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## *JARRING BODIES: THOUGHTS ON THE DISPLAY OF UNUSUAL ANATOMIES*

*ALICE DOMURAT DREGER\**

This past April I woke up suddenly from a frightening yet laughable little dream in which I couldn't breathe because Governor John Engler, dressed in a power suit, was sitting on my naked chest. My dreams have always been this transparent; they would bore a psychotherapist. I knew immediately when I awoke what this dream was about. The next day I had an appointment with a professional photographer who was going to take a picture of me, bare except for my wedding ring on my left ring finger and a hospital bracelet around my right wrist. After he developed the picture in black and white—assuming I didn't chicken out—he would use PhotoShop to make three changes: impose a stark measurement grid behind me, black out my eyes with a rectangular band, and blur what my mate, Aron, calls “the naughty bits.”

This picture would then be used for an anthology I was editing about the medical treatment of people born intersexed—the kind of people who used to be called hermaphrodites. I wanted to use this picture to make a point about the difference it makes whether people (including doctors and medical students) see intersexed people primarily the way medical books show them, or the way intersexed people see themselves. The volume, *Intersex in the Age of Ethics*, includes autobiographies of living intersexed people, and accompanying many of the autobiographies are photos of the authors looking like “normal” people [1]. They are shown with their

\*Science and Technology Studies, Lyman Briggs School, Holmes Hall 3-35, Michigan State University, East Lansing, MI 48825.

Email: dreger@msu.edu.

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pets and their lovers, clothed and smiling, with clear, focused eyes—very much *not* blacked out.

The chief aim of the inclusion of a textbook-style picture was to contrast clearly these two kinds of images. The picture illuminated the paradox of the masking of patients: making patients anonymous by using pseudonyms (or no names) and by shielding their faces is great for protecting their privacy, but it is also terrible for the way in which it immediately dehumanizes them. Contributing a photo of myself in the medical textbook style also showed how anyone, even a non-intersexed person like me, could look rather pathological if photographed this way.

I learned from contriving this “medical” photo of myself that the intersex activist Cheryl Chase was absolutely right when she told me the only thing the black band over the eyes accomplishes is saving the viewer from having the subject stare back. Even with my blackened eyes and blurred parts, those who know me can recognize me in that picture. This being the case, the decision to do this photo shoot was not an easy one, as indicated by the stressful dream in which Governor Engler embodied my university and by my choice to have the “naughty bits” blurred, something you would never see in medical texts about intersex, since the whole point of those photos is to show the sexual anatomy. Yet the decision to do the photo addressed the lament, chiming in my consciousness, that I had heard time and again from intersexed people about their medical “exhibitions.” These people were talking about the general problem of medical textbooks showing intersexed people not just as different but as tragically deformed [2]. But they also spoke of specific personal experiences. They themselves, as children and adolescents, had been repeatedly subjected to physical and visual examinations by medical students, residents, and attending physicians [3]. Although it was certainly not the medical professionals’ intentions, these “exhibitions” had left the subjects feeling freakish and violated—“like insects tacked to a board for study” [4].

This outcome is painfully ironic, since the central goal of the medical treatment of intersex is to help intersexed people feel normal and happy [5]. Protocols for treating intersex children are founded upon the belief that ambiguous sexual anatomy constitutes “a *social* emergency” [6]. Although ambiguous genitals may signal an underlying metabolic disorder, they themselves are not diseased; they just look different—sometimes very different. Specialist clinicians often use “normalizing” surgical and hormonal treatments to try to make intersexed children’s anatomy look non-ambiguous, because they understand that social responses to ambiguity can cause the intersexed person (and those around him or her) confusion and distress. So, paradoxically, in the effort to train students and residents how to alleviate the freakish feelings sometimes associated with unusual anatomies, people with unusual anatomies are examined, presented, and represented in ways that make them feel freakish [7].

I thought this phenomenon was specific to intersex until one of my undergraduate students figured out that I study the biomedical treatment of unusual anatomies and came seeking sympathy for what she had had to experience as the result of being born with a facial deformity. She confessed to me, without my prompting, that she would need another operation soon and that she could handle the surgery, but dreaded the inevitable endless line of white coats come to look at her face. We talked about her jumble of emotions, the gratitude and anger she felt for her surgeon as she was obligated to sit mute while he instructed his students where he would cut her. I asked her how she dealt with her troubles, and she told me that, whenever she complained, people assured her what a rich life she was living. She said, laughing under her tears, she would pretty happily trade her heavy cream life for one of skimmed milk.

