

RHETORIC
OF THE MEDICAL MANAGEMENT
OF INTERSEXED CHILDREN

"And why, coy youth," [Salmacis] cries, "why thus unkind!
Oh may the Gods thus keep us ever join'd!
Oh may we never, never part again!"
So pray'd the nymph, nor did she pray in vain:
For now she finds him, as his limbs she prest,
Grow nearer still, and nearer to her breast;
'Till, piercing each the other's flesh, they run
Together, and incorporate in one:
Last in one face are both their faces join'd,
As when the stock and grafted twig combin'd
Shoot up the same, and wear a common rind:
Both bodies in a single body mix,
A single body with a double sex.

- Ovid, *Metamorphosis*

Nursie: You almost were a little boy, my cherry pip.

Queen Elizabeth: What?

Nursie: Yea. Out you popped out of your Mummy's tumkin, and everyone shouted, "It's a boy! It's a boy!" And then someone said, "But he hasn't a wrinkle!" And then I said, "A boy without a wrinkle? God be praised, its a miracle! A boy without a wrinkle!" And then Sir Thomas More pointed out that a boy without a wrinkle is a girl...

- "Bells." *Black Adder II*

INTRODUCTION

In the Fall of 1998, a call came through to a local, nonprofit HMO in a rural, though growing county of northern California. The call was from an attending physician at a local hospital. She was attempting to reach the HMO's medical director to discuss a situation she had never confronted before: a member of the health plan had just given birth to a healthy child, but she was not exactly sure what gender to assign the child. The genitals of the child appeared

ambiguous to her, and she needed both treatment direction from the medical director, as well as a clear answer as to what utilization protocols would be covered by the health plan.

The attending physician and the medical director agreed to follow the current medical guidelines, run tests to ascertain any potentially life-threatening conditions that were the underlying causes of the condition, work with a team of specialists to assign an "optimum sex of rearing", and schedule surgeries to begin the long process of constructing "real looking" genitals.

The result of the tests on this particular child are confidential, as are the specific surgical procedures or outcomes agreed upon by the surgeon and the parents. However, this much can be shared: The health plan covered the costs of the procedures, and justified its decision on the basis of "medical necessity". The surgical intervention and follow up hormone treatments were covered, because the ambiguously gendered body of the infant was deemed to be *medically* "at risk". Presumably, a gender was "discovered", its contours literally carved upon the body of the child, and the family sent home with instructions on follow-up care. And the HMO, in general an economic institution of medical management not prone to "experimental" procedures nor particularly proactive in seeking out costly long-term medical procedures, agreed with this judgment.

Approximately a year later, a tenured and well respected member of the faculty of the junior college in the same region made public his decision to undergo a transformation of his gender assignment, identity and role by leading his first class session of the semester as a woman. He, too, was a member of the same health plan at the time, and asked it to pay for his treatment. In contrast to the decision rendered with respect to the child, the HMO denied this member's pre-service authorization request, and did so on the basis of it not being a "medical necessity".

Apparently, not having a clear gender is a medical emergency and something worth correcting, but not being assigned the "right" gender is not. More importantly, the role of the

patient's full knowledge and consent, in cases of transgender medical procedures, *ipso facto* renders the treatment medically "unnecessary" and "patient-driven", whereas in the case of the newborn child, it is the child's *lack* of knowledge and consent that renders the situation a medical necessity.

All other factors being equal, and in both cases they were,¹ this looks to be a serious inconsistency. After all, why is the one case "necessary" and the other "optional", when what is at stake in both cases is gender assignment? It is my intention in this essay to focus upon the rhetorical aspects of the decision making processes undertaken by physicians that lead them to believe that in the case of intersexed children, medical intervention upon the newborn *must* take place. By all accounts physicians believe they are doing the "right thing" by these children. By which they seem to mean that they are offering the child a chance for a "normal" life. By which they also seem to mean that the gender to which the child is assigned will be accepted by the child (and parent) when s/he grows up, and that the treatment protocol provides the child-as-patient the full rights to disclosure and informed consent that is otherwise extended to all other patients.

It is an open question, indeed an increasingly asked question, whether such expectations are indeed the case.

INTERSEXES

It is extremely difficult to ascertain with any certainty the frequency of intersexed births. This is due to a variety of reasons. In the first place, the frequencies with which the various conditions that often lead to a diagnosis of intersexed birth are themselves wide ranging. Secondly, it is difficult to decide what to count as "sexual ambiguity", since several of the conditions that can lead to intersexed diagnosis do not necessarily always lead to genital ambiguity which would prompt the diagnosis. Thirdly, there is the difficulty of knowing whether one has chosen a broad enough population sample, including geographical variations, from which to derive statistical

evidence. Finally, history and culture provide the *sine qua non* of the identification of intersexed, since both determine the conditions and criteria of what constitutes "male" and "female" as well as the degree to which the differences between them are defined.

Nevertheless, many, including and even perhaps especially physicians, would be surprised to learn that, given all the caveats mentioned above, researchers are beginning to quote an average number of 1.7 births per 100. This number was arrived at from frequency estimates of various categories of intersexuality representing a variety of populations, and should be taken to be an "order of magnitude, rather than a precise count."² It is also quite clearly the case that different population samples would vary in the number of such diagnoses. Still, to put this number in perspective: even if this estimate was off by a factor of 10, it would mean that the number of intersexed births in the United States would be more than cystic fibrosis (1 in 2,500 "Caucasian" births),³ Down syndrome (1 in 800 - 1000)⁴ or Albino births (one in 17,000),⁵ any of which are generally well known. Here alone in the United States that would mean several thousand intersexed children born each year. Of course, we don't hear about them, for a variety of reasons, including silence, shame, and fear among the most obvious. Another reason, just as obvious, but often overlooked: the system of birth registry eliminates any possibility of mentioning them by limiting entry to "male" or "female" only. A third reason is that the conditions upon which this estimate is based often only result in "required" surgery upon an intersexed infant with a frequency of 1 in 2,500 births.

What, exactly, are such conditions? The list is rather extensive (over 25 conditions are mentioned in Conte and Grumbach, 1989),⁶ but I will mention some of the most common (or well known):⁷

Condition	Cause	Features
CAH (Congenital Adrenal Hyperplasia)	Genetic malfunction of one or more of six enzymes involved in making steroid	In XX children with ovaries, can cause an increase in the size of the

Condition	Cause	Features
	hormones.	"clitoris" and a fusing of "labia" (genital "virilization" or "masculinization"). In some cases, the salt metabolism of the individual can be disrupted, resulting in a life-threatening condition if not treated. At puberty, "masculinization" continues.
AIS (Androgen Insensitivity Syndrome)	Genetic change in the cell surface receptor for testosterone	In XY children with testicles, can cause underdevelopment of the "penis", presence of "labia" and a vagina (usually short). At puberty, "feminization" continues. The undescended testicles are prone to becoming cancerous after puberty.
5-AR (5-alpha reductase deficiency)	Genetic malfunction of one of the enzymes involved in converting testosterone into dihydrotestosterone.	In XY children with testicles, can cause underdevelopment of the "penis", presence of "labia" and a vagina (usually short). At puberty, however, testosterone can be read by the receptor cells, so the body grows taller, stronger, more muscular, with increased facial hair and a deepening of the voice.
Gonadal Dysgenesis	Variety of causes, not all genetic. A catch-all category.	Individuals whose gonads do not develop properly (asymmetrical gonads, mixed gonads ovo-testes).
Klinefelters syndrome	XXY chromosome pattern (actually, a variety of patterns, this one being the most common).	Individual with testes and "penis", but suffering from a form of gonadal dysgenesis causing infertility. At puberty there is often breast enlargement.
Turners syndrome	XO chromosome pattern (actually, a variety of patterns, including XY/XO) .	Individual with ovaries, but suffering from a form of gonadal dysgenesis causing infertility.
Hypospadias	Variety of causes.	XY individuals with "penis" and testes, whose

Condition	Cause	Features
		urethra does not run to the tip of the "penis". The meatus may be at the underside of the "penis", or may be at its base. Sometimes, the penis may be significantly curved (chordee).
Clitoromegaly	Variety of causes.	XX individual with ovaries and vagina, whose "clitoris" is deemed larger than "normal".
Micropenis	Variety of causes.	XY individual with testes, whose "penis" is deemed smaller than "normal".

These are just a few of the conditions that can contribute to the eventual identification and classification of an intersexed individual. However, it is important to note that the relationship between a given condition and the diagnosis of intersexed is not one-to-one. It is not that simple. Some of the conditions listed above (CAH, AIS, 5-AR, some variations of gonadal dysgenesis) may go undiagnosed, since the degree of impact upon the morphology of the body can vary from person to person, and in some cases can vary in the course of the life of an individual. Others of the conditions (hypospadias, clitoral hypertrophy, micropenis) may simply be a subjective diagnosis on the part of the attending physician.

