome often have an unusually small penis (micropenis) and undescended testes. At puberty, most affected individuals do not develop typical secondary sex characteristics, such as facial hair and deepening of the voice in XY adolescents, or menstruation and breast development in XX adolescents.

f. ***Klinefelter Syndrome*:** A child with Klinefelter syndrome has XXY chromosomes, as opposed to the typical patterns XX or XY. This occurs when one parent's sperm or egg has an extra X chromosome from atypical cell division. The testes and penis may be smaller than typical. Klinefelter syndrome has a prevalence of about 1 in 500 children, and is not ordinarily diagnosed before puberty.[18]

g. ***Turner Syndrome*:** A child with Turner syndrome has the chromosome pattern X, instead of the typical XX or XY. This occurs when one parent's sperm or egg is lacking an X chromosome

[18] Blackless et al., *supra* note 3, at 152; Greenberg, *supra* note 17, at 283; Albert de la Chapelle, *The Use and Misuse of Sex Chromatin Screening for Gender Identification of Female Athletes*, 256 J. Am. Med. Ass'n 1920, 1922 (1986).

due to atypical cell division. Children with Turner syndrome may have underdeveloped ovaries; their external genitalia generally appear female-typical, but may be less developed. They generally will not develop menstrual periods or breasts without hormone treatment. Turner syndrome affects between 1 in 2,500 and 1 in 5,000 newborns.[19]

h. ***Persistent Müllerian Duct Syndrome (PMDS)*:** Persons with PMDS have XY chromosomes and male-typical reproductive organs and external genitalia, but also have a uterus and Fallopian tubes. This condition occurs when the Müllerian ducts—internal structures that ordinarily break down in an XY fetus—remain and develop as they would in an XX fetus. PMDS is ordinarily not diagnosed at birth, and individuals with this variation often have a male gender identity.[20]

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[19] Kutluk Oktay, et al., *Fertility Preservation in Women with Turner Syndrome: A Comprehensive Review and Practical Guidelines*, 29 J. Pediatric & Adolescent Gynecology 409–16 (2016); Blackless et al., *supra* note 3, at 152; Greenberg, *supra* note 17, at 284.

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

i. ***Ovotestes*:** Ovotestes are gonads that contain both ovarian and testicular tissue. People with ovotestes are predominantly XX, but some are XY or have different chromosomal patterns in different cells (*see* "Mosaicism," *infra*). Some people with ovotestes have external genitalia that look typically male; others have external genitalia that look typically female; and still others have genitalia that do not look typically male or female.[21]

j. ***Mosaicism*:** As a result of atypical cell division in early embryonic development, some people are born with a mosaic karyotype, meaning that their sex-chromosome pattern varies from cell to cell. A person with mosaicism may have an XX chromosomal pattern in some cells, and an XY pattern in others.[22]

B. Intersex People Have Been Recognized By Law And Medicine For Millennia

Intersex people have been recognized by law and medicine for millennia, and the complex nature of "sex" was well-understood at the time Title IX was enacted in 1972.

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

[22] Wilson & Reiner, *supra* note 4, at 122; Clinical Guidelines, *supra* note 6, at 7; L. Sax, *How Common is Intersex? A Response to Anne Fausto-Sterling*, 39 J. Sex. Res. 174, 175 (2002).

For example, classical Jewish writings identify six sex categories—male, female, and four that would be recognized today as intersex. These variations are mentioned hundreds of times in the Jewish Mishnah, Talmud, and legal codes.[23] Intersex variations were also recognized in Greco-Roman culture. Pliny's *Natural History* refers to "those who belong to both sexes, [whom] we call by the name of hermaphrodites[24] … [or] Androgyni."[25] Justinian's Code, too, recognized "hermaphrodites" and provided that they should be assigned whichever "sex … predominates."[26]

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[23] *More Than Just Male and Female: The Six Genders in Classical Judaism*, Sojourn Blog (June 1, 2015), https://goo.gl/5BsHzS; Julia M. O'Brien, ed., 1 OXFORD ENCYCLOPEDIA OF THE BIBLE AND GENDER STUDIES 311–12 (2014).

