

IMPERATIVES OF NORMALITY

From “Intersex” to “Disorders of Sex Development”

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In May 2006 the U.S. and European endocrinological societies published a consensus statement announcing a significant change in nomenclature. No longer would nineteenth-century variations on the term *hermaphrodite*, or the more newly introduced term *intersex*, be used in a medical context to describe “congenital conditions in which development of chromosomal, gonadal, or anatomical sex is atypical”; instead the preferred term henceforth would be *disorders of sex development* (DSDs).¹ The announcement met with a certain amount of controversy, as evidenced by the letters—from some intersex activists as well as their allies—sent to the *Archives of Disease in Childhood* in the months immediately following the statement’s publication. Those objecting to the new terminology focused on the description of intersex conditions as “disorders,” which they described as “stigmatizing” to the individual who should be spared identification “as” a disorder.²

The treatment to which infants and children with intersex conditions have been subject since the 1950s is by now well known. Medical management of intersex, with its concern with removing any sexual ambiguity, has focused in short on surgical “fixes” for what might otherwise be understood in contemporary terms as social, political, or psychological matters of sexual identity.³ In light of these practices, it would indeed seem that an effective response would be to take intersex out of the domain of medicine altogether, to “demedicalize” conditions that might otherwise count as ordinary human variations. Certainly many of those writing in response to the consensus statement rallied behind the suggestion of biologist Milton Diamond and attorney Hazel Beh, who argued for using the term *variations of sex development*.⁴ But while it is easy to make the case that differences in genital appearance should be understood as matters of variation, such terminology does not permit appreciation of the genuine health challenges faced by many individuals with intersex conditions.

The change in nomenclature together with its attendant controversy raised significant questions that merit further exploration. Foremost is the question of the status of intersex with respect to the constitution of personal identity: has intersex taken on the status of an identity, or is it a condition that is merely incidental to one's person? The objections made to the change in nomenclature seem to take for granted first that there are such things as "intersexuals," which would render the characterization of the condition as a disorder offensive.⁵ The second concern with the new nomenclature is related to the first—namely, that the pathologization putatively effected by the new nomenclature would constrain unduly the range of possibilities of affected individuals to understand themselves. That is, the pathologizing label would limit people's subjective possibilities by containing them within its terms. Underlying these two claims, I want to propose, is an implicit understanding of intersex(uality) as analogous with homosexuality. However well meaning, this comparison—together with its liberatory aims—is misplaced and reinforces the very conceptualization of intersex as a "disorder like no other" that it is intended to challenge.

In what follows I want to consider how the change in medical terminology could be understood as progressive. It brings the prospect (though of course not the certainty) of a shift in focus from gender and genitalia (and the emphasis on cosmetic surgery that has been figured as necessary for the living of a "normal life") to the *medical conditions* including the endocrinological and metabolic imbalances—sometimes severe and even life threatening—associated with some intersex conditions. Such attention is especially lacking in care for affected adults, who, having left the care of increasing numbers of pediatric specialists, find no physicians knowledgeable about the progression of a given condition or who will support them in establishing appropriate hormone replacement to compensate, for example, for the removal of gonads.⁶

In the first part of this essay, I examine the historical convergence of the treatment of homosexuality and intersex. I argue that the contemporary association of homosexuality with intersex risks obscuring those concerns unique to the treatment of intersex conditions and the consequences for affected individuals. The complex and persistent identification of homosexuality with intersex since the nineteenth century nevertheless requires that we reckon with this historical relation and its shaping of the motivations both for the prevailing standard of care that has been so harmful and for the organized resistance to these practices in the intersex movement. In response to the proposal for the change in nomenclature, we must confront the surprising fact that doctors and activists alike have focused on matters of gender and genitalia at the expense of the ordinary health concerns

of affected individuals. Michel Foucault's understanding of the power of "normalization," I argue in the essay's second part, can help us make sense of the history of medicalization and its pernicious effects, but in addition can allow those with intersex conditions and their allies to understand the positive possibilities that the change from intersex to DSDs can bring. Rather than fight for the demedicalization of intersex conditions that indeed have consequences for individuals' health, acceptance of this change can transform the conceptualization of intersex conditions from their past treatment as "disorders like no other" to "disorders like many others." Understood in these terms, medical attention to those with atypical anatomies should be recast from a preoccupation with "normal appearance" to the concern with human flourishing that is the putative aim of medical practice.

Pathological Convergence: Homosexuality and Intersex

There is every reason to consider the treatment of homosexuality, both historical and contemporary, alongside the medical management of intersex conditions. At nearly every moment in modern medical investigation and the popular imagination alike, each has been implicated in the other. In the nineteenth century "sexual inversion" was understood as "the tendency to embody physical characteristics associated with the opposite sex," an idea that "homosexuals were in some sense constitutional hermaphrodites."⁷ This close tie between hermaphroditism and homosexuality has a longer history, however. According to Foucault, it was not the mixing of sexes in individuals that was threatening in seventeenth- and eighteenth-century France but the crime of making "use of their additional sex" through homosexual behavior.⁸ While the close connection between physical sex and object desire was, as Jennifer Terry notes, "eventually undermined as Freud's theories of sexuality achieved greater notoriety and influence in the scientific community," fears about homosexuality have shaped the medical management of intersex since the 1950s when the standard of care was first formulated.⁹ As Anne Fausto-Sterling recounts in *Sexing the Body*, it would make sense for laypeople, and particularly parents of children with intersex conditions at midcentury, to conflate homosexuality—still understood as a "disorder of psychologic sex"—with intersex. "If," as she writes, "intersexuality blurred the distinction between male and female, then it followed that it blurred the line dividing hetero- from homosexual." But even if parents made category errors that "pioneers" of medical management such as John Money and John and Joan Hampson would not, Fausto-Sterling clarifies that heterosexual orientation nevertheless counted as a significant indicator of the success of medical management.¹⁰ It appears that little

has changed in the last sixty or so years. Projected sexual orientation continues to figure in decisions on gender assignment (and with it, surgical correction) of infants, as a recent survey of physicians revealed, and parents are encouraged in their expectations for “normal” (i.e., heterosexual) outcomes for their children.¹¹