In fact, often what necessarily (as opposed to sufficiently) "causes" the eventual identification of intersexuality is not the presence of one of these conditions *per se*, but the perceptual confusion of the attending physician regarding the morphology of the genitals of the individual. The doctor and medical profession since the 19th century presume the existence of two and only two genders, and regulate bodies according to a belief of "one body, one gender".⁸ Only after the doctor finds him or herself confused about the genitals (and in the case of adults, the relationship of the genital morphology with secondary gender characteristics such as breast development, facial hair, and other "anthropological" features) do the series of tests

take place to determine the underlying condition for the confusion. These can include cytologic screening, chromosomal analysis, assessing serum electrolytes, hormone, gonadotropin and steroids evaluation, digital examination, and radiographic genitography. Once the condition is identified, then the classification of which kind of intersexuality is made, and the discussion regarding what to do about it begins.

Modern medical psychosexual guidelines⁹ suggest the following: 1) that gender assignment should go to the gender most likely to maintain reproductivity, good sexual function, normal-looking external genitalia and stable gender identity; 2) the decision should be made as early as possible, within the newborn period, but no later than 18-24 months, with initial genital construction surgeries performed within this timeframe; 3) parents and professionals should be fully committed to the final decision about gender assignment and the subsequent gender of rearing, should inform the child with age-appropriate explanations about their situation, and should follow up with the administration of gender-appropriate hormones at the onset of puberty.¹⁰

Established by the work of John Money, the guidelines are premised upon the assumption that children are psychosexually neutral at birth, and that any child could be assigned either gender as long as the anatomy looks believable (to both parents and child) and all parties are convinced of the assignment. Today, following these guidelines and their broad adoption,¹¹ when confronted by an ambiguously gendered child, the attending physician declares a "social emergency" and a team (which can consist of the original referring physician, pediatric endocrinologist, pediatric urologists, geneticist and a possibly a psychologist, psychiatrist or a psychoendocrinologist) is called together to diagnose the conditions underlying the ambiguity, to ascertain the body's "true" gender, and to decide upon the gender assignment and gender of rearing.

How do they do that? Once they understand the underlying condition, enough is known about how the genitals will develop in specific circumstances and they employ the following

rules: 1) "Genetic females should always be raised as females, preserving reproductive potential, regardless of how severely the patients are virilized." 2) "In the genetic male, however, the gender of assignment is based on the infant's anatomy, predominantly the size of the phallus." If the child is XX and *can* be fertile, everything will be done to turn her into a female. This can include, in cases of "virilization", surgeries to reduce the size of the phallus to a more acceptable size (physicians specify .2 to .9 centimeters as an "appropriate" "clitoral" size for a newborn, based upon a table of "normal" sizes),¹² and to create a "functioning" "vagina" (defined as one that can allow the entry of a "normal sized" penis without pain when an adult).

On the other hand, if the child is XY, then the test for determining the gender assignment shifts from reproductivity to sexual performance, as defined by appropriate "penile" length and the ability to stand up to urinate. Appropriate length is 2.5 to 4.5 centimeters for a newborn.¹³ If the "penis" is below 2.5 cm, or the child has a hypospadiac "penis", the child will more often than not be assigned a female gender. This is due to the fact that, generally speaking, the surgeons have had a difficult time fashioning a "penis" that can successfully live up to the social standards required of it. On the other hand, vaginoplasties "only" have to fulfill one function: the vagina must be deep and wide enough to hold a penis.¹⁴

Once the procedures have been performed, in order for the protocol to succeed the physician must provide explanations to the parents, and later to the developing child, that will not undermine the certainty of the assignment. Consistency in maintaining the gender assignment and its clarity according to the "one body, one gender" norm is vital to the success of the guidelines, and it starts early. It begins with the first consultation with the parents after the intersexed child has been identified by the physician as such. Rather than telling the parents that the child has a mixture of sexual characteristics, the guidelines suggest that the physicians approach them by stating that the child really *does* have a gendered identity, but that the genitals and gonads are incomplete, and the "true sex" of the child has to be more clearly investigated. Accordingly, the physician is directed to state that the gender of the child is

not yet "finished", and their procedures will help to "correct" and "complete" this development. During this time physicians generally counsel parents not to discuss the situation with family members or friends, nor to name the child. If asked, the parents are counseled to avoid gender pronouns when referring to the child, using phrases like "our baby", "our child", etc. Only after the "true sex" has been chosen are the parents told of the results of the investigation, the name is chosen, the birth record filled out, and the surgeries are scheduled. Integrity of the gender identity system is thereby maintained, and consistency of this message plays a key role in the assignment process.

Then, as the child grows up, physicians are told to avoid providing the parent and the child with full medical explanations of the child's condition, and to counsel the parent how to answer the unavoidable questions that will arise as a result of the follow-up procedures and examinations. AIS individuals, for example, are not told they have an XY chromosome complement and that the surgery performed was upon testicles.¹⁵ Instead, they are told that they had a hernia operation, for example, or that underdeveloped organs, or gonads, inappropriate to being a girl were taken out. "[A]ccurate patho-physiological explanations are not appropriate and medical honesty at any price is of no benefit to the patient."¹⁶ "Discretion" becomes a fundamental aspect of the guidelines, since the guidelines depend upon clear, congruent and consistent messages being sent to the parents and the child so as not to create confusion. Success of the adoption of the gender assignment is premised upon the intersexed individual *not knowing they are intersexed*. Truth telling within this protocol threatens the very success of the protocol, since it would mean informing the parent and the child/young adult that the gender of the child was in question.

The ideal result of current medical guidelines, then, looks like this: The intersexed child is assigned a gender based upon adherence to a system of two and only two genders premised upon the ideal of "one body, one gender". The parent and the child need never learn the full facts about the intersexed condition of the child, but instead are told that the "true gender" has

been identified. Any follow up surgeries and hormone replacement therapies are easily explained without reference to any hint of ambiguity of the gender assignment, and are successful in the resulting morphology of the body. The child grows up, behaving "properly" for the assigned gender, never questioning his/her gender identity, and never learning or caring to learn about his/her medical history.

Unfortunately for those committed to maintaining the guideline, evidence is mounting that this outcome isn't as easy to come by, nor as successful as it is represented or assumed. In the last 10 years or so, a growing number of voices have begun to question the efficacy, success and ethics of the current protocol. Some of the concerns voiced have focused on the principle of deception and the effects it has upon the patient.¹⁷ Others have focused upon the fact that no long-term follow up research has been done to ascertain the "success" with which these individuals have adjusted to their assigned gender. This not only puts in question the scientific basis upon which the procedures are exercised (and justified), but also seriously challenges whether the principle of "informed consent" has been legally¹⁸ and ethically applied.¹⁹ Recently, the work of John Money has been questioned and severely undermined.²⁰

Finally, the intersexed themselves are beginning to join in the discussion and recount their experiences with the protocol, and their criticisms range from calls to reform the protocol to outright rejection of it. Lately, there has been a growing awareness, not just in the medical community of the difficulties these guidelines and their procedures have generated for some, but among the intersexed that there are, indeed, others like them!

Rather than represent these criticisms here in detail, I would like to bring a slightly different approach to the issue from any that has gone on before. Medical ethicists, from the perspective of their field, have focused upon "autonomy" of the patient and the issue of "informed consent" of the intersexed child/young adult in the management of their "condition". Physicians, falling back upon the tools of their discipline, have focused upon the need for long-term follow-up "outcome" reports to determine the success of their protocols. Still again, gender and cultural

critics have drawn from their theories to ponder the implications that intersexuality has within current "performance" and "construction" theories of gender formation and classification.

As a complement to these efforts, I wish to focus upon the rhetorical dynamics at work in the process of diagnosis and treatment by treating these as instances of functions of a specific trope of power: namely, the trope of the gendered formation of the subject. Elsewhere, I will elaborate upon the relationship of the intersexed to other so-called "third genders" in order to see how the body functions as a site upon which the trope of gender formation operates.²¹ For the purposes of this paper, I will limit my issue to a more modest purpose of describing, through a rhetoric of power, how the rhetoric of diagnosis and treatment functions in the management of intersexed children.

It is my thesis that current medical guidelines use rhetorical power dynamics to create a state where practices of the diagnosis of the "disease" and the procedures used in "curing" lead the patient to a state of "illness" wherein no "healing" can ever be achieved. As such, we learn not only a little bit more about the way in which current medical management operates (and therefore provide more reasons for its fundamental revision), but also point out the ways in which sexual identity is formed.