[24] "Hermaphrodite" is now recognized as a pejorative term and is not recommended for use outside of historical reference.

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

[26] 1 Enactments of Justinian: The Digest or Pandects, tit. 5 para. 10 (Scott ed. 1932), https:/bit.ly/2LecBPy; *see also* Michaela Koch, DISCURSIVE INTERSEXIONS: DARING BODIES BETWEEN MYTH, MEDICINE AND MEMOIR 31.

In medieval and Renaissance Europe, "hermaphrodites" were often regarded as a third sex and recognized by law or custom.[27] Twelfth-century French theologian Peter Cantor noted that the Church "allow[ed] a hermaphrodite … to use the [sex] organ by which (s)he is most aroused" and to "wed as a man … [or] as a woman" accordingly.[28] De Bracton's 13th-century treatise on English law classified people as "male, female, or hermaphrodite."[29] And, in a treatise regarded as a founding document of English common law, 16th-century jurist Lord Coke wrote that "[e]very heire is either a male[, a] female[, or] a[] hermaphrodite."[30]

In the Victorian era, medical thought divided humans into five sex classifications. In addition to male and female, this included (a) "true hermaphrodites," with both testicular and ovarian tissue (*see* "Ovotes-

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

[28] Preves, *supra* note 27, at 536–37.

[29] Henry de Bracton, 2 ON THE LAWS AND CUSTOMS OF ENGLAND 31 (Thorne trans., 1968), http://amesfoundation.law.harvard.edu/Bracton/Unframed/English/v2/31.htm.

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

tes," *supra*); (b) "male pseudo-hermaphrodites," with testicular tissue and external genitalia that were not male-typical; and (c) "female pseudo-hermaphrodites," with ovarian tissue and external genitalia that were not female-typical.[31] Freud discussed "hermaphroditism" during this time,[32] as did pioneering sexologist Richard von Krafft-Ebing.[33]

Intersex people continued to be recognized into the modern era. A widely-read 1955 paper on "human hermaphroditism" observed that there were six factors that define "sex"—chromosomes, gonads, hormones/secondary sex characteristics, internal reproductive structures, external genitalia, and sex of rearing—and that these factors do not always align.[34] And by the 1960s, over a decade before Title IX was enacted, the causes of specific intersex variations such as congenital ad-

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

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

[33] Richard von Krafft-Ebing, PSYCHOPATHIA SEXUALIS 304 (Charles Gilbert Chaddock trans., 1894); Reis, *supra* note 7, at 55-81.

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

renal hyperplasia, androgen insensitivity syndrome, and Klinefelter syndrome were already understood and documented.[35]

II. INTERSEX VARIATIONS UNDERMINE THE BOARD'S DEFINITION OF "SEX"

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

First, "physiological" sex is nowhere near as clear-cut as the Board assumes. The term has no single meaning, and experts can disagree on a given child's "physiological" sex. A purely "physiological" understanding of sex, therefore, would not provide any advantages in terms of objectivity. Indeed, in many cases, it would be positively incoherent.

Second, determining a child's "physiological" sex (however that term is defined) would require intrusive examinations of their anatomy and genome, at least in some cases. Such examinations would be traumatizing, impracticable, and likely unconstitutional. Nobody would de-

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

fend inflicting these examinations on students for the purpose of deciding which restrooms they should use.

Third, the Board's policy is no more protective of students' privacy interests than a policy that permits students to access restrooms in accordance with their identity. Assuming sharing a *restroom* with people with different bodily characteristics implicates a privacy interest—which is questionable—even under the Board's preferred regime, students will frequently share restrooms with intersex peers whose sex characteristics may not all align with their own.

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

The Board asserts that "sex" must be given a strictly "binary" and purely "physiological" interpretation. However, despite its extensive reliance on the concept, the Board fails to specify the supposedly "binary … physiological distinctions" that it contends justify disregarding an individual's gender identity. Board Br. 20, 31; *see* Grimm Br. 11 ("The Board has never explained how it defines or determines 'biological gender [sic].'").