This historical connection between homosexuality and intersex does account, I think, for why resistance to the DSD nomenclature makes good sense on its face. It was, after all, the successful battle against the pathologization of homosexuality—its critical removal from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*—that has provided the foundation for the ongoing effort to secure social and political acceptance since the era of the “invert.”¹² And certainly the intersex movement, from its inception in 1993, when Cheryl Chase announced the formation of a support group for those with intersex conditions, has made use of language and practices employed throughout the history of gay liberation and queer activism.¹³ The very formation of the Intersex Society of North America was a reclamation of the medical term *intersex*; its publication of the newsletter *Hermaphrodites with Attitude* and the recording of the very first gathering of individuals with intersex conditions in the video *Hermaphrodites Speak!* evoke the rallying call for gay men and lesbians to “come out of the closets and into the streets,” and bring to mind the contemporaneous activism of the 1990s practiced by groups like Queer Nation.¹⁴

Queer activism has provided not only a model of political activism but ready allies in demands for radical change in medical practice.¹⁵ This alliance has been forged by means of what might be understood as a visceral sympathy that gay men and lesbians, and particularly those who have been subjected as children to various forms of “gender policing,” may experience for those who are or have been objects of intersex management.¹⁶ That shame is so central to the “normalizing practices” that commonly characterize the stigmatization of those with atypical anatomies and those with “deviant” sexual desires alike underscores why so many people with intersex conditions and queer activists would find common cause.

But while we might understand the enforcement of norms of gender (which always already entail norms of sexual desire) to shape the experience of those whose behavior and bodies defy these norms, we should take care to note the important differences between them. What sets the experience of those with atypical sexual anatomies apart from the pervasive sorts of “gender training” (from which no one is spared) are the conspicuous marks of enforcement borne by those with intersex conditions. While one could argue that we all wear the mark of gender on our bodies, such a characterization would trivialize the significant differences between the traces of the usual enforcement of gendered behavior and

the literal scars borne by children submitted to surgery. This critical difference suggests a danger of identifying too closely the interests of LGBT communities with those with intersex conditions. Ignoring the points where the experience and interests of queer and intersexed diverge, we risk obscuring the unique needs of those with intersex conditions. The kinds of needs to which I here refer are those that *medicine has itself ignored or marginalized* in favor of a disproportionate, or even what appears in some cases to be a kind of hysterical, concern with gender and genitalia. These include the “ordinary” kinds of health problems associated with diverse intersex conditions, the sorts of challenges for which individuals with just about any other medical diagnosis would expect care as a matter of course.¹⁷ These should become more salient when we consider what should be routine medical care for adults who must manage sometimes critical endocrinological imbalances from congenital adrenal hyperplasia (CAH) or hypopituitarism. Other conditions might require hormone replacement therapies as a result of the removal of gonads, or because gonads do not function at all (as is the case with some conditions), or their function is insufficient to prompt the pubertal changes that many individuals want.¹⁸

Where homosexuality was, as historian Jonathan Ned Katz puts it, “an invention” of the nineteenth century, and the homosexual, in Ian Hacking’s terms, “a made-up person,” intersex conditions resist comparable characterization as productions of history.¹⁹ I do not dispute, of course, that the multiple histories of hermaphroditism have been, and should be, recounted. In the changing understandings of the morphology of the person whose sex does not fit easily into male or female, the putative moral consequences of these differences, and the spectrum of cultural responses to those individuals — social, medical, juridical — there are indeed many stories to be told.²⁰ But while some individuals with intersex conditions embrace an identity as “intersex,” many, and some have suggested most, do not in fact choose to identify in this way (and conversely, many who are not born with a genetic or endocrine disorder affecting sex development *have* identified themselves as intersex).²¹ It is therefore critical that we not lose sight of the fact that even as there are what might be described as cultural constructions of hermaphroditism, many intersex conditions are also at the same time conditions that benefit from, or positively require, medical intervention. In this respect the history of intersex management may be more aptly compared with the storied past of a disease such as tuberculosis, a medical condition whose “truth,” as Hacking has put it, was slowly transformed by the late-nineteenth-century discovery of the “brute fact . . . that [tuberculosis] is a specific disease transmitted by microbes.” This discovery — of an underlying cause of a condition that had previously been attrib-

uted to a different sort of individual or societal “ill” — changed but did not immediately displace the earlier belief that “consumption was not only a sickness, but a moral failing, caused by defects of character.”²² So while tuberculosis, unlike consumption, was understood at last to be a disease that was contagious, it was nevertheless considered in the United States “a disease of only some, not all people, essentially the immigrant and the poor, not the middle or upper classes.”²³

The comparison between intersex conditions and tuberculosis is obviously a limited one: while some intersex conditions (such as CAH or 5-alpha-reductase deficiency) can be heritable, intersex conditions are not contagious. Tuberculosis was associated with populations of people and activated government campaigns promoting public health; intersex conditions are generally considered individual matters, and secrecy — intended, according to physicians, to protect the privacy of individuals and their families — is maintained.²⁴ The comparison may nevertheless underscore the importance of attending to the underlying physiological conditions of a disease or disorder, even as we take account of the abundance of social meanings at work — a dimension that the comparison to homosexuality, as I have suggested, risks minimizing. Invoking the historical case of tuberculosis suggests that there is room both for robust criticism of the stigma attached to the bodies of those who contract the disease (or those understood to be “at risk”) and for appreciating the importance of treating the condition. If at least for some period social stigma and medical “truth” coexisted in the case of tuberculosis, we may similarly regard intersex treatment to be in a state of transition.

The ongoing tension between treating intersex as a social problem (that has fallen to medicine to “cure”) versus a medical problem (in the ordinary sense) is most starkly evinced by the fact that cosmetic genital surgeries for infants and children remain a significant component of care, and so understandably continue to occupy a central position in the controversy over treating affected children. The section on “Surgical Management” in the consensus statement reflects the equivocal position taken by medicine toward those with intersex conditions. While surgery may be necessary to address specific problems caused by some conditions such as “mixed” gonads that have a genuine risk of malignancy, the statement’s discussion of surgery foregrounds instead cosmetic procedures aimed at “normalizing” the appearance of genitals. That the statement does not explicitly advocate cosmetic surgery is nevertheless a tremendous advance, but the significant acknowledgment that “it is generally felt that surgery that is carried out for cosmetic reasons in the first year of life relieves parental distress and improves attachment between the child and the parents” should give pause. While, as the statement admits, “the systematic evidence for this belief is lacking,” cosmetic

surgery is by no means ruled out. The statement instead advises that “only surgeons with expertise in the care of children and specific training in the surgery of DSD should undertake these procedures.”²⁵ The fact that cosmetic genital surgery aimed not at improving function or securing health remains so salient indicates the extent to which medicine maintains for itself a central role in normalization, a point that draws us back to the comparison between the histories of intersex and homosexuality.