RHETORIC OF POWER

What I would like to do is to explore how a rhetorical approach might help us understand the processes by which doctors and families come together to decide upon the fate of the intersexed child. I choose to employ an approach I have elsewhere called a "rhetoric of power"²² that is distinct from an ethical or philosophical approach, in order help us to see certain dynamics that would otherwise be overlooked by these other approaches.

What is a "rhetoric of power"? It is a rhetorical approach to communicative exchanges that analyzes the function of power upon and within the discursive, extra-linguistic, pre- and post-performancial constraints and strategies of argumentation and persuasion at work in any given

symbolic encounter between a rhetor and an audience. It relies heavily upon what Perelman and Olbrechts-Tyteca term the frameworks and starting points of argumentation, and considers the material dimensions of communication in order to take into account not just the multiple intentionalities, nor only the multiple contextualities, but also and particularly the disciplinary constraints of the production of knowledge.

In other words, it asks and tries to answer a deceptively simple question: how does power shape rhetoric, and rhetoric shape power, in specific acts of communicative exchange, given specific historical and institutional settings?

For our task, however, it will perhaps help if I were to become more specific. Through a rhetoric of power we can analyze the physician-patient as specific habits of linguistic exchange ("bedside manner", particular instances and ways in which physicians and patients speak to one another, the ways in which physicians speak to each other about patients, etc.). In other words, a rhetoric of power can and does consider those dimensions traditional to rhetoric: how people use language to talk to and influence one another. But it also does more. A rhetoric of power considers aspects of this exchange that are not immediately "linguistic", but which have an impact by setting a context within which linguistic exchange takes place, such as: 1) institutionally sanctioned patterns of behavior, 2) disciplinary habits that constrain the exchange, 3) the assumptions of authority brought to the exchange by both participants and 4) the communal and societal contexts informing this exchange.

In other words, a rhetoric of power views the physician-patient relationship as more than simply identifying a diagnosis and implementing a cure. It considers the inventional means by which symptoms and diagnoses are identified, the presumptions governing this process, the efforts at securing conviction to follow through on certain procedures, the institutional sanctioning of preferring certain practices to others, the effects of these rhetorical dynamics upon both patients and physicians as active participants in the production of knowledge and persuasion.

The goal of an approach of a rhetoric of power to medical practices, then, is to raise up for consideration the wide range of institutional, personal, and discursive assumptions, their manifestations, and their outcomes upon the physician-patient relationship. It is to make physicians and patients more sensitive to the roles they play, depending upon one another to bring to a successful conclusion the pursuit of bringing the patient to a state of "health".

From the perspective of a rhetoric of power, it is clear that rhetoric suffuses any doctor-patient exchange. With respect to the question of the medical management of the intersexed, here, briefly, are some of the more obvious examples of the way rhetoric enters into the picture:

1) The selection of data to be considered relevant to identifying and determining gender. A scientific discipline draws data from a body of knowledge familiar to those in the discipline. Nevertheless, scientific debates concern themselves with the choices made within the discipline and how these choices constitute this body of knowledge: "choice of the facts deemed relevant, choice of hypotheses, choice of the theories that should be confronted with facts, choice of the actual elements that constitute facts."²³ The method of each science implies such a choice and the history of that field reveals its changing adherence to certain choices over others.

Data that are chosen by the physician to determine gender identity are, simply, genital appearances. No other data are considered, at least not at first. Now, this seems relatively straightforward enough, and insofar as the genitals appear according to expectation, and insofar as the genitals are supposed to display a presumed gender dichotomy of two and only two available genders, the data ought to be sufficient for the physician.

It is only when a body presents data that do not conform to these expectations that other data are considered. As we have seen, these data are derived from internal sources of the body in an effort to "draw out" the body's "true gender". Suddenly, chromosomes enter the picture, gonads, internal genital structures, electrolyte levels and hormones. At this point, genital

appearance becomes just one of several data that then enter into the discussion, all of which focuses on the body as a source of hidden, internal data in need of discovery and interpretation.

What does not enter into the discussion are other factors just as determinative for the identification of the intersexed child's gender: the success of the psychosexual protocol with respect to the unquestioning adoption of assigned gender; the standards by which to judge this success; long-term follow up research on those who have undergone treatment; success of specific surgical procedures with respect to genital construction. Inasmuch as the intersex team presumes that the guidelines provide a successful treatment protocol and base their decisions upon it, data concerning its successful outcomes do not enter into the picture.

In other words, the data that are chosen for consideration by the physicians do not include the results of their decisions, the outcomes of the protocols. Instead, they include only those data that *presume* protocol's successful results. If there is any question about the success of the outcome, the intersex team never asks it, allowing the guidelines to fulfill their own prophetic success.²⁴

2) The presumption of the "self-evidential" quality of gender "facts". With respect to gender identification, it is part of the process of gender assignment that everyone knows what they are looking for: there is a penis, scrotum, testicles, and their presence signals a biological "given" that a person with these is a "male". There is also a clitoris (distinct from a penis), labia (distinct from a scrotum), and vagina (that leads to the uterus), and a person having these is clearly and biologically determined "female". It is "self-evident" that there exist two and only two genders, that a body must have only one gender associated with it, and that the genitalia function as the determinate of gender identity.

Setting aside the issue of "ambiguous genitalia" and the implications these may have upon the "self-evidential" nature of the male/female binary gender paradigm, one thing should strike

us as odd about this concept: if it is as simple as that, how does one explain the phenomenon of transgenderism? The datum that individuals who were assigned a particular gender at birth, premised upon what were for the physician at the time of birth unquestionably clear gender markers, would suggest a different source or standard for determining gender identity. How does a "male" come to be "trapped inside the body of a female", or vice versa, when nothing on the body itself would indicate such a move?

Similarly, evidence exists that a number of intersexed children have not accepted their assigned gender. Even though psychosexual management of the intersexed holds that "nurture" can overcome "nature", it is the construction of genitalia that becomes the focus of concern: if the genitals can send clear, unambiguous signals to the child and parents, then they will adapt themselves to those signals and accept the gender being communicated by them. For whatever reason, and for however many or few incidents of rejection we might discover, anecdotal evidence suggests that the relationship between genitals and identity isn't as clear cut as physicians presume.

It seems that the self-evidential nature of genitals = identity (that those genitals send clear signals, that they shape gendered identity, that this identity can be clearly distinguished between two and only two options, that these options are "natural" and "foundational") is not as sturdy as assumed, suggesting a severe limitation on the part of the physicians and the psychosexual guidelines of available evidence used for making a gender assignment.

3) The selection of accepted methods of interpreting these data. The methods for interpreting the data of gender identity include, first and foremost, looking at the genitals. If there is a penis, then the individual is "male". If there is no penis, then the individual is a girl. It is only when this method cannot be clearly applied do other methods enter in, as we have been discussing.

However, what is just as clear from the discussion, above, is not the case that these other data *necessarily* provide enough clear evidence of gendered identity that their presence alone secures the assignment. That gonads can be asymmetrical or mixed-mosaic, that chromosomes come in more than XY and XX, that growth hormones have an effect upon the body that would not be anticipated by a model that assumes two and only two genders, "one body, one gender". This would suggest the difficulty in arriving at a foundational, once-and-for-all determinate for gender.

In the face of this, physicians constructed a classification system to help sort the variety of data and their interpretation. Drawing from 19th century taxonomies, at least three classes of "abnormal" gender variation exist: "female pseudo-hermaphrodite" (a "real" woman whose secondary gender characteristics originally classified her as a "man"), "male pseudo-hermaphrodite" (a "real" man whose secondary gender characteristics originally classified her as a "woman"), and a "true hermaphrodite" (a person with both ovary and testicular tissue). These labels serve as a methodological basis upon which to sort out the various indicators, and to place the intersexed child into a "known" spectrum of conditions and their results.

Yet, even this classification system does not hold the final authority of gender determination. That responsibility is left to the surgeons and their enforcement of key cultural norms: Can a "female pseudo-hermaphrodite" become a "successful" woman with the right sized clitoris, the potential for fertility, and a vagina that allows penetration by a penis? Can a "male pseudo-hermaphrodite" become a "successful" man with a penis that functions according to social mandates? The method chosen to assign gender devolves back upon the genitals and how well they live up to the social and cultural expectations required of them, and not upon the physical indicators "discovered" through the process of diagnosis.

It is important also to consider the interesting role the physical body plays during this phase of "data interpretation". What is typically thought of as the foundational and unassailable

determinate of gender identity becomes cast under a cloud of suspicion if its signals are seen as "ambiguous". The body "lies".□

Here is where a hermeneutics of suspicion enters into the question of identity. Once the genital body loses its status as self-evidential datum by displaying genitals that do not conform to other presumptions, it is declared "faulty", "abnormal", or "incomplete", thereby ruling out its standing in the decision-making enterprise. Other aspects of the body, those that are not obvious, those that are hidden to all but the specialists, come to the fore. Once these have been "discovered", the "truth" has been produced, and the genital body is forced to conform to that "hidden" truth.□What is interesting about this, given what we've been saying above, is how the body, once the fundamental determinate of gender identity, is now disciplined into conformity by surgical means according to nonphysical standards.