I've got a pretty skimmed-milk anatomy myself, though I grew up in the kind of family that gets stared at a lot. My sister looks almost exactly like me except for her full habit and the giant, wooden rosary that hangs from her belt down to her sensible shoes; my biological brother is a gangly hippy artist with a crooked nose once broken in a fight; my adopted brother is black with blue eyes and show-stopping dreadlocks as long as my sister's rosary; my father uses a wheelchair and is pushed around by my mother, who for her part uses wrap-around sunglasses that make her look like a geriatric Martian. But me—my family nickname is “the normal one.” I've never been sure if it is a slur. Perhaps that explains my attraction to these issues.

I first came to the topic of intersex nine years ago, when, as a graduate student in History and Philosophy of Science, I was groping around for a dissertation topic. My advisor, the historian of embryology Fred Churchill, knew I was interested in the interplay of gender and science in the 19th century, and he suggested I look at hermaphrodites since (at that point) very few historians or philosophers had. I thought I would look at the history of embryology and evolutionary theory—Darwin's barnacles and all that—but Fred kept telling me to look at the medical journals. I couldn't figure out why he would suggest this route; I had never heard of human hermaphrodites, and figured that if they existed, they must be very rare. When, after two years, I finally decided to follow his suggestion, I immediately discovered the enormous medical literature on the phenomenon. My apartment quickly flooded with textual and photographic visions of people who so recently had been invisible to me.

I kept close by a letter from Fred, typed on university stationery, explaining the legitimacy of my research, just in case I ever got raided or had my bags searched on the way home from a research trip. But in spite of this precaution, only very gradually did events convince me that I needed to think more critically about the medical representation of intersexed people. First, I had an article on the topic of the Victorian biomedical treatment of hermaphroditism accepted to *Victorian Studies*, and the journal's

editors wanted to put two of the pictures that accompanied my article on the volume's cover [8]. These were sketches and photographs from 1890s British medical journals. But the editors discovered that, if they did this, they might have to wrap in brown paper those copies going to Canada: a new anti-pornography regulation could otherwise cause all sorts of problems. Being immersed in a medical culture (and being married to a fourth-year medical student), it took me a few months of protesting "But these are just medical pictures!" before I realized the issue was more complicated than that. I had trouble coming to terms with the fact that medical pictures in a different context might well count as pornographic. Gynecological exams were a lot easier for me before I realized this.

When the *Victorian Studies* article came out, I received a few emails from people who told me that they found my work interesting because they themselves had been born intersexed. I should have known that this would happen; my research led me to believe there would be a lot of people out there who had the same conditions with which late Victorian doctors struggled. But the medical literature had kept hermaphrodites as essentially voiceless subjects, uneducated about their conditions. I had gotten used to them being that way.

Nevertheless, it would have been obnoxious to write about the history of intersex without listening to what intersexed people thought about my ideas, so I started to have conversations with intersexuals—but only very reluctantly. It wasn't that I was afraid of any kind of "p.c. policing" tactics, because most of them didn't want to police my work, but to engage with it. I am sure instead my reluctance came from my all-too-personal encounter with the basic threat of unusual anatomies: they force the question of what and who is normal, and the much tougher question of why we should prefer the "normal." Is it good to be "the normal one"?

We like to ground particular identities (woman, straight, adult, educated, authoritative) in particular anatomies (female, not-too-butched, physically mature, dull haircut and glasses, able-bodied and articulate), and the fact was that these people messed up the anatomy/identity rules and dichotomies and hierarchies I enjoyed keeping stable. I didn't mind writing about them as "other," but when they started to step up off the page and to the phone, that made me nervous. No longer would it just be me writing historical representations of medical representations of them. Indeed, for the first time I had to face full force the fact that I was—like the doctors whose history I was studying—creating yet another representation of them as "other." And were they "other"?