Normalizing Medicine

It is disappointing that the authors of the consensus statement did not assume a more critical view of cosmetic genital surgery, but it should not be surprising. “Normalizing” surgeries, as they are known in medicine, together with accompanying hormone treatments, have constituted the standard of care for children with intersex conditions for decades now. Originally surgical correction of genitals to conform to sex assignment was thought to be essential to the development of a healthy gender identity.²⁶ While the original rationale was famously challenged over a decade ago, little immediate change in treatment occurred.²⁷ In place of what initially appeared to be a robust theory about psychosocial development in children was left a vague yet unrelenting concern with “normal appearance” and the “normal life” that this appearance was supposed to promise.

Normalization is not only a term descriptively employed by physicians for cosmetic genital surgery in those with intersex conditions, but following the work of Foucault, it has also become critical theoretical shorthand to signify the pervasive standards that structure and define social meaning. Norms are at once everywhere and nowhere. They are explicit and conspicuous in any number of standards with respect to which one may be tested or assessed, with respect to body (as in mass or function) or mind (and one’s cognitive ability or deficit). They are also unspoken, seemingly “natural,” and internalized as one’s “own,” as is often the case with gender norms. Whether conspicuous or not, we must reckon with the fact that “there is,” as Lennard Davis has succinctly put it, “no area of contemporary life in which some idea of a norm, mean, or average has not been calculated.”²⁸

Medicine has played a central role in the modern development of the norm, and “medical power,” as Foucault claims, “is at the heart of the society of normalization.”²⁹ In the ancient period conceptions of health were conceived in terms of harmonious functioning in the individual; medicine was regarded as “a set of techniques for curing ills and of the knowledge they require.”³⁰ This view of medicine would persist in the eighteenth century, but medicine would also come to

“embrace a knowledge of the *healthy man*, that is, a study of *non-sick man*, and a definition of the *model man*” (34; emphasis in original). Medicine assumes, in other words, a “normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and the society in which he lives” (34).³¹ The formulation of the understanding of the model man sets the stage for a further development in the nineteenth century that would see a subtle but important change from a focus on “health” to “normality.” For Foucault the eighteenth-century standard of health was concerned with qualities that could be understood as specific to a particular being—namely, “vigour, suppleness, and fluidity, which were lost in illness and which it was the task of medicine to restore” (35). Such qualities were understood to a certain extent to be judged and regulated by the individual, through diet and exercise, for example, which entailed “the possibility,” as Foucault writes, “of being one’s own physician” (35)—the possibility, that is, that the evaluation of an individual’s health could be determined and regulated only with respect to and by oneself, rather than a measure or command imposed from without. Nineteenth-century health, by contrast, “was regulated more in accordance with normality than with health; it formed its concepts and prescribed its interventions in relation to a standard of functioning and organic structure.” Consequently, Foucault writes, the medicine that previously took as its object “the structure of *the organized being*” was transformed into “the *medical bipolarity of the normal and the pathological*” (35; emphasis in original). It was no longer the judgment of the individual that mattered most, but that of “experts” who would be authorized to evaluate and treat the individual as prevailing standards dictated.

Consistent with Foucault’s periodization, Alice Dreger has detailed the nineteenth-century development of the taxonomic system used to classify hermaphroditic “types.” This taxonomy has persisted until today, and the change in nomenclature is intended to correct its misleading and confusing emphasis on gonadal anatomy (once understood to be linked to gender identity and sexual behavior), and to reflect current understandings of the diversity of intersex conditions and their specific features.³² According to the old taxonomy, “normal” females and males were defined as presenting only standard female or male anatomy, respectively, while so-called male and female pseudohermaphrodites and true hermaphrodites presented different kinds of mixtures of male and female anatomy.³³ Such divisions, together with the medical practices aimed to “correct” the abnormalities they denoted, may be understood to exemplify the “art of punishing,” a critical component of the society of normalization:

the art of punishing . . . is aimed neither at expiation, nor even precisely at repression. It brings five distinct operations into play: it refers individual actions [or bodies, in the field of medicine] to a whole that is at once a field of comparison, a space of differentiation and the principle of a rule to be followed. It differentiates individuals from one another, in terms of following the overall rule: that the rule be made to function as a minimal threshold, as an average to be respected or as an optimum towards which one must move. It measures in quantitative terms . . . the “nature” of individuals. It introduces, through this “value-giving” measure, the constraint of a conformity to be achieved. Lastly, it traces the limit that will define difference in relation to all other differences, the external frontier of the abnormal.³⁴

The language of “punishment” may seem out of place with respect to treatment of intersex conditions. It would be farfetched indeed to claim that parents or even doctors are punishing children for their difference. Yet, accounts of adults reflecting on their experiences as they grew up strongly suggest a subjection to a “punitive operation” consistent with the exercise of power Foucault so vividly describes in *Discipline and Punish*. Consider sociologist Sharon Preves’s interview with Tiger, who reports having had sixteen surgeries to correct hypospadias, spending most of his summer vacations in the hospital while friends went to camp or on family vacations.³⁵ Others recount chilling experiences of repeated displays made of their bodies in hospitals and public clinics. Carol was humiliated by what she called the “parades” of physicians, residents, and interns — in one visit she counted more than one hundred — who “touched, poked, looked, mumbled, and left” (67). Anthropologist Katrina Karkazis’s interviews with adults recount the stern proscriptions they received against questions or comments about their surgically corrected bodies; others who had surgery as young adults report the performance of surgeries without their consent, making one twelve-year-old feel, in her word, “freakish.”³⁶

Rather than an action undertaken intentionally (whether willingly or reluctantly) by physicians and parents, however, what Foucault means by punishment here is better captured in the passive voice, referring not to an action intended by a particular agent or agents but to an action occurring *through* them. The “offense” that provokes the punishment in the first place is itself similarly construed. Rather than conceived as a wrongdoing committed by an individual, normalization acts on “the whole indefinite domain of the non-conforming” — for example, failing to

achieve a certain level of performance or, as in the case of intersex, being born with atypical anatomy.³⁷ By contrast to the more familiar conception of a “judicial penalty” (183), this “penalty of the norm” is more helpfully understood as a new “rationality,” a way to make sense of practices and bodies that insists on homogeneity and so both fixates on—and aims to correct—individual differences figured as abnormal (199). The operation of normalization here exemplifies Foucault’s provocative characterization of power as “both intentional and nonsubjective”: “There is no power,” he claims, “that is exercised without a series of aims and objectives. But this does not mean that it results from the choice or decision of an individual subject.”³⁸