4) The presumption that a statistical norm is normative for gender. For physicians, there exists a presumption that what constitutes the "normal"□ought to be normative for□determining gender identity.□Indeed, one could argue that statistical norm *defines* the genitals: a clitoris is "not" a clitoris until conforms to the statistical norms. Until that time, it can be "mistaken" for a penis, or is viewed as "monstrous". Similarly, a penis isn't a penis, until it achieves a certain length. The physician will spend a great deal of effort determining the size of a newborn's penis to ascertain whether it will be able to meet certain expectations regarding size and length. The application of hormones (e.g., HCG testing) to determine penis growth is performed, and if successful, the penis is allowed to stay; otherwise, it is chopped off. (Oddly enough, this procedure permanently arrests the growth of the penis for the rest of the life of the patient, so what might have become a statistically normal penis for a baby does not change as the child undergoes puberty.²⁵)

What is disturbing about this, is that this question of size has no medical value whatsoever. In all but one condition (CAH), the conditions underlying intersexuality do not put the patient at risk. Nevertheless, statistical deviation from the norm with respect to genital formation (the size and shape of a "penis" or "clitoris"),□gonadal formation (the presence of two, similarly structured

gonads that are clearly either ovaries or testes, but not both), hormone affects upon the body and the "secondary sex factors" it displays, become a cause for medical intervention: a statistical infrequency becomes a "medically necessary intervention". Rather than intersexuality leading the physician to question the "normative" function of the statistical "norm" and to reconsider what is "normal" about human gender formation, the body of the intersexed is made to conform to the statistical "norm", to confirm it.

5) The role of social values, and indeed a hierarchy of values, when determining gender.

Values play a fundamental role in the determination of gender. Several values can be quickly mentioned: the scientific value of "discovering" the underlying conditions of intersexuality; the scientific value of identifying a fundamental determinate of gender; the statistical value of genital appearance; the social value of gender identity; the implicit values in the rhetoric of categorizing and labeling certain physiological conditions associated with intersexuality; the implicit values of heterosexuality in the construction of these categories and their labels;²⁶ technological values at work in ascertaining "successful" surgical outcomes. Medicine is not the objective pursuit of truth, devoid of values and premised upon demonstrative reasoning. Medicine, as a human discipline, is replete with the stuff of human culture.

Later, we will explore the relationship of the physician-patient exchange to the broader cultural context shaping this exchange. For the moment, I only wish to point out that values, while an unavoidable element in medicine, also shift and change. As the history of medicine shows us, there is no "once and for all" value that overrides all others in the field of medicine. The prominence of some values are replaced in different places and at different times with other values. Often, it is a question of a "hierarchy of values" that a group's identity (or a philosophical/ethical system's identity, or an "era" of a discipline's history) can perhaps best be described. After all, everyone can agree that "health" is a value worthy of the pursuit of medicine. What becomes difficult to do, however, is to define what one means by help, since by the act of defining certain values are held up, while others are left out.

For the physician deciding the gender assignment of an intersexed child, the conflict arises between the sacred value of "do no harm" and the social value of "full integration into society". The one value asserts an individual-level, case-by-case purview, while the other demands commitment to the broader group. With respect to the situation of an intersexed child, it is clear that social values override all other considerations in the discussion, and do so in spite of the lack of evidence that "no harm" results, and growing evidence that the opposite is the case.

One example might help to clarify what I mean. Consider the case of CAH children, the only condition in which the child may be deemed at "risk". The "virilizing" effects of androgens upon the developing fetus presents a child whose genitals "look" "male". If the child is born in Europe or in the United States, medical practice is to assess the fertility potential of the ovaries, and if adult fertility is possible, to operate upon the body of the child in order to construct a "female" body type. There are various reasons given for this, but whatever the specific reasons, it is clear that the value of "female" reproductivity, assuming heterosexuality, is clearly at work as the most important for determining the gender assignment. If, however, the child is born in, for example, Saudi Arabia, medical management is to declare the child as "male", and to perform no surgeries upon "him". Here, the culture cache of male offspring overrides the value of potential fertility. A "son" has been born, and the doctor will not insist upon constructing out of "him" a "daughter", nor would the family. Instead, a treatment protocol that ensures the continuing health of the CAH child will be implemented, and the child will return home to the family without surgical reconstruction.

The former situation plays up two interesting aspects of intersex management: a) the determination of "male" or "female" gender assignments is not medical, nor biological, but is entirely a social construct dependent on cultural attitudes regarding the roles such identities play and the importance of those roles to the family, culture and society; and b) even children diagnosed with CAH, which carries with it a potential health risk-factor, can be managed without surgical gender reassignment.

6) The role of audiences during the discussion of determination. With respect to the psychosexual guidelines, it is clear that information is shaped depending on with whom it is intended to be shared. Physicians will speak with other physicians and specialists, to the exclusion of the parents of the intersexed child, in ways that maintain a limitation of ease of understanding for those outside of the discipline. Here we can point to the use of highly specialized vocabulary regarding diagnostic techniques, their results, and the technical/surgical options. The purpose of such is to maintain knowledge within the hands of a few and to shift the terms of the discussion in ways that maintain the validity of the protocol itself, and the physician's authoritative role in it as arbiter of gender identity and social gatekeeper.²⁷

Another whole approach is taken to the parents, who are taught, through specific phrases and gestures, a rudimentary form of embryology in an express effort. This is done for several reasons: a) to help the parent to "see" the ambiguity facing the physician; b) to help the parent locate the difficulty upon the body of the infant; c) to maintain the rigid male/female dichotomy; d) to allow the physician to pursue the hidden "truth" within the body; e) thereby to place the body in suspension, and give into the hands of the physician the ability to complete the body's arrested development. In this way, the body is placed at the disposal of the physician's role as "healer", and the parents are addressed in a way that helps them to recognize this role, accept its diagnosis on the basis of specialized knowledge and skill, and thereby maintain the authority of the physician as the one to direct treatment.

Still another approach is brought to the child, whose role is simply to accept, without question, the body as it has been surgically altered to conform to the child's assigned gender. The result is secrecy, denial, even outright deception in an effort to avoid presenting the child with any evidence that might suggest a confusion of genders had existed within their bodies. The child is never allowed an active role in the decision making process regarding the surgical interventions made upon the body. The child, throughout its life, is effectively *silenced*.²⁸

7) The goal of the protocol to "convince" the intersexed individual, parents, and society that the individual is, indeed, what they have been assigned to be. The success of the method does not lie in overcoming the obstacles to health that places the intersexed child medically at risk. As we have seen, the only "risk" to the child (aside from CAH electrolyte imbalance, or AIS testicular cancer) is social, and it is with respect to this basis alone that "success" is sought. Interestingly, the means by which this goal is achieved is by making available to the physician all the tools of the trade (discourse, surgery, pharmacology) to create a context of treatment for the intersexed within which no other options are available. One is made either male or female. One is not told about the conditions treated, or their impact upon the body. The implications that the body once held for justification of the treatment itself are never addressed, nor are the values that support the treatment ever questioned. The physician declares an emergency, assembles a team, acts as though the treatment has proven success, and carves the gender upon the body through procedures that are themselves presumed to be completely successful. Careful use of language, and the commitment to pursue a course of total conviction regarding the validity of the gender assignment, lays the foundation upon which, it is hoped, the intersexed child can make a transition into society without questioning what has happened, is happening or will happen to their body. Success is only achieved when everybody pretends nothing ever "went wrong".

After considering these several rhetorical aspects of the physician-patient exchange, I hope it has become clear that the deliberations, diagnoses, treatments performed by physicians are more than just "sharing information", more than the simple relating of "facts" and "evidence" or the results of demonstrative reasoning. They are rhetorical activities that have profound material consequences and effects upon the lives of people directly and indirectly engaged in the conversations about the intersexed.

THE RHETORICS OF "HEALING" THE INTERSEXED

So far, what we have explored is what would be termed the rhetoric "in" the exchange between physician and patient. However, for a rhetoric of power, this is only scratching the surface. There is much more that can be considered, aspects which would best be described as the rhetoric "of" the physician-patient exchange, a dimension of analysis and criticism that would consider the modalities of power on a broader level.