I met, electronically, an intersexed person who had appeared on a daytime talk show to talk about her anatomy and experiences. Offline I pooh-poohed this tacky exhibitionism, and online I told her I was sorry she felt she had to go that route. She surprised me by informing me that she had enjoyed the experience and believed it was important work for her to do.

She had much more control over her representation on a talk show than she did in the medical arena—for one thing, she got to keep her clothes on around all these strangers—and rather than making her feel freakish or ashamed the way the medical profession (accidentally) had, the talk show host and audience validated her.

By that point in my research, I had been consulting present-day medical books for my work, but only to learn the current biological understanding of the various kinds of intersex. Finally I started to read those present-day texts with a critical eye, and when I did, one of the first things that struck me was how much more human intersexuals looked in the 19th-century pictures, especially the early and mid-19th-century ones. In those pictures, we see the whole body, face and all. Often the subject stands in a classical pose, looking almost proud. The person's identity is not hidden with pseudonyms or facial masks. The focus is still on the whole person, not just the parts.

These early 19th-century pictures show the influence of contemporary showy public exhibitions of and by people with unusual anatomies, and indeed hint at the very blurry distinctions that existed then between medical and public displays. An 1815 sketch of the hermaphrodite Marie-Madeleine Lefort shows her at the Paris Academy of Medicine. She appears to be on a stage, with curtains behind her. Her hair is up in a turban as if to make her seem even more theatrical and more exotic than she already is, with a combination of a well-groomed moustache, plump breasts, a recognizable vulva, and a sizable phallus [9].

At the very time my ears began to fill with living intersexuals' complaints about the "raw deal" they were getting from medicine, I began to uncover evidence of a time when the "deals" made between medical professionals and people with unusual anatomies were much more overt and perhaps more evenly rewarding. For example, in the 1830s, the hermaphroditic Gottlieb Göttlich earned fame and fortune by exhibiting himself at medical schools and to the lay public across Europe and the British Isles. When Göttlich was born on 6 March 1798, in the Saxon village of Nieder Leuba, those present at the birth presumed Göttlich female, and so the child was baptized and raised Marie Rosine Göttlich. Like dozens (and perhaps hundreds) of hermaphrodites after her, Marie Rosine's sex came under suspicion when an apparent double hernia drew medical attention and the suspicion that the "herniated" organs of this "woman" were in fact descended testicles. In November of 1832, Professor Friedrich Tiedemann at the University of Heidelberg examined Göttlich and declared Marie Rosine was "evidently a man, with genitals of uncommon conformation. She will dress herself, therefore, in men's clothes, and adopt the name of Gottlieb."

Göttlich made the most of this sex-change idea, engineering for himself a very fruitful change of identity. With written testimonies to his masculin-

ity in hand from the well-known Tiedemann of Heidelberg and Johann Blumenbach of Göttingen, Göttlich donned male clothing, obtained a passport that indicated his new sex, and went on the road, something a person with a female passport and little source of income would have had a much harder time doing. During his 1830s career as a traveling hermaphrodite catering to the curiosity of medical men and lay people, Göttlich made his way all over the European continent and British Isles. At medical schools, he stripped down, posed with a proud expression, and was examined by scores of men of science and medicine who came to see this curious case and render their often conflicting opinions as to the “true sex.” Importantly for my point here, in exchange for letting them examine him and publish reports about him, the medical and scientific men gave Göttlich certificates which testified that his case was of deep interest to the medical man, the naturalist, the phrenologist, and the physiologist [10]. These were used in turn to generate still more interest and profit. In fact, when a corrective operation was offered him, Göttlich “declined all surgical aid.” He remained “averse to a proposal of this kind, since it would at once deprive him of his . . . easy and profitable mode of subsistence” [11].

Exhibitors like Göttlich frequently set up, in the early and mid-19th century, these sorts of tacit exchange of goods and services with medical men. Those with peculiar anatomies let intensely curious medical and scientific men examine them, and the biomedical men not only enjoyed some free voyeurism—it is clear voyeurism was part of the attraction—but they also published their accounts of the unusual anatomies and thereby increased medical knowledge of the conditions as well as building their own professional reputations. In exchange, the medical and scientific men gave the exhibitors expert opinions about their conditions, occasional medical treatment, and written expert testimonies to their strangeness. Exhibitors like Göttlich used these testimonies in advertisements and penny pamphlets to drum up ever more business.