This operation of power that establishes, as Foucault writes, “the Normal . . . as a principle of coercion” is evident in the standards of phallic size first discussed outside medicine by Suzanne Kessler and mordantly represented in the “phall-o-meter” distributed by the Intersex Society of North America early in its formation.³⁹ According to the standard then current through the 1990s, a clitoris larger than one centimeter would require cosmetic reduction, while a baby with a penis smaller than one inch at birth would be reassigned female. Between the areas of less than one centimeter and greater than one inch lay precisely this domain of nonconformity that was so disturbing as to prompt the treatment that would otherwise be regarded as a gross violation of children, physical and emotional. One might ask to whom these bodies were disturbing. From parents’ accounts, it is not at all clear that they themselves were disturbed; rather, reports suggest that they were worried about how *other people* would regard their children. In other cases it appears that it was doctors who instructed parents that their children had a problem that merited correction and made threats posed as questions about how others—members of the family or caregivers who would change diapers or, in the case of boys, the peers who would be so ruthless in the locker room—would see their child.⁴⁰

When criticisms of cosmetic genital surgeries too narrowly cast their concerns in terms of the repressive power of normalization, they ignore a critical dimension of this power as Foucault describes it.⁴¹ In *Discipline and Punish*, he insists that “we must cease once and for all to describe the effects of power in negative terms: it ‘excludes,’ it ‘represses,’ it ‘censors,’ it ‘abstracts,’ it ‘masks,’ it ‘conceals.’ In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production.”⁴² Even as we must be vigilant in efforts to resist the effects of a normalizing power that has led to the classificatory systems that have wrought so much harm, we must acknowledge the fact that these very efforts

are also constitutive of power. Foucault elaborates on this point in the first volume of the *History of Sexuality*, finding in the production of homosexuality an exemplary case:

There is no question that the appearance in nineteenth century psychiatry, jurisprudence, and literature of a whole series of discourses on the species and subspecies of homosexuality, inversion, pederasty, and “psychic hermaphroditism” made possible a strong advance of social controls . . . but it also made possible the formation of a “reverse” discourse: homosexuality began to speak in its own behalf, to demand that its legitimacy or “natural-ity” be acknowledged, *often in the same vocabulary, using the same categories by which it was medically disqualified*.⁴³

If the “normalization” of the homosexual by nineteenth-century medicine marked the production of a new limit of abnormality, and with it the abnormal individual, twentieth-century resistance to this process must likewise be understood in these terms but in reverse — as an effort, that is, to recast normalcy, to understand *as normal* this new person the homosexual, and eventually those who would identify as LGBT. The recasting of normalcy in this case would, as Foucault suggests, make use of the medical category, not in the sense of the one constricting norm against which all should be evaluated, but to understand homosexual orientation in the “older” sense of the individual standard of health that nevertheless remains active in, and provides significant validation of, current conceptions of normality. In short, the normalizing power that produced this individual as an object of the burgeoning business of psychiatric medicine produced — “improbably,” “spontaneously,” in Foucault’s words (96) — Gay Pride and Rainbow Families, the Human Rights Campaign, and GenderPAC.

In turning once more to the history of homosexuality we should take care not to overlook the fuller picture that the history of normalization portrays, together with the lessons it teaches. Among these is the lesson that normalization “makes up people,” as Hacking, following Foucault, puts it. “Making up people,” Hacking writes, “changes the space of possibilities for personhood.”⁴⁴ In the case of LGBT people, it seems, Hacking’s point is obviously borne out, but not in any straightforward way. Where the pathological production of “the homosexual” once only limited the possibilities for personhood, it has since proven both to expand and to limit in new ways those possibilities.⁴⁵ Gay and lesbian adults have found in the United States comparatively greater “freedoms” in becoming subjects of law, politics, and ordinary social discourse. Almost daily reports on the status to

pass legislation banning discrimination in employment, the adoption of children, or the right to marry are testament to how the pathologizing label “homosexual” produced the possibility for those so marked to throw off the imputation of psychiatric disease and to demand social and political recognition. Nevertheless if adults may find in the claiming—or “reclaiming”—of gay identity what we might understand as enhanced possibilities for action, we will not find at this point a similarly expanded space of possibilities for children. The suspicion that a child has “homosexual tendencies,” for example, may result in treatment for gender identity disorder. In teenagers it can result in psychiatric institutionalization or in being cast out from one’s family. In examining criticisms of the DSD nomenclature as pathologizing, then, we must carefully attend to the normalizing assertion that a person with an intersex condition is, or should historically be understood as, a “kind” of person.

Histories of hermaphroditism suggest that people with unusual sexual anatomies have been treated as kinds of persons, and as Chase has written, “the older terms ‘intersex’ and ‘hermaphrodite’ clearly label the person, not a medical condition that the person has.”⁴⁶ Many of those critical of the new nomenclature appear to accept without reflection that persons with intersex conditions are a “type” of person, and so regard as normalizing the “pathologization” putatively entailed by the new nomenclature, yet not the very historical production of the “hermaphrodite.” That is, critics seem to take for granted that there is this person, the hermaphrodite, a natural kind, but regard medicalization as a political instrument of repression. For Foucault at least there is no ground to maintain that medicalization of intersex is normalizing but that the assertion of an intersex “identity” is not. If normalization shapes what he terms the “grid of intelligibility of the social order,” we must understand *both* the medicalization of intersex, as well as the production of the figure of the hermaphrodite, whether in history or today’s intersex activist (the “hermaphrodite with attitude”), to be counted among normalization’s effects.⁴⁷ Criticisms of the new nomenclature, and particularly those that suggest the language of “variation” or even “divergence,” seem to suggest that there is some space outside or beyond normalization, but if it truly constitutes the grid of intelligibility, then we will find no such space.⁴⁸ We must come to terms instead with our reliance on this grid—on the way that conceptions of the normal and the abnormal shape the way we see and understand, what and how we know, and so paradoxically how we may resist practices by what might be understood as a literal reformation of these conceptions.

The implicit claim of LGBT activists is that a healthy sexuality or gender identity cannot be defined in the narrow nineteenth-century terms that divided

normal from abnormal, heterosexual from homosexual, but must be understood in terms of the individual and what is right—that is, what is normal—for her. What this provisional victory suggests is that even as the effects of normalization can be resisted, that very resistance occurs within the terms it defines and by which it is defined in turn. We should not mistake the “depathologization” of homosexuality (its removal from the *DSM*) and the increasing acceptance of LGBT individuals as a triumph against this power, which is “everywhere,” but acknowledge it as a moment that vividly illustrates that “where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power.”⁴⁹ In looking to the history of homosexuality, then, we should not forget that resistance runs in multiple directions. The depathologization of homosexuality is notoriously linked to the development of the diagnosis of gender identity disorder, widely understood as an effort to “prevent” the development of homosexuality (and later, transsexuality) in children.⁵⁰ And we know that the idea that there could be “a hermaphrodite” whose sexual identity could confound the clear boundaries separating man and woman, boy and girl, gave impetus to the idea that such aberrations could be surgically corrected, and that children with unambiguous gender identities and normal sexual desires would result.