For the purposes of the current context, I would like at this time to focus upon and present only one particular cluster of modalities of power at work in the management of the intersexed. I would like to explore more closely how the concepts of "healing", "curing", "disease" and "illness" are constructed rhetorically through certain acts of naming, disciplining, evading and constructing.

For the purposes of this paper, therefore, "healing" is not just the process of diagnosis and care management for the sake of eliminating a "diseased" or "unhealthy" state. It is, instead, the whole plethora of relationships at work when patients, physicians, technicians, families come together to reintegrate the patient into society as a "whole" member.

"Curing" is therefore just one aspect of "healing", and to be pronounced "cured" is a rhetorically performative activity (label) signifying a change in responsibilities and activities at work between all the players. Let us consider more closely, but briefly and building upon what we have already discussed, the ways in which power shapes rhetoric, and rhetoric shapes power in the interaction of the four terms with respect to the intersexed.

The Rhetoric of Disease: When is a newborn, an intersexed newborn, in need of immediate clinical and surgical intervention? Surprisingly, a straightforward answer to this question can't be found. While several conditions have been identified as leading to intersexuality, and while tests are available to discern the particular etiology of the condition, they are only performed after the physician has already declared the child to be intersexed. It is only after the physician "sees" the child's "ambiguous genitalia" that it's condition is confirmed.

Now, this is no criticism per se, since the "art" of diagnosis and treatment typically proceeds along similar lines: symptoms are described or are witnessed, and the underlying condition for them is identified by tests that help to confirm an initial diagnosis. The question regarding the identification of intersexed children as such, is what symptoms do physicians initially rely upon? How does a physician first come to "recognize" the genitalia as "ambiguous"?

While scales of "normal" clitoral and penis lengths for newborn children have been developed, the attending physician doesn't usually stand around with a ruler trying to measure the size of the phallus. Nor do medical studies on the intersexed offer any evidence of the use of standard, "objective" measures. In fact, the literature is replete with phrases such as "ambiguous genitalia", "expected size", "appears small", "judged on the basis of...in relation to the size of the patient", none of which are defined or specified any further than this. It seems that something either "intuitive" or "self-evidential", or both, is at work when a physician takes a look at the genitals. They just "are" ambiguous.²⁹

Of course, it may be that in such cases the "ambiguity" would be "obvious" to any observer. Nevertheless, this does beg the question of just how "ambiguous" ambiguity is allowed to be before labeling the child intersexed and commencing with the prescribed interventions.

One of the reasons for this murkiness is that there is no medical standard of gender assignment and genital appearance that isn't also entangled with cultural, and even personal, aesthetic notions of how the genitals should "properly" look and function. One of the reasons for this is, quite simply, intersexuality is not a medical issue at all. It has always, only been a cultural issue that medicine has attempted to control by bringing to the issue of gender identity its tools of medical management.³⁰

So, it should come as no surprise that expectations on the part of physicians have a profound affect on their judgment ("what you hope to see is what you get"). For example, the presence of the phallus can outweigh all other indicators in the initial gender assignment.³¹ Of course, this

difficulty is related to whether one sees a "small penis" or a "large clitoris". The problem is, such a judgment is itself dependent upon preconceived notions of how a "penis" or a "clitoris" is "supposed" to look. These notions are replete with cultural, and not medical, presumptions and expectations of performance, size and appearance.

And they are notoriously malleable. A "penis" (even a severely hypospadiac one) is what a "boy" has, the gender of whom is what the physician is supposed to be determining in the first place. A "clitoris" is what a "girl" has, even if it is enlarged and accompanies fused "labia". For the psychosexual protocol, what is important is the assignment and its complete adoption of the gender, and this assignment is premised upon either assumed fertility of the XX chromosome child, or the ability of the penis to fulfill its cultural role.

In other words, the end determines the beginning. The gender you assign the child determines how you will view the child's ambiguity, and how you will proceed with the "necessary" corrections. Once a physician decides the signs of ambiguity are "confused", because the objects are not fulfilling their preordained and necessary role of clear, male/female marking, the physician then goes on to decide which of the two genders the genitals can measure up to fulfilling best. If it is decided the phallus is "too small" to be a boy, the child becomes a girl whose clitoris is "too big". Same goes with a "girl" whose fused labia and phallus are inappropriately sized/formed, who is then "fixed" so she can later be allowed to breed.

It never occurs to the physician that, perhaps, the genitals are just what they are and don't need fixing at all.³² It never occurs to the physician that if the genitals are confusing to them, this may only signal the need to test to identify specific health risk factors. Any such decision on the physician's part is simply a physician-driven mandate premised upon unquestioned assumptions about gender identify and formation.

That this is a *physician*-driven mandate is usually elided in published studies. Usually, these articles speak of the parent's "discomfort" and "confusion", of the parent's "demand" for

intervention and rectification. But rarely do these studies refer to anything more than this. It is not entirely clear how much discomfort is expressed, how insistently they make demands, what demands they make, and when the parents get to this stage.

Suzanne Kessler, on the other hand, has done a remarkable job in providing us with examples of the way parents view their intersexed children in their own words. She quotes from letters from parents who describe their initial reaction to their children as "perfect" and "perfectly healthy". Some of them kept using these terms, even while describing their children's genital anomalies and the procedures physician's prescribed for "correction".³³

Other parents described how physicians altered their perception of their children, stating "we had no idea there was anything wrong", or "no one ever expressed feelings there was something 'wrong' with him", or that the physicians, not the parents, had some question as to the gender of the child.³⁴ When parents did show concern for their child's state, it was more to do with the potential health issues (regarding CAH, in particular) and medical treatment options than with gender identity and genital appearance: Which hormones and how often? What do the surgical procedures do? What kind of follow up is necessary? How healthy will the child be? It was also clear that when the genitals and the procedures upon them were mentioned, the discussions about them were shaped by the rhetoric of the psychosexual guidelines and physicians, with little or no mention, for example, about the experiences of the child undergoing such operations.³⁵

While it is a stretch to universalize from the few, exemplary cases she presents, one cannot help but wonder how exceptional they are. Given that, historically, intersexed children and adults were not a problem until medically defined as such;³⁶ legally, the problem of intersexuality was a question of inheritance and suffrage;³⁷ and clinically, underreporting of intersexed conditions continues to occur, and adult intersexed cases are known for their rarity in the literature, it seems a reasonable hypothesis that, without the intervention of the physician,

the parent would not question the health or gender condition of the child. The child's body is held under suspicion by the physicians, not the parents.

What is clear in this murky area of "defining the intersexed" is that its existence is primarily, if not solely, determined by the rhetoric of the physician.

Rhetoric of Curing: So, once the physician is convinced of the ambiguity of the genitals, has instructed the parents to recognize it, runs the tests and determines the gender to be assigned to the child, how does the physician justify the necessity of the surgery? After all, it is not clear, either from the perspective of the parents (according to what we mentioned, above), nor from a health-risk perspective, that genital operations are at all necessary.

In order to justify surgery, the literature draws from a variety of inventional techniques, which could be summarized as a rhetoric of tragedy. Terms such as "necessary", "must", "demand" and "require" become part of the discourse of physicians when describing these operations.³⁸ The psychosexual management guidelines suggest that without the surgery, neither the parents nor the child will accept the gender assignment, since the genitals would not clearly display the appropriate and distinctive markings. The parents might reject the child.³⁹

Fear of teasing and the assumption of childhood trauma resulting from it, figures large in the literature, without any specific documentation regarding the experience of intersexed children who have not undergone surgery.⁴⁰ The "locker room" test in particular plays a vital role for judging the adequacy of size and shape of the "penis".⁴¹

The medical reports on these surgeries use terms such as "disfiguring and embarrassing", "deformed", "offensive", "troublesome", "ungainly", "unsightly" when discussing "clitorises" deemed "too large".⁴² When describing "micropenises", the language is not as dramatic, but can nevertheless verge on the tragic: a child with such a "heartbreaking" condition "must" be raised as "females", they are "doomed to life as a male without a penis". A "small" penis must be constantly reaffirmed in its adequacy to fulfill masculinity. After testosterone treatments are

administered on the child, physicians look for a reaffirmation "of his allegiance to all things masculine." Parents are reported as having "encouraged more appropriate male behavior".⁴³

It seems a great deal rides upon what is essentially only an issue of measurement.