For example, is the Board suggesting that schools classify children by their *external genitalia*? If so, what about children born with genitalia that do not resemble what we think of as typical for "male" or "female" bodies; or who are born with female-typical genitalia and whose genitals masculinize at puberty; or who are born with external genitalia typical of one sex, but who have chromosomal patterns, gonads, or secondary sex characteristics typical of another sex? Is the Board, in the alternative, suggesting that children be classified by their *internal sex organs*? If so, what about children who have streak gonads that did not develop into testes or ovaries, or ovotestes which contain both ovarian and testicular tissue? By their *sex chromosomes*? If so, what about children with XY chromosomes who appear phenotypically female (*e.g.*, as a result of AIS); or children with XX chromosomes who appear phenotypically male (*e.g.*, as a result of CAH); or children with atypical chromosomal combinations such as XXY; or children with mosaicism, whose sex chromosomes vary from one cell to another? Or is the Board suggesting a holistic test that balances all of these factors? If so, what is the weighting to be assigned to each factor, and whose task is it to weigh them? *See* Grimm Br. 12 (discussing the Board Superintendent's

incoherent responses when asked how the Board's policy would apply to intersex students).

Koomah, an interACT-affiliated individual born with a form of mosaicism, summarizes the problem clearly:

> I have XX and XY chromosomes. Can I use both [restrooms]? Can I not use either of them? Genetics are far more complicated than just XX or XY . . . .
>
> There's a lot of diversity in anatomy as well! [W]hat does that mean for those [like me] with . . . "uniquely intersex genitals?" Because not everyone has binary genitals.
>
> My question would probably be "What restroom would I use, in that case?" If we're going to base it on chromosomes, what restroom would I use? If we're basing it on genitals, which restroom would I use?[36]

Kat Caldwell, another interACT-affiliated intersex individual, expressed similar concerns. As a result of AIS, Kat was born with XY chromosomes, internal testes, and female-typical external genitalia. Kat explains: "If it comes down to my chromosomes, I'm supposed to use the men's room." If the rule is based on genitalia, however, "my genitalia

[36] Telephone interview with Koomah, Feb. 8, 2017.

and my chromosomes don't match up. So essentially [the rule] leaves no place for people like me."[37]

The existence of intersex individuals like Koomah and Kat belies the Board's premise that physiology necessarily provides an "objective" basis for determining which restrooms students are to use. Board Br. 27, 33, 34. An intersex student's "physiological" sex may depend entirely on *which* physiological trait one chooses to privilege. There is no inherently objective basis on which to make that choice. Indeed, because of the diversity of medical perspectives, trained experts can and do disagree on the "correct" sex to assign to an intersex child.[38]

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

[38] *See, e.g.*, Anne Tamar-Mattis, *Report to the Inter-American Commission on Human Rights: Medical Treatment of People with Intersex Conditions as a Human Rights Violation*, Advocates for Informed Choice 5 (March 2013) ("There is still controversy and uncertainty about gender assignment in [cases of partial AIS], and it can go either way, depending largely on the doctor's judgment."), https://goo.gl/Nf7Xt7; David A. Diamond et al., *Gender Assignment for Newborns with 46XY Cloacal Exstrophy: A 6-Year Followup Survey of Pediatric Urologists*, 186 J. Urol. 1642, 1643 (2011) (reporting that only 79 percent of surveyed clinicians agreed on a male gender assignment in 46XY cloacal exstrophy).

Because even "physiological" sex is (and always has been) ambiguous in some cases, a strictly "physiological" understanding of sex cannot answer the question presented here.

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

The Board contends that allowing students to use restrooms that match their gender identity would place schools in the difficult and perilous position of evaluating how a student "'presents' his or her gender identity." Board Br. 40-41. By contrast, the Board suggests, a regime assigning students to restrooms based on "physiological" sex would be easy and straightforward to administer.