While we might understand the significant harm caused by these surgeries to have played an important role in producing the intersex activist, it is not at all clear that people with intersex conditions themselves agree that they are a type of person because they have a given condition or because they suffered a particular harm. Nor is it clear that promoting acceptance of intersex as an identity is necessarily an effective strategy for advancing the health and well-being of people with intersex conditions, adult or child. It was arguably this notion that a condition—whether manifested in ambiguous genitalia or a karyotype that does not in some way correspond to morphology—denoted a “kind” of person, which led to the understanding of intersex as what could be called a *disorder like no other*.

Physicians have long regarded intersex conditions as urgent problems of gender and genitalia, framed as the most significant components of identity since the nineteenth century.⁵¹ Working to effect a “normal” gender identity (in some cases through cosmetic genital surgery, but in other cases, such as those concerning androgen insensitivity or cloacal exstrophy, through deception of affected individuals and sometimes even their families), doctors’ collective aim seems to have been preventing the consolidation of any identity other than that of standard male or female. In focusing as they have on questions of gender and genitalia, and so by extension on questions of personal identity, physicians have treated intersex in ways that defy most conventional understandings of ethical medical practice: how

else can we see the awarding of a prize by the Canadian Medical Association for the argument that the truth of a patient's (abnormal) condition—the knowledge of which must be essential to her participation in her own medical care—be withheld from her?⁵² Is there another case in which one can imagine a physician claiming—on the invitation of a prestigious medical journal, no less—that cosmetic surgery to achieve a more normal appearance is necessary to secure a parent's love?⁵³ It is precisely medicine's treatment of intersex conditions as “disorders like no other” that permits the routine violation of established ethical principles that would be unthinkable in other areas of medical practice.⁵⁴ Such instances must certainly be regarded as egregious effects of the power of normalization. But what if instead of resisting medicalization we were to insist instead that physicians treat intersex “normally,” that is, not as rare and unusual cases that justify extraordinary practices but as *disorders like many others*?

Some may balk at the language of “disorder.” To the extent that “disorder” is taken to apply to a person who would consequently be considered “disordered” (as it most certainly was in the case of homosexuality), rather than a condition that one has (as is the case in any number of disorders for which the term gives no pause), then there is good reason to take issue with the term or, more precisely, to challenge its employment in certain contexts. Sexual orientation does not need “fixing”; gender identity and genital appearance similarly require no intervention. What—ironically perhaps—makes intersex a condition like no other is that it has been treated both by physicians aiming to “correct” the condition and by many of the activists who have resisted these same practices as an issue of identity—as the “problem” of gender and genitalia that has marked its medicalization since the nineteenth century. At the same time, intersex conditions occupy an almost entirely uncontroversial—but for that no less normalizing—medical terrain that has been inconsistently addressed by physicians and activists alike. These include hormone changes related to a given condition that may threaten an individual's well-being; more starkly, intersex conditions can and indeed have distracted physicians from detecting serious illnesses that might have been obvious in other cases. Granting that the medical cannot be neatly disentangled from the social, stakeholders in the debate over nomenclature can nevertheless agree that there are distinctions between the cultural issues of identity in which medicine has intervened and narrower matters of health, be they urgent in the case of a newborn with salt-losing CAH, or longer term, as is the case with different kinds of hormone replacement or special vulnerabilities to other conditions over the lifespan. Proponents for “demedicalization” of intersex conditions have focused principally on social issues and have not considered seriously the fact that atten-

tion to the important needs of affected individuals to receive health care attentive to their conditions is something that requires the application of a “pathologizing” term, be it disease, disorder, or injury—the only categories that authorize medical intervention.⁵⁵

If the change in nomenclature can promote the important development of attention to the genuine health issues associated with many intersex conditions, and so displace the concerns with sexual identity, then intersex can be counted among the many disorders for which the terms *normal* and *abnormal* are taken to mark differences—some consequential and others less so—in the functioning of human bodies. We do not question the characterization of cancer as an abnormal division of cells, for example; those with thyroid disorders like Hashimoto’s are grateful for the normalization of thyroid hormone levels treatment can bring. The operation of normalization in producing the distinctions between the normal and the abnormal in these cases forcefully illustrates how this power must be recognized not only to promote docility but to enhance a subject’s capacities as well.

In *Self-Transformations*, Cressida Heyes helpfully draws critical theoretical attention to those “positive” aspects of normalizing power toward which Foucault gestures in *Discipline and Punish* and the first volume of *The History of Sexuality*, but does not emphasize until his subsequent work focusing on “care of the self.”⁵⁶ While the power Foucault earlier described aims to limit possibilities for action, to train or “discipline” bodies to perform in certain ways and to produce particular effects, this power works at the same time to enhance capabilities in those same bodies; as Foucault writes, “the body that is manipulated, shaped, trained, which obeys [and] responds, becomes skilful and increases its forces.”⁵⁷ Foucault’s example of the young student assigned the repetitive writing of lines or the military man doing his drills are the classic examples; his analysis applies just as well, however, to the person managing diabetes, who must work to maintain normal levels of insulin through a whole variety of disciplinary means: controlling her diet, maintaining an appropriate level of exercise, taking and testing her blood, and of course submitting herself to specialists who will evaluate the results, prescribe additional measures or medications, and thus refine the treatment regimen. Success in managing her disorder can prevent any number of complications of diabetes, including heart attack or stroke, blindness or limb amputation, and will surely result in “the increase in capabilities [*capacités*] often interpreted by a liberal political tradition simply as the increase in autonomy.”⁵⁸ The goal of effective management of diabetes is, in short, the living of a “normal” life—that is, a life as free as possible from the serious risks of the condition that would generally be taken to hamper human flourishing.⁵⁹

What the change in nomenclature can promise, though obviously not guarantee, is the possibility that DSDs could be similarly regarded. To the extent that the effects of a given DSD curtail one's capacities and so impede one's projects, it should be understood as a disorder like any other, and appropriate treatment offered. But if the effects of a DSD are benign or might be understood to provoke concerns that would be understood as social rather than medical, then psychosocial support should be offered. This is the intervention most urgently needed for parents of newly diagnosed newborns or children who may require assistance in grappling with diagnoses of DSDs, both because, as we know from the experience of parents of children diagnosed with any number and variety of congenital disorders, parents frequently need support when, in Dreger's words, they "have the child they weren't expecting" and also because, as we know from adults with DSDs, it is not the medical condition or even the social stigma associated with having atypical anatomy that causes psychic pain, but the projection of the stigma onto them by their parents and physicians.⁶⁰ We should, in other words, seek to recast what it means to "normalize intersex conditions": we need no longer understand normalization to entail the surgical correction of so-called ambiguous genitalia but the treatment of intersex conditions as disorders like any other.