So, in the tragic atmosphere of an intersex diagnosis, surgeries become a necessity. In fact, so committed to surgical intervention, physicians have been known to perform genitoplasty upon children without prior authorization, in addition to other surgical procedures being performed at the time.⁴⁴ There are available to the surgeon a wide range of genitoplastic techniques available: cliteroplastic and phalloplastic surgeries for the phallus (its reduction, resection, elimination, or, in the case of a hypospadiac penis, reconstruction), vaginoplasties to help construct and elongate the vagina, labioplasties to "improve" and "naturalize" the look of the labia majora.⁴⁵ All of these current surgical techniques are touted as producing "normal" looking genitals, and as vastly improved techniques from those that had been favorable in previous years.⁴⁶

Indeed, to hear the physicians talk about it, the surgeries are quite a success. Results are routinely categorized as "excellent", "acceptable", resulting in achieving a "satisfactory cosmetic result", "normal or near normal anatomic appearance", obtaining vaginal openings "adequate for sexual intercourse", achieving "excellent results" in hypospadiac repairs, and almost always the surgeries result in "minimal complications."⁴⁷ The protocol demands the surgeries as necessary, the surgeon report ever improving "excellent" results.

Unfortunately, three issues confront us here. First, as of yet, and in spite of the thousands of genital surgeries performed each year on cancer patients and transgendered adults, no meta-analyses of surgical outcomes have been offered.⁴⁸ What we do know is, depending on the condition, from 30% - 80% of children receiving genital surgery undergo more than one procedure, many from upwards of three to five.⁴⁹ Additionally, summarizing reports on vaginoplasties on 314 individuals, Fausto-Sterling found only 2/3 of the studies gave specific

criteria for success. She and her colleagues found high frequencies of complications leading to additional surgeries, occasionally a call for postoperative psychological follow up to help patients accept the surgery, and, in general, poor success rates (the highest reported 65% "satisfactory introitus and vagina").⁵⁰ Reductive cliteroplasties fared much worse: inadequate criteria for "success", focusing primarily upon cosmetic and not orgasmic criteria, and only one of the studies performed long-term follow up.⁵¹ The results for phalloplasty on hypospadiac penises were mixed: these "men" experienced their first sexual encounter at the same age as "normal" "males", and showed no significant difference in "sexual behavior or functioning". But, they were a lot more timid about seeking out sexual contacts, this timidity growing with the number of surgical procedures performed.⁵² Almost half of the "boys" who underwent surgery between 1985-1992 had to undergo secondary operations to repair the results of the first surgeries.⁵³

Not exactly the levels of success one would be led to believe.⁵⁴

Second, if pediatric surgeries are so successful for infants, why are the same techniques so difficult for adult transgendered patients? Reports from the transgendered community reflect a large number of transsexuals opting out of genital surgery altogether, and those that do undergo genitoplasty and succeed in "passing" cosmetically, report scarring, numbing, residual pain, the need for repeated dilation or catheterization, and sometimes difficulty with maintaining hormonal therapy without unwanted side-effects.⁵⁵ Surgeons operating on adult transsexuals provide a much different picture of the results, a more nuanced rhetoric seeking to generate more "realistic" expectations regarding surgical outcomes.⁵⁶

Finally, the context of genitoplastic surgery is a context of silence in an effort to construct "normalcy". This is potentially quite problematic for the patient, who is never advised (when too young) or told (when older) what these surgical interventions are about. Aside from the ethical issues of "informed consent" we noted earlier, the rhetorical effect of isolation and powerlessness is quite real. Here is where the procedural protocols for "curing" create a condition of "illness" for the child, rendering the child silent and without power.

Between the declaration of "ambiguous" genitals, the authoritative assignment of gender, the rhetoric of tragedy surrounding the condition of the child, the "necessity" of surgical intervention, the frequency of secondary surgical procedures, and the commitment of the protocol to shelter the child from any knowledge of the intersexed condition, the physician places and keeps the intersexed child in a state of continued medical management and separation. "Curing" creates and maintains a state of "illness".

Rhetoric of illness: So, the surgery is declared "successful", and the child and parents go home ready to live "normal" lives according to the gender identity "discovered" and "constructed". But what, exactly, does "success" mean? We mentioned earlier the difficulty with which medical standards can be found and applied to the surgical outcomes. Here I would like to consider something more subtle: the paradox at the heart of the protocol.

What I mean is, the rhetorical effect of current medical management blurs the distinction between the "natural" and the "constructed". It proceeds first by taking the "natural" gender indicators on the body of the newborn and turning them into a problem. It holds the body under judgment of suspicion, and expresses this suspicion in a way that suggests that the body has not completed its development: the gender is "there", only it is "hidden". Insofar as the gender is indeed "there", the body has been rejected in its typical role of "natural" foundation for gender identity. The physician demands that the body conform to a preset agenda. What is "natural" has been rejected. The solution? To "construct" a body through surgical techniques and hormone replacement. But it is this "constructed" body that reflects the "true" gender. It is this "constructed" body that is described as "natural".

The body of the intersexed is thereby placed in a very strange zone. It is, for all intents and purposes, a cyborg body, a construction of organic and technological components that are supposed to represent more naturally the authentic gender. The success of the protocol depends upon the intersexed child and the parents ignoring all the artificiality the body displays and accepting it as "natural". It is dependent upon a denial of the daily experiences of

encountering its own artificiality, experiences intensified each and every time the protocol and its procedures are employed (secondary surgeries, dilation, catheterization, hormone injections/ingestion, follow up consultations, therapy sessions). It requires for its success the patient and parents to undergo Orwellian doublethink.

Reports from the intersexed support this theoretical conclusion.⁵⁷ Granted, the sources are those who are motivated to speak, so they do not likely represent all intersexed people, but their experiences reflect our rhetorical analysis. The collection of essays assembled by Alice Domurat Dreger shows a consistency of themes: isolation and a sense of "monstrosity", anger at the deception and silence they repeatedly confronted, shame at the hands of physicians who put them on display, humiliation at the stigmatization experienced by repeated medical interventions,⁵⁸ pain from surgical scarring and physical therapy,⁵⁹ little sex drive, few experiences of orgasm.⁶⁰ Additional first-person testimonials from the Intersexed Society of North America relate similar messages.

Parents have a difficult time, as well. Reports from the view of the parents are rare in medical literature, and even difficult to find on the Web. But what has been culled reflects the other side of this experience, and it looks no better. Consider the fear and sense of helplessness at being told their healthy newborn is intersexed. Time and again parents talk about preparing for the time when they can talk to their child, and defend their decisions on the basis of ignorance or obligation.⁶¹ Consider the report of a mother whose 18-month old intersexed child stopped pulling out her own eyelashes and biting her nails only after the mother stopped all efforts at dilating her vagina. Or the child who is scared of her "tube".⁶² Or the child who has to squeeze urine out of a diverticulum each time he pees, because of the damage he suffered at the hands of a pediatric urologist. Or the five year old who says, "I hate my dong, I wish I was born a girl," after two surgeries to "correct" his hypospadias. Imagine the experience of utter anger vented by the adult intersexed at their parents after the truth has been revealed. Parents, too, suffer.

The "curative" procedures and interventions designed to help the intersexed children "heal" have, instead, made them feel "ill" at ease - with themselves, their physicians, their society. Upon the body of the intersexed are carved the markings of a gender ideal, strictly for the purposes of bringing comfort to others, regardless of the pain and isolation experienced by the intersexed child. Excuses, such as helping the parents to bond, only lead one to question the price paid for conformity: are such excuses used in the case of Down syndrome children? And yet, the markings of Down syndrome are far more public than genitals. Excuses, such as the difficulty the child will face with their peers, only lead one to wonder: it is difficult being Black in this society, so shall we bleach the skin of African American children to ease them into social conformity? And, yet, skin is far more public than genitals. We will pay to coerce a body to fit our social vision of two and only two genders, a body that has no voice nor understanding of what has brought about the need to undergo unnecessary and often debilitating surgery. But how great a cost, upon the integrity and wholeness of the person, are we willing to pay simply to make us, and not them, feel more comfortable?

Rhetoric of Healing: Healing requires the reintegration of the "diseased" and the "ill" into their community. It requires a systemic revision of medical protocols that isolate the patient from the community. In the case of the intersexed, it means the wholesale rejection of current practices in favor of a new paradigm that breaks open "male" and "female", that makes information freely available, that empowers the intersexed individual and parents to make informed decisions free from coercion.

Several alternatives to the psychosexual guidelines have been offered, by ethicists, practitioners, gender theorists and the intersexed themselves⁶³ in a reaction to its troubling procedures, assumptions and results. These alternatives run the gamut from theoretical ponderings by academicians, to concrete calls for revision or outright reconstitution of current practices.

Some see in the intersexed the possibility for a fundamental reordering of cherished social beliefs regarding the rigidity of the male/female gender dichotomy. The intersexed, transgendered and queer communities have begun to note the profound challenge they create to the heterosexist paradigm and the social and moral structures that are founded upon it. Alternative identities are being shaped and formed wherein the intersexed give themselves a place in society, a name that does not bring them shame. The theoretical implications of such gender fluidity have been explored by social constructionists such as Kessler and McKinnon,⁶⁴ Fausto-Sterling,⁶⁵ Devore,⁶⁶ and others. Each of these, and others, are seeking to find room for those that transgress the paradigm, to make room by exploring the possibility of other kinds of gendered identities. They argue for a vision of a different world.