This concept of fair exchange comes through loud and clear in the report of one of the medical men, William H. Pancoast, M.D., who attended the Philadelphia autopsy of the Bunker twins [12]. When Chang and Eng Bunker, the famous “Siamese Twins,” died on 17 January, 1874, in Mount Airy, North Carolina, their widows initially decided to keep the brothers’ conjoined remains in a cool cellar and allow any curious soul a glance for 25 cents. (They probably did this to help support the 21 children Chang and Eng left behind.) But on 1 February a contingent of medical men from Philadelphia showed up to claim the remains for “science and humanity.” As Pancoast remarked in his autopsy report to the College of Physicians in Philadelphia:

To advance their own interests [Chang and Eng] frequently consulted medical men in different parts of America and Europe, as to the safety of a surgical operation to divide the band and release them from their peculiar connection; [but]

these consultations [with medical men] were mainly used to excite the curiosity of the public, as it is believed by those who knew them well, that they never, except once, seriously contemplated such an operation.

In exchange for medical men's long-running help in "exciting the curiosity of the public," Pancoast "held [it] to be a duty to science and humanity, that the family of the deceased [Bunker twins] should [now] permit an autopsy. [For] the twins had availed themselves most freely of the services of our profession in both hemispheres, and it was considered by many but as a proper and necessary return" that the family should turn over corpses, free of charge, so the medical men could finally satisfy their curiosity about the details of the Bunkers' internal anatomy.

Compared to the Bunkers', the biographies of the conjoined sisters Millie and Christina are much more troubling because the sisters, born to an enslaved African-American woman in 1851, were sold, bought, kidnapped, and repeatedly exhibited by people who did not have their best interests in mind. It does appear that they finally wound up with a caretaker who fairly shared the profits of exhibition with them, but that alleged happy ending to their biographies might in fact have been concocted by yet another inhumane handler for publicity purposes. I am interested in Millie and Christina's biographies here chiefly because they again exemplify the way in which a chance to examine a peculiar anatomy was traded for a salable expert testimony. When young children, Millie-Christina were brought to New Orleans, for a "command performance,"

in obedience to a request from the medical faculty of that city, asking that she be brought there for scientific examination. Rooms were taken and every preparation made for the contemplated examination, after which she was to be placed on public exhibition. . . . The examination . . . at length took place and proved most satisfactory, every physician in attendance concurring in pronouncing her Nature's greatest wonder. *Being endorsed by the medical faculty*, she was now put on public exhibition. [13, emphasis added]

Millie-Christina repeatedly and without charge performed their songs and dances privately for doctors, and the amazed medical men in turn handed them usable endorsements. Millie-Christina's penny pamphlets sold to the general public included "certificates of eminent medical men," and so it was appropriate that one stanza of Millie-Christina's theme song chimed:

Two heads, four arms, four feet,  
All in one perfect body meet,  
I am most wonderfully made  
All scientific men have said.

Indeed, exhibitors used the automatic-respectability of the testimony of medical men to include in their penny pamphlets intimate details of the sexual anatomy of those exhibited, discourse which would otherwise have

been considered quite lewd. For example, because it was presented in the form of a straightforward quotation from two medical doctors, a report of Millie-Christina's sexual anatomy could be included in pamphlet sold to the public. It was safe and acceptable for the lay public to read that Millie-Christina had "separate bladders, but one common vagina, one uterus to be recognized, and one perfect anus," as long as this information came from the lips of a medical doctor. Doctors thereby gentrified and legitimated a performance that might otherwise be simply distasteful. Medicine was consciously used to keep the charge of pornography at bay—in the very way I used it, unconsciously, to keep myself from having to see my own subject as anything akin to pornography.