Conclusion

The comparison between intersex and homosexuality has a long history. If I have suggested here that this history is a fraught one, it is because it has functioned at so many levels both to extend and to limit understanding of the treatment of intersex conditions and the effects of that treatment for affected individuals. Medical treatment of intersex conditions for the better part of the last century has indubitably constituted another chapter in the story of modern medicine's role in the pathological production of individuals, a chapter that has followed directly on that of the making of the homosexual. At the same time, too-close identification of homosexuality with intersex has led intersex activists and their allies to ignore the underlying health conditions that may result in atypical anatomies. Employment of the DSD nomenclature, I have argued, can "normalize" in a positive sense intersex conditions by directing attention to appropriate and ethical treatment, and away from the issues of identity that are not—as the history of the treatment of homosexuality has taught us so well—the business of medicine. All this is to say that in evaluating the proper treatment of intersex conditions we must look not only to the history of homosexuality with which it has been problematically identified but to the history and contemporary treatment of other conditions as well. In the

history of tuberculosis we find that social prejudice can shape medical practice in harmful ways; in diabetes and other endocrinological or metabolic disorders we may find conditions that have a good deal more in common physiologically with intersex than homosexuality and can provide models of care. Foucault's analysis of normalization, I believe, can help us distinguish between the "crushing effects of normalization" entailed by treatment and those effects of normalization that enable human beings by providing enhanced capacities.⁶¹ In clarifying that the underlying conditions of DSDs must be the object of treatment, I have argued, the new nomenclature can be normalizing in this latter sense. If in so doing it works to produce disciplinary effects on the physicians providing treatment in the care of infants, children, and the adults they grow up to be, then medicine will once more assume its traditional role in promoting human flourishing.

Notes

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1. Despite its prevalence it is important to note that *intersex* was never formally adopted by physicians as a diagnostic term. On the change in nomenclature, see I. A. Hughes et al., "Consensus Statement on Management of Intersex Disorders," *Archives of Disease in Childhood* 91 (2006): 554–63. For a discussion of the history of the development of the nomenclature, see Ellen K. Feder and Katrina A. Karkazis, "What's in a Name? The Controversy over 'Disorders of Sex Development,'" *Hastings Center Report* 38, no. 5 (2008): 33–36.
2. See, for example, Marie-Noëlle Baecheler, letter to the editor, *Archives of Disease in Childhood* (2006), adc.bmj.com/cgi/eletters/91/7/554#2562; David Cameron, letter to the editor, *Archives of Disease in Childhood* (2006), c.bmj.com/cgi/eletters/91/7/554#2479; and Milton Diamond and Hazel G. Beh, letter to the editor, *Archives of Disease in Childhood* (2006), adc.bmj.com/cgi/eletters/91/7/554#2460. See also the documents at the site of Organisation Intersex International, www.intersexualite.org/Disorders_of_Sex_Development.html (accessed July 29, 2008).
3. Corrective genital surgeries are not entirely unique in this respect. Appearance-altering surgeries intended to enhance psychosocial health rather than physical function include limb-lengthening surgeries for children with achondroplasia, as well as secondary surgeries to improve appearance in children with cleft lip and palate. For

- discussion of the ethical problems these surgeries provoke, see Erik Parens, ed., *Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality* (Baltimore: Johns Hopkins University Press, 2006).
4. Diamond and Beh, letter to the editor.
 5. For example, the term *intersexual* is used by Anne Fausto-Sterling, *Sexing the Body: Gender Politics and the Construction of Sexuality* (New York: Basic, 2000), 31; and Sharon E. Preves, *Intersex and Identity: The Contested Self* (New Brunswick: Rutgers University Press, 2003), 97.
 6. This is a particular problem for the majority of individuals with intersex conditions assigned female, who may be reluctant to seek gynecological care and who may be especially vulnerable to illnesses typical of aging women, including osteoporosis. See, for example, Katrina A. Karkazis, *Fixing Sex: Intersex, Medical Authority, and Lived Experience* (Durham, NC: Duke University Press, 2008), 228.
 7. Jennifer Terry, "Anxious Slippages between 'Us' and 'Them': A Brief History of the Scientific Search for Homosexual Bodies," in *Deviant Bodies: Critical Perspectives on Difference in Science and Popular Culture*, ed. Jennifer Terry and Jacqueline Urla (Bloomington: Indiana University Press, 1995), 135. See also Michel Foucault, *An Introduction*, vol. 1 of *The History of Sexuality*, trans. Robert Hurley (New York: Vintage, 1990), 43, 101.
 8. Michel Foucault, *Abnormal: Lectures at the Collège de France, 1974–1975*, ed. Valerio Marchetti and Antonella Salomoni, trans. Graham Burchell (New York: Picador, 2003), 67–68.
 9. Terry, "Anxious Slippages," 135.
 10. Fausto-Sterling, *Sexing the Body*, 72. See also Monica J. Casper and Courtney Muse, "Genital Fixations," *American Sexuality Magazine*, March 16, 2006, www.nsrc.sfsu.edu/MagArticle.cfm?Article=595&PageID=0; and Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* (Cambridge, MA: Harvard University Press, 1998), 8–9.
 11. In a 2004 survey of pediatric endocrinologists and urologists, a startling proportion (42 percent and 57 percent, respectively) reported that projected sexual orientation of infants informs decisions on gender assignment (D. E. Sandburg et al., "Intersexuality: A Survey of Clinical Practice," *Pediatric Research* 55, no. 4 (2004): abstract 869; cited in Karkazis, *Fixing Sex*, 142); on parental expectations, see Suzanne J. Kessler, *Lessons from the Intersexed* (New Brunswick, NJ: Rutgers University Press, 1998), 26; and Peter Hegarty and Cheryl Chase, "Intersex Activism, Feminism, and Psychology: Opening a Dialogue on Theory, Research, and Practice," *Feminism and Psychology* 10 (2000): 125–26.
 12. Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton: Princeton University Press, 1987).
 13. Cheryl Chase, letter to the editor, *Sciences*, July–August 1993, 3; Preves, *Intersex and Identity*, 88. As Karkazis attests, gay activism and queer theory have been by no

means the only influences here; feminist as well as health care and disability activism were also important (*Fixing Sex*, 246), but I would suggest a certain priority in the influence of the gay rights movement for the reasons that I have detailed here.