Other alternatives, even those of the theorists mentioned, above, take a pragmatic approach to medical management, albeit some more radical than others. Diamond and Kipnis⁶⁷ offer three recommendations: 1) a general moratorium on genital surgery without the consent of the patient; 2) the moratorium not be lifted until comprehensive long-term studies are developed that set standards for successful outcome and judge results accordingly; 3) efforts be made to undo the damage done by the practice of deception by physicians. Wilson and Reiner⁶⁸ offer a new paradigm wherein 1) emphasis is placed upon inclusion of both parents and developing child in the process of gender assignment, to be worked through with a team that now includes a child psychiatrist or pediatric psychologist to act as liaison between parent and physicians; 2) all surgery should be limited strictly to that necessary to preserve child's health; 3) open and accurate communication be shared with the developing child; 4) hormone therapy and genitoplasty only occurs when the young adult is in a position to determine for themselves their gender identity. Howe⁶⁹ adds to these the suggestion that any negative reactions by parents to their children be viewed as *pathological*, not natural, and that caretakers find ways to help intersexed children feel comfortable about themselves and not turn

them into objects of pity or shame. These physicians, psychiatrists and ethicists are not concerned with "curing", but with "healing".⁷⁰

Unlike the others, who are professionals with ties to clinics and universities, Helena Harmohn-Smith, founder of the Hermaphrodite Education and Listening Post (HELP), is a mother of an intersexed child. She recently published her increasingly popular "Ten Commandments" for treating intersexed newborn children. They are worth listing as a confirmation of, and experiential counterpoint to, the reforms offered, above. 1) DO NOT tell the family to not name "the child"; 2) DO encourage the family to call their child by a nickname; 3) DO NOT refer to the patient as "the child"; 4) DO call the patient by the nickname/name chosen by the parents; 5) DO NOT isolate the patient in an NICU; 6) DO allow the patient to stay on a regular ward; 7) DO connect the family with an information and support group; 8) DO NOT isolate the family from information or support; 9) DO encourage the family to seek a counselor or therapist; 10) DO NOT make drastic decisions in the first year, including surgeries. A parent is not concerned about "curing"; she is concerned with "healing".

Perhaps among the most radical is Fausto-Sterling's call to take all these suggestions one step farther by pondering the possibilities suggested by gender theorists and imagine a world wherein the intersexed are recognized not as "abnormalities", but are one of a variety of possible gender formations, none of which need be premised upon physical genitals at all. After all, physical genitals are rarely publicly visible and "form a poor basis for deciding the rights and privileges of citizenship."⁷¹ Instead, we can learn things from the history of homosexuality, the change from "transsexualism" to "transgenderism", and the existence of "third genders" in other societies, that might help us envision and create a culture where gender variability is no longer supplanted by demands for conformity. Cultural genitals (that is, the presentation and performance of social gender)⁷² and physical genitals need not, do not always match. The reasons for demanding their coordination with each other comes from commitment to a particular, heterosexual view of marriage, family structure, sexual practice. Focusing upon physical genitals is a reductionistic

enterprise, and often violently so. Shifting to cultural genitals would alleviate the problems that are confronted by the intersexed (and transgendered and homosexuals), including legal quandaries regarding their right to free association (marriage) and equal protection (freedom from discrimination and violence). Fausto-Sterling calls for a world where two "sexes" are not enough.⁷³

What is shared among them all, from a mother's commandments, to the clinicians' disciplinary rhetoric, to the activists' call for change, to the gender theorist's "utopian vision", is a deep commitment to a process of "inclusion" and the right to exist free from coercion of medical impositions and deceptions that lie at the heart of the psychosexual protocol. In opposition to the isolation, shame, and cognitive dissonance that is necessarily experienced as a result of current medical practices, these folks all offer "healing" alternatives that seek not only to redress the damage done by current practices, but also to envision a new paradigm of the physician-patient relationship, indeed of the patient-social relationship.

The future of the intersexed is a future that must decide between two choices: a protocol that harms the individual by curing him/her, or an approach that gives the individual a place where s/he belongs. Only time will tell which direction will be taken, but it is interesting to see a movement of physicians, ethicists, parents and intersexed giving voice to "healing" alternatives.

CONCLUSIONS

The results of our studies bring to us a greater appreciation of the modalities of power and persuasion throughout the management protocols regarding intersexed children and adults: the number of presumptions regarding "facts", the selection of data, the "self-evidentiary" basis of gender assignments, methods of interpretation, the role of "normalcy", social values and audiences in the production of gender identity through surgical intervention. More interestingly, and perhaps more powerfully, we also noted how "disease" is first created by the physician's diagnosis, how the processes of "curing" brings about social isolation and denial on the part of

the patient and family ("illness"), a situation that can never lead to "healing", how alternative models seek to create a space of "healing" in reaction to the current protocols. A rhetoric of power brings new insights to the discussion of the reform of current medical management policies of the intersexed, insights not yet considered by ethicists, policy makers, or gender theorists: that the intersex is a rhetorical, not physiological state of existence. It reveals that the current practices meant to address their existence do so at the expense of healing. Even if an unassailable and self-evident foundation to gender dimorphism is unquestionably and universally uncovered; even if through surgical and cloning techniques genitals can be fashioned that function without trauma or loss of sensation; even if disclosure and "informed consent" are fully enacted: the medical approach of management and intervention *cannot* succeed, because its rhetoric requires a commitment on the part of the intersexed individual (and parents, friends, colleagues, playmates) that *nothing is wrong in the first place*. The paradox of the rhetoric of the medical management of the intersexed is simply this: if nothing is wrong, then why are all these powerful sources (of medicine, of gender ideology, of social expectations) all directed at my body?

Lest I come off suggesting that the fault lies solely in the hands of the physician, I must clarify that this is both *exactly* what I want to say, but also *precisely not* what I want to say. It is clear that physicians have alternatives, that they are aware of them, and that they are hearing from more and more people that their actions upon these children do not have the positive effects they assume. Insofar as they are aware of the difficulties with the surgeries, the lack of evidence in support of the guidelines, and the feedback they are beginning to hear not just from a "vocal minority" of patients, but from their own colleagues in medicine and ethics, at the very least they can, if they so choose, decide not to embark upon a course of surgery and deception. They can, even under tremendous pressure, choose to find other approaches.

On the other hand, these "tremendous pressures" may be overwhelming. It is possible, even likely, that parents may react in a pathological way to the information that their child is

intersexed. Endocrinologists and urologists each have their own ways of handling situations that they come across, and it would be strange, indeed, if they did not draw from their education and experience to develop solutions. Medical rhetoric that speaks of "advances" over the past make it difficult for practitioners not to cast a wary eye on dissent, esp. internal, within their own ranks. It is also possible that intersexed adolescents and adults participate willingly in their own management, when they choose to, a kind of "silent majority", perhaps. It is not "just" the physician's fault.

In the end, it is clear that the intersexed child becomes the focus of a great many modalities of power, from many different origins, all working to carve an identity upon its body: physicians, disciplinary habits, social ideologies, parental fears, legal requirements, all are at work attempting to place this child in one of only two available boxes: male or female.

On the other hand, a small but growing convergence of forces are seeking to provide a space for that child wherein identity might be given a chance to grow on its own, in the freedom to determine for itself its own fate/role in the world.

¹ It is known that the child did not have Congenital Adrenal Hyperplasia (CAH), a condition that would have serious medical consequences, if left unattended.

² A. Fausto-Sterling, *Sexing the Body: Gender Politics and the Construction of Sexuality* (New York: Basic Books, 2000), 51-53. The number is derived from frequency statistics of specific diagnoses of conditions that are related to intersexuality. They are not reflective of a count of the number of intersexed births, since this number is hidden in other data. This information was originally published as M. Blackless, A. Charuvastra, A. Derryck, A. Fausto-Sterling, K. Lauzanne, and E. Lee, "How Sexually Dimorphic are We? Review and Synthesis," *American Journal of Human Biology* 12 (2000), 151-166.

The number offered by Anne Fausto-Sterling is higher than the rough estimate of "one to three in every two thousand people" offered by A. Dreger, *Hermaphrodites and the Medical Invention of Sex* (Cambridge, MA: Harvard University Press, 1998), 42, although Dreger has since come to accept the higher number.

³ Cf. http://www.phd.msu.edu/DNA/cf_fact.html from Michigan State University DNA Diagnostic Program.

⁴ Cf. <http://www.ndss.org/aboutds/aboutds.html#incidence> of the National Down Syndrome Society.