As the above discussion makes clear, that is completely backward. Setting aside the definitional question just discussed, determining a child's "physiological" sex in disputed cases would be far more difficult than determining their gender identity. Moreover, assessing physiological sex—unlike gender identity—would require inspections of students' genitalia, internal sex organs, and/or DNA. The notion of lining schoolchildren up for forced examination of their sex organs, palpation of their gonads, or extraction of their genetic material to determine restroom

access is horrifying. One could hardly think of a greater affront to the dignity of American schoolchildren.

In fact, the Supreme Court has observed that far less intrusive bodily searches in the school context cause "serious emotional damage" and violate "both subjective and reasonable societal expectations of personal privacy." *Safford Unified Sch. Dist. v. Redding*, 557 U.S. 364, 374–75 (2009) (finding this was the case where school officials forced an adolescent student to "'pull out' her bra and the elastic band on her underpants," even though they did not see her breasts or genitals).

Although the specter of school "sex testing" may seem far-fetched, it is not clear how else the Board's policy would be applied. It is impossible to tell from a student's clothed appearance what their sex organs look like or what their chromosomal patterns are—whether they are intersex or not. Indeed, intersex students often themselves lack knowledge of their intersex variation. Even their families and physicians may not know. For example, interACT-affiliated youth Hans Lindahl did not know she had an intersex trait until age 15, when she learned she had been born with XY chromosomes and gonads that were neither testes nor ovaries. This would never have been apparent to

Hans's schoolteachers or principals, because Hans was assigned "female" sex at birth and her appearance is "very feminine."[39] Only an invasive and humiliating "sex testing" regime would have revealed that Hans's sex characteristics were not typically female. Permitting students to use restrooms matching their genuinely held gender identity would avoid this dystopian scenario.

3. Assigning Students To Restrooms Based On "Physiological" Sex Does Not Protect Privacy

Finally, the Board argues that students must be assigned to restrooms on the basis of "physiological" sex in order to protect the "privacy" of other students. Board Br. 49-53.

As a threshold matter, the Board never explains how a student's "privacy" is violated merely because a child in an adjoining stall has sex characteristics different from their own. In today's schools, students generally do not see each other nude—especially in the *restroom*. *See* Grimm Br. 39-41 (noting that this is true of Mr. Grimm's school); *see G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 822 F.3d 709, 723 n.10 (4th Cir. 2016), *vacated on other grounds*, 137 S. Ct. 1239 (2017).

[39] Telephone interview with Hans Lindahl, Jan. 17, 2017.

Beyond those issues, however, the presence of intersex youth in our nation's schools means that students will inevitably share restrooms with peers whose sex traits differs from their own, *even if the Board's position prevails*. Whichever "physiological" sex an intersex student is deemed to possess, and whichever restroom they are consequently assigned to use, the other students who use that restroom will not all have genitals, gonads, and/or sex chromosomes that resemble theirs. *Cf.* Grimm Br. 42 (noting that "placing a boy who is transgender in the girls' restroom [or vice versa] would still mean that students would be in the presence of students with 'anatomical and physiological differences'"). Thus, in addition to the serious drawbacks discussed above, using "physiological" sex to assign students to restrooms will not even provide the ostensible privacy benefit that the Board trumpets as its main redeeming feature.

* * *

In sum, the Board's arguments in support of its "physiological" reading of "sex" do not withstand scrutiny. The Board's preferred regime would be *less* clear-cut, *less* administrable, and *less* protective of

students' privacy than a regime that permits students to use the restroom consistent with their gender identity.

CONCLUSION

Because Mr. Grimm is transgender, this case has been framed as a case about transgender students. But the Court's decision will also profoundly affect the lives of many thousands of intersex youth. The rule that the Court adopts in this case must be workable in light of the reality of intersex students' bodies, and it must respect their dignity and human rights. The Board's proposed rule does not.

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Respectfully submitted,

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I hereby certify, pursuant to Fed. R. App. P. 32(a)(7) and Circuit Rule 32(b), that the attached brief is proportionally spaced; uses a type-face (Century Schoolbook) of 14 points; and contains 5,290 words (excluding portions exempted by Fed. R. App. P. 32(a)(7)(B)), as counted by Microsoft Office Word 2010, which was used to produce this brief.

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I hereby certify that on November 25, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

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