14. *Hermaphrodites Speak!* dir. Cheryl Chase, Intersex Society of North America, 1996. Morgan Holmes's injunction to "seize the name 'intersexual' as our own and take away its pathologizing power" is the most direct statement of this point ("Queer Cut Bodies," in *Queer Frontiers: Millennial Geographies, Genders, and Generations*, ed. Joseph A. Boone et al. [Madison: University of Wisconsin Press, 2000], 106). Other moving and provocative examples of this sort of "coming out" and reclamation of "intersex" can be seen in the first-person narratives in the collection *Intersex in the Age of Ethics*, ed. Alice Domurat Dreger (Hagerstown, MD: University Publishing Group, 1999).
15. This change is "radical" in the sense that it challenges standard practice in nearly every respect, but we must always recall that this change asks only that physicians act in accordance with established principles of evidence-based medicine, as well as in conformity with the bioethical standards supposed to guide that practice.
16. "Gender policing" includes the treatment of young children for gender identity disorder and teenagers who have been subjected to institutionalization. For an extended discussion, see Ellen K. Feder, *Family Bonds: Genealogies of Race and Gender* (New York: Oxford University Press, 2007), 45–60.
17. In this respect, the treatment of those with intersex conditions may be compared with the medical treatment of women through much of the twentieth century, whose difference from men was disregarded in most health research, with the result that medical care provided to women was often inappropriate. For an extended discussion, see Sue V. Rosser, *Women's Health—Missing from U.S. Medicine* (Bloomington: Indiana University Press, 1994).
18. There is certainly a broad range of individuals diagnosed with intersex conditions who might seek hormone replacement. For some, hormone therapy might not be understood precisely as a "choice," given the serious risks of osteoporosis for those without gonads; others might elect hormone replacement because the function of their gonads is at odds with their gender of assignment. In the latter case there is significant overlap with those who are transgendered. For a discussion of the issues involved in medicalizing these conditions, see Judith Butler, "Undiagnosing Gender," in *Undoing Gender* (New York: Routledge, 2004), 75–101.
19. Jonathan Ned Katz, *The Invention of Heterosexuality* (New York: Dutton, 1995); Ian Hacking, "Making Up People," in *Reconstructing Individualism: Autonomy, Individuality, and the Self in Western Thought*, ed. Thomas C. Heller et al. (Stanford: Stanford University Press, 1986), 222–36. It is not the case, obviously, that homosexual practices were unrecognized before this time; Katz's claim is instead that the category of "the homosexual" (together with "the heterosexual") transformed the meaning of sexual desire and divided people along the axis normal/abnormal that the homo-/heterosexual terms consolidated and naturalized.

20. For a provocative argument on the narrative figuration of intersex, see Iain Morland, "Narrating Intersex: On the Ethical Critique of the Medical Management of Intersexuality, 1985–2005" (PhD diss., University of London, 2005).
21. Arlene B. Baratz, letter to the editor, *Archives of Disease in Childhood* (2006), adc.bmj.com/cgi/eletters/91/7/554#2590; Alice Domurat Dreger et al., "Changing the Nomenclature/Taxonomy for Intersex: A Scientific and Clinical Rationale," *Journal of Pediatric Endocrinology and Metabolism* 18 (2005): 732; and Karkazis, *Fixing Sex*, 261.
22. Hacking, "Making Up People," 227.
23. Sheila Rothman, *Living in the Shadows of Death: Tuberculosis and the Social Experience of Illness in American History* (Baltimore: Johns Hopkins University Press, 1994), 181. David Barnes's history of tuberculosis in France is also illustrative here. From the early nineteenth century, he recounts, "consumption or *phthisis* was [understood as] an individual, inscrutable, and all but random killer, probably hereditary and somehow related to passion. In the 1830s, under the July Monarchy, the disease was for the first time seen as socially discriminating, choosing its victims from certain professions and from poor neighborhoods. Beginning in the 1840s, being a consumptive woman signified in certain circles heightened sensibility and emotion as well as the redemptive power of suffering. From the late 1860s through the early 1880s, as the Third Republic established itself, the disease was possibly contagious. Around 1900, tuberculosis was a national scourge, highly contagious, lurking around every corner and symptomatic of moral decay" (*The Making of a Social Disease: Tuberculosis in Nineteenth-Century France* [Berkeley: University of California Press, 1995], 13). In the United States in the early twentieth century the spread of tuberculosis was associated with vagrancy, poverty, and immigration (Rothman, *Living in the Shadows of Death*, 191). Of the last, Alan Kraut recounts that Eastern European Jewish immigrants at midcentury were despised by racists as "tuberculous" both for their supposed susceptibility to tuberculosis and for their ability to withstand the disease (*Silent Travelers: Germs, Genes, and the Immigrant Menace* [Baltimore: Johns Hopkins University Press, 1994], 155–56).
24. Even as the preservation of privacy is taken to be paramount in medical management of intersex, we should not forget the many stories of those who have been, and continue to be, subjected to photographic sessions for purposes of research, as well as repeated exams by medical residents for educational purposes. It appears that the privacy of the family, rather than the individual patient, is at issue. It may also be that the public is being protected, of course, from the "revelation" that sex is not simply binary, but this is far from an explicit rationale for secrecy. See, for example, Kessler, *Lessons from the Intersexed*, 32.
25. Hughes et al., "Consensus Statement," 557.
26. As is now well known, this theory was advanced by John Money and his associates,