Robert Bogdan has noted in his studies of freak shows that many so-called freaks of the 19th century earned quite a lot of money exhibiting themselves and were thereby able to lead financially secure lives [14], and the trade in medical testimonies obviously helped in this realm. The Bunkers used their substantial income from exhibitions to buy farms and slaves, and as long as the farms were profitable (i.e., before the Emancipation of enslaved people), they chose not to exhibit themselves for money. According to the tales told about them, Millie and Christina eventually used the money they earned to buy the plantation on which their mother had been enslaved. Today, by contrast, although unusual anatomies are often displayed in medical circles, on television, and in the popular press, the profit of exhibition is not typically earned chiefly or directly by the exhibited [15], and "respectable" people are obligated, as I felt I was, to find public exhibition via venues like talkshows pathetic and distasteful. "These things are *medical problems!*" we cry. "They belong in the confines of the clinic."

Now, I am not looking to suggest that we return to the "freak show" era, nor to suggest that doctors "help" their patients by providing them with testimonies of how odd they look. We do not know whether most 19th-century exhibitors would have chosen this means of profit if an alternative had been available, or whether many would choose it today if it were a real option. I am hardly romantic about the great age of exhibitions. But I do find it remarkable, given where we are today, to recognize that there was a time when the doctors were quite publicly thrilled to get an audience with these patients, when they would, in very public prose, celebrate them as extraordinary, bizarre, amazing—when they would recognize these people as authorities of a unique and strangely attractive experience.

A critical shift happened subtly in the 19th century, as medical professionals became more prestigious and more aligned with science. Earlier physicians were quite willing to exchange concrete and enthusiastic testimonies for access to particular interesting bodies (and the stories of the experiences that came with those bodies). By contrast, later physicians offered instead the much more abstract value of "the good of humanity" in exchange for ready and unlimited access to *all* unusual bodies. We see

over the course of the 19th century the fading of the idea that the medical or scientific man should have to actually give something immediate in exchange for access to interesting anatomies.

Today, biomedical professionals tend to feel a primary *right* to seeing and using and owning unusual anatomies—whether those anatomies be ancient skeletal remains, extraordinary genes, or patients deemed “faci-nomas.” The right of access is claimed not because the professionals have given that particular unusual person something in return, but because, in a very abstract and universalized sense, science and medicine serve all of humanity. A few weeks ago I was composing an email to an intersexed acquaintance when I heard on National Public Radio that Harvard University’s archeology museum was having to return the bones of Native Americans to a group of indigenous people of the southwest. How clear the moral to the radio story: science was being robbed of its rightful access to the rare and unusual anatomy, and scientific progress was thus being impeded. A part of me did indeed feel indignant on behalf of the scholar-scientists. The link between present-day “descendants” and the people whose bones were being “returned” seemed so tenuous, the loss to science so great. And yet again, the education I’ve been given by people with unusual anatomies barreled into my consciousness, demanding I think of the other side. Who ought to own this body and the stories that can be drawn from it?

One of the many “services to all humanity” that biomedical science seeks to perform is the prevention and “normalization” of congenitally unusual anatomies. This is why biomedicine gets free and easy access to those unusual anatomies. But think of the irony. People with unusual anatomies (profoundly short, intersexed, and so on) hear medical professionals saying: “We get to see you, examine you, and display you at will, because we’re trying hard to fix and prevent people like you.” Of course, what medicine is really trying to prevent and alleviate is the *suffering* of these kinds of people, but when the fact is—as it is for all of us—that one’s identity is very grounded in the experience of one’s anatomy, the elimination of the anatomical experience at some level equates to the elimination of the self.

How shocked are some doctors to hear that intersexuals might not want to be displayed so that they and others like them can be “normalized,” to hear people with profound short stature say the three inches gained from human growth hormone injections might not make up for the constant negative attention to whether they measure up. How shocked are some scientists to be told that Native Americans might not be interested in hearing what “really” happened to their ancestors’ bodies. And I find myself in the middle, deeply uncomfortable, not just questioning the “standards” of sex, of height, even of digit numbers, but now questioning the standards of science and medicine. What has happened here? Don’t we all agree on the search for truth, the pursuit of beauty? Don’t we know what is pornogra-

phy and exploitation, and what is science and medicine? Don't we know what counts as the search for a fact, and what counts as a mythical quest, and what counts as the copping of a cheap thrill?