- among them Joan and John Hampson, and later Anke Ehrhardt. See, for example, Joan G. Hampson, John Money, and John L. Hampson, "Hermaphroditism [*sic*]: Recommendations concerning Case Management," *Journal of Clinical Endocrinology and Metabolism* 16 (1956): 547–56; and John Money and Anke A. Ehrhardt, *Man and Woman, Boy and Girl: The Differentiation and Dimorphism of Gender Identity from Conception to Maturity* (Baltimore: Johns Hopkins University Press, 1972).
27. See Milton Diamond and H. Keith Sigmundson, "Sex Reassignment at Birth: Long-Term Review and Clinical Implications," *Archives of Pediatric and Adolescent Medicine* 151 (1997): 298–304, which revealed what would come to be known in John Colapinto's words as "The True Story of John/Joan" (*Rolling Stone*, December 11, 1997, 54–73, 92–97). See also research by William Reiner, such as "Gender Identity and Sex-of-Rearing in Children with Disorders of Sexual Differentiation," *Journal of Pediatric Endocrinology and Metabolism* 18 (2005): 549–53. Consonant with Reiner's research the consensus statement does urge greater caution in matters of sex reassignment, which has typically entailed sex reassignment of 46XY boys born with micropenis or severe hypospadias.
 28. Lennard J. Davis, *Enforcing Normalcy: Disability, Deafness, and the Body* (New York: Verso, 1995), 23.
 29. Michel Foucault, "The Social Extension of the Norm," in *Foucault Live: Collected Interviews, 1961–1984*, ed. Silvére Lotringer, trans. Lysa Hochroth and John Johnston, 2nd ed. (New York: Semiotext(e), 1996), 197.
 30. Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage, 1994), 34. See also Jacques Jouanna, *Hippocrates*, trans. Malcolm B. DeBevoise (Baltimore: Johns Hopkins University Press, 1998), 326, 331; and G. E. R. Lloyd, ed., *Hippocratic Writings*, trans. J. Chadwick (New York: Penguin, 1983), 262.
 31. Davis makes more explicit than Foucault here the implication of eugenic medicine, drawing a direct line between its notorious history and the birth of the norm (*Enforcing Normalcy*, 24–38).
 32. Dreger et al., "Changing the Nomenclature," 730, 732–33.
 33. Dreger, *Hermaphrodites*, 35–40.
 34. Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (New York: Vintage, 1979), 182–83.
 35. Preves, *Intersex and Identity*, 31.
 36. Karkazis, *Fixing Sex*, 221.
 37. Foucault, *Discipline and Punish*, 179.
 38. Foucault, *Introduction*, 95.
 39. Foucault, *Discipline and Punish*, 184; Kessler, *Lessons from the Intersexed*, 40–44.
 40. See, for example, Melissa Hendricks, "Is It a Boy or a Girl?" *Johns Hopkins Magazine*, November 1993, 12. The refrain "what about the locker room?" unfortunately

retains currency. Dreger's response to such queries is apt here: "Yes, what about the locker room? If so many people feel trepidation around it, why don't we fix the locker room? There are ways to signal to children that they are not the problems and, [surgical] normalization technologies are not the way" ("When Medicine Goes Too Far in the Pursuit of Normality," *New York Times*, July 28, 1998).

41. One such critique is Elizabeth Reis's "Divergence or Disorder? The Politics of Naming Intersex," *Perspectives in Biology and Medicine* 50 (2007): 535–43.
42. Foucault, *Discipline and Punish*, 194.
43. Foucault, *Introduction*, 101; emphasis added.
44. Hacking, "Making Up People," 229.
45. A nuanced account of this point may be found in Ladelle McWhorter's Foucauldian account of her experience in *Bodies and Pleasures: Foucault and the Politics of Sexual Normalization* (Bloomington: Indiana University Press, 1999).
46. Cheryl Chase, letter to the editor, *Archives of Disease in Childhood* (2006), adc.bmj.com/cgi/eletters/91/7/554#2546.
47. Foucault, *Introduction*, 93.
48. See, for example, Diamond and Beh, letter to the editor; and Reis, "Divergence or Disorder?"
49. Foucault, *Introduction*, 93, 95.
50. See, for example, Edgardo J. Menvielle, letter to the editor, *Journal of the American Academy of Child and Adolescent Psychiatry* 37 (1998): 243–44; and Shannon Minter, "Diagnosis and Treatment of Gender Identity Disorder in Children," in *Sissies and Tomboys*, ed. Matthew Rottnek (New York: New York University Press, 1999), 9–13.
51. Foucault, *Introduction*, 155–56.
52. Anita Natarajan, "Medical Ethics and Truth-Telling in the Case of Androgen Insensitivity Syndrome," *Canadian Medical Association Journal* 154 (1996): 568–70.
53. See the invited response to Joel Frader et al., "Health Care Professionals and Intersex Conditions," *Archives of Pediatric and Adolescent Medicine* 158 (2004): 426–28, by Erica Eugster, "Reality vs Recommendations in the Care of Infants with Intersex Conditions," *Archives of Pediatric and Adolescent Medicine* 158 (2004): 428–29.
54. The remarkable lack of evidence supporting successful outcomes of cosmetic genital surgeries and sex reassignment means that intersex surgeries are experimental procedures; in this respect these treatments take their place in a notorious history of medical experiments in the United States, including the sterilization of children diagnosed with mental illness (reviewed by the U.S. Supreme Court in *Buck v. Bell*, 274 US 200 [1927]) and the Tuskegee syphilis study from 1932 to 1972 (James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment*, rev. ed. [New York: Free Press, 1993]).
55. Medicine has certainly not been consistent in its use of nomenclature. Patricia A. Ross notes that any physical problem was long cast as "disease," and "disorder" was

introduced to distinguish physical from psychiatric conditions (“Sorting Out the Concept *Disorder*,” *Theoretical Medicine and Bioethics* 26 [2005]: 136n2). Disorder has been employed far more widely than Ross suggests, however. A recent edition of a textbook for medical students and pediatricians uses the term to describe all manner of conditions that warrant medical care. Chapter headings include “Allergic Disorders,” “Musculoskeletal Disorders,” “Disorders of the Nervous System,” and so on (Lucy M. Osborn et al., *Pediatrics* [Philadelphia: Elsevier Mosby, 2004]).

56. Cressida J. Heyes, *Self-Transformations: Foucault, Ethics, and Normalized Bodies* (New York: Oxford University Press, 2007), 64.
57. Foucault, *Discipline and Punish*, 136; see also 138.
58. Heyes, *Self-Transformations*, 77.
59. The concept of “human flourishing” is most closely associated in Western philosophy with Aristotle’s treatment of *eudaimonia*, frequently translated as “happiness.” I have found the concept helpful in this context precisely because the philosophical provenance of the term connotes for contemporary thinkers a concept of flourishing that is historically specific, emerging from a particular cultural context.
60. Alice Domurat Dreger, “What to Expect When You Have the Child You Weren’t Expecting,” in *Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality*, ed. Erik Parens (Baltimore: Johns Hopkins University Press, 2006), 253–66.
61. Heyes, *Self-Transformations*, 7.