After a long time of dwelling on the harmful side effects of medical “exhibitions” of patients, an idea came to me when I visited the Mütter Museum, the great anatomical oddity museum at the College of Physicians of Philadelphia. There the visitor will find a large number of wax models of various pathological presentations—small pox on the tongue, syphilis on the genitals. These models were used to teach medical students in the 18th and 19th centuries, when it was unlikely that a medical student would see all he should before he went into private practice. Given all the technology we have, I wondered, couldn't two and three-dimensional models and CD-ROM simulations of various conditions be used more often in place of the “parades” of students and residents, parades that scar patients, especially children? When I put this to Aron, he objected that there is nothing like examining it in person. I had to agree, but then there is also nothing like having your genitals examined and remarked upon by scores of strangers.

Indeed, today's typical reliance on real patients over models and simulations is rather bizarre: it means a medical education is dependent in large part on what or who happens to show up during one's various clinical rotations. By contrast, the use of wax models recognized that, left to chance, the medical student would not necessarily see all the things he should before he left to practice. Today, with intersex, for example, a medical student might see, in his or her training, one living example of intersex, but that one living example will hardly be representative of the dozens of presentations of intersex. And if the point of presenting the one available case is to show medical students what “ambiguous genitalia” look like in person, it begs the question of whether the genitalia are really so ambiguous as to need medical attention.

In the end, watching my own partner go through medical school and then a residency, I've come to think that the display of patients is not simply about educating physicians with regard to the medical conditions. As in the 19th century, a given physician's examination and display of a patient is as much about establishing that physician's place within the institutions of medicine as it is about establishing the patient's disease within the nosologies of medicine [16]. The display of the patient is therefore necessarily about constructing the patient as the unauthoritative, needy “other.”

If I am correct about this complex motivation for medical display, then however well intentioned medical professionals are—and I do believe the vast majority are very well intentioned—the practice of displaying voiceless, virtually identity-less patients to large numbers of other medical professionals will not change simply by the recognition that it may harm the patient.

The word *monster* shares the root with *demonstrate*, the *monstrous* is that which portends. The ancient reaction to “monsters” was to kill the mes-

senger. The more recent reaction has been to paint the anatomically unusual person as unfortunate, in need of paternalistic care. In this unique age of ours, between the age of killing the messenger and preventing the messenger, in the age in which the messengers are starting to speak, to object, to engage, to be heard, I wonder what the reaction will be. I know that I have found it terribly difficult to convince some that people with unusual anatomies not only *do* have a voice, but that they *should* have a voice, a say in the deal, the right to criticize and perhaps even dictate how they will be displayed, how the knowledge and technologies that come from the study of their bodies will be used.

I suppose for some people, what I am suggesting is the equivalent of a freak show, a show in which medicine itself becomes the subject on display to be prodded and questioned. And when one is desperately sick and frightened, in need of medical rescue, the idea of stripping medicine bare and examining *it* seems obscene indeed. It seems to add only to the pain medicine is supposed to kill. I know that the one time I laid in a hospital bed, wondering what was wrong with me, I would have happily accepted an all-powerful, all-seeing version of medicine, no matter how little of my flesh that hospital gown covered.

It was on the occasion of my first visit to the Mütter Museum, when I was just out of graduate school, that I had the revelation that jarring bodies get put in jars—contained physically and conceptually—in an attempt to contain all the confusion and pain and even thrill they cause.

During my second visit, after having talked to a lot more people living with unusual anatomies, it dawned on me how strange it would be, if I were a giant or a dwarf, a conjoined twin or a hermaphrodite, to see my kind of people displayed so that my kind of people might dwindle in number. I had a jolting daydream of a time when the “freaks” would come to repatriate their own ancestors, tired of the deal getting more and more unbalanced.

And it was during my last visit, the first time I managed to visit with Aron (now a chief resident) and his very different professional vision, that I came to understand the intense and almost universal attraction to these anatomies, these bodies that loosened all the boundaries and set us all in motion. As we both stared into the cabinets, I was not just seeing a historical artifact, and he was not just seeing a genetic anomaly. I understood finally how that attraction to their gravity has led to so many power struggles over them. I wondered to myself if the universal attraction might lead to some kind of peace. But to recognize the subject as who we might be—even who we might *want* to be—is to dissolve all the glass that separates us and let the monster out of the jar.

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