⁵ Cf. <http://www.cbc.umn.edu/iac/facts.htm#whatis> of the International Albinism Center of the University of Minnesota.

⁶ F. A. Conte and M. A. Grumbach, "Pathogenesis, Classification, Diagnosis, and Treatment of Anomalies of Sex," in *Endocrinology*, L. De Groot, ed. (New York: Saunders, 1989), 1810-1847.

⁷ In the following table, the terms "penis", "clitoris", and "scrotum" and "labia" are all placed within quotation marks to signal the contextual-basis of the terms: the same phallus and skin are labeled "penis", if it is presumed the person is "male", or "clitoris" if the person is presumed "female".

⁸ Cf. Dreger, *Hermaphrodites*, 79-109.

⁹ American Academy of Pediatrics, RE9958, "Evaluation of the Newborn With Developmental Anomalies of the External Genitalia" *Policy Statement*, 106/1 (July 2000).

¹⁰ J. Money, J. G. Hampson, J. L. Hampson, "Hermaphroditism: Recommendations Concerning Assignment of Sex, Change of Sex, and Psychological Management," *Bulletin of Johns Hopkins Hospital* 97(1955), 284-300; *ibid.* "Imprinting and the Establishment of Gender Role," *Archives of Neurol Psychiatry* 77 (1957), 333-336. See also J. Money, *Sex Errors of the Body and Related Syndromes: A Guide to Counseling Children, Adolescents, and Their Families*, 2nd ed. (Baltimore, MD: Paul H. Brookes Publishing, 1994).

¹¹ Cf. the work of H.F.L. Meyer-Bahlburg, "Gender Identity Development in Intersex Patients," *Child Adolesc Psychiatric Clin N Am* 2 (1993), 501-512; *ibid.*, "Gender Assignment in Intersexuality," *Journal of the Psychology of Human Sex* 10 (1998) 1-21; and American Academy of Pediatrics RE9958.

¹² S. Oberfeld, et al., "Clitoral Size in Full-Term Infants," *American Journal of Perinatology* 6/4 (October 1989), 453-454.

¹³ "A micropenis is...defined as having a stretched length of less than two and a half standard deviations below the mean for age or stage of sexual development." J. M. Riley and C.R.J. Wodehouse, "Small Penis and the Male Sexual Role," *Journal of Urology* 142 (1989), 569-571. For a newborn, that means a minimum acceptable length of 2.5 centimeters.

¹⁴ Note: it does not have to be self lubricating, sexually sensitive, or reshape itself during intercourse, all of which functions are found in non-surgically constructed vaginas. The standard is that it function adequately in intercourse, which was defined by one practitioner as "successful vaginal penetration." See A. Dreger, "'Ambiguous Sex' or Ambivalent Medicine," *The Hastings Center Report* 28/3 (May/June 1998), 24-35: 30f.

¹⁵ B. Minogue and R. Taraszewski, "The Whole Truth and Nothing But the Truth?" (Case Study), *The Hastings Center Report* 18/5 (1988), 34-35. A. Natarajan, "Medical Ethics and Truth Telling in the Case of Androgen Insensitivity Syndrome," *Canadian Medical Association Journal* 154 (1996), 568-570.

¹⁶ Fausto-Sterling, *Sexing the Body*, 65.

¹⁷ Besides the many first-person narratives in the collection of essays by A. Dreger, *Intersex in the Age of Ethics* (Hagerstown, MD: University Publishing Group, 1999) see also <http://www.isna.org/library/bibonline.html> for links to several first-person essays available on line.

¹⁸ H. Beh and M. Diamond, "An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?" *Michigan Journal of Gender and Law* 7 (2000).

¹⁹ Insofar as the standards of "success" with respect to the cosmetic genital surgeries have not been clearly defined, much less universally adopted, these practices have no particular warrant

to justify their use. Insofar as the cosmetic surgeries are performed in order to facilitate acceptance on the part of both the child and the parents the assigned gender, and no follow up research has been offered to ascertain the "success" of this process, the protocol itself is unproven and experimental. Therefore, any consent given on behalf of the child by the parent cannot be "informed".

²⁰ M. Diamond, and H.K. Sigmundson, "Sex reassignment at birth: long-term review and clinical implications," *Archives of Pediatric and Adolescent Medicine* 151 (1997), 298-304. However, note S. Bradley, G. Oliver, A. Chernick and K. Zucker, "Experiment of Nurture: Ablatio Penis at 2 Months, Sex Reassignment at 7 Months, and a Psychosexual Follow-up in Young Adulthood," *Pediatrics* 107/1 (July 1998), electronic article 9.

²¹ J. David Hester, M. Gardella, *The Quest for the Hysterical Jesus: Power, Bible and Third Genders* (forthcoming).

²² Cf. J.D.Hester Amador, *Academic Constraints in Rhetorical Criticism of the New Testament* (Sheffield: Sheffield Academic Press, 2000), where I develop this approach more thoroughly.

²³ C. Perelman and L. Olbrechts-Tyteca, *The New Rhetoric: A Treatise on Argumentation* (Notre Dame, IN: Notre Dame University Press, 1969), 116.

²⁴ From an historical point of view, it would be interesting to consider how physicians selected certain evidence as "facts" which they were to use in helping to identify and determine a person's gender. In the 19th century, discussions about which physiological, gross anatomical, and even anthropological features of an individual revealed that individual's "true" gender. Even today, certain "facts" are included, while others excluded, in this process: gonadal, chromosomal, endocrinological, internal and external reproductive indicators, including genital size, can play a role. What history helps us to see is how these data shift and change over time as to their relative importance as factors helping to determine a person's gender: the introduction of certain technologies shifted the importance away from gonads, eventually settling on genital appearance. Dreger's work, *Hermaphrodites*, has been instrumental in bringing to us an awareness of this.

²⁵ Cf. S. Kessler, *Lessons from the Intersexed* (New Brunswick, NJ: Rutgers University Press, 1998), 69.

²⁶ See Dreger, *Hermaphrodites*, 110-138, and Fausto-Sterling, *Sexing the Body*, 71-73.

²⁷ Cf. J. Money, "Psychological Counseling: Hermaphroditism," in *Endocrine and Genetic Diseases of Childhood and Adolescence*, ed. L. I. Gardner (Philadelphia: W. B. Saunders, 1975), 609-618: 613, where he states, "...medical terminology has a special layman's magic in such a context; it is final and authoritative and closes the issue."

²⁸ Cf. Kessler, *Lessons from the Intersexed*, 32: "[Physicians] talk as though they have no choice but to respond to the parents' pressure for a resolution of psychological discomfort and as though they have no choice but to use medical technology in the service of a two-gender culture. Neither the psychology nor the technology is doubted, since both shield physicians from responsibility."

²⁹ Cf. Kessler, *Lessons from the Intersexed*, 33.

³⁰ Cf. Dreger, *Hermaphrodites*. 167-201.

³¹ Kessler, *Lesson from the Intersexed*, 44-46.

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- ³² As reported in J. Colapinto, "The True Story of John/Joan," *Rolling Stone Magazine* (December 11, 1997), 54-97, John Money's studies in his early years at Johns Hopkins reviewed 105 cases of individuals born with "ambiguous genitalia" who did *not* undergo surgery to "fix" them. Their research found 95% of them did not suffer from what is currently called "gender dysphoria", but were quite accepting of their gender identities and bodies.
- ³³ Kessler, *Lessons from the Intersexed*, 93.
- ³⁴ Kessler, *Lessons from the Intersexed*, 94.
- ³⁵ Kessler, *Lessons from the Intersexed*, 96-97
- ³⁶ Dreger, *Hermaphrodites*, 15-78.
- ³⁷ Cf. Fausto-Sterling, *Sexing the Body*, 30-36.
- ³⁸ Cf., e.g., Kessler, *Lessons from the Intersexed*, 38.
- ³⁹ Kessler, *Lessons from the Intersexed*, 19.
- ⁴⁰ Noted by Kessler, *Lessons from the Intersexed*, 34.
- ⁴¹ Cf. Kessler, *Lessons from the Intersexed*, 70; see also, K. Kipnis and M. Diamond, "Pediatric Ethics and the Surgical Assignment of Sex," in *Intersex in the Age of Ethics*, 173-193: 183.
- ⁴² Cf. Kessler, *Lessons from the Intersexed*, 35-36.
- ⁴³ Kessler, *Lessons from the Intersexed*, 38.
- ⁴⁴ B. Wilson and W. Reiner, "Management of Intersex: A Shifting Paradigm," in: *Intersex in the Age of Ethics*, 119-135: 119.
- ⁴⁵ For an excellent and accessible summary of these techniques, see Fausto-Sterling, *Sexing the Body*, 56-63.
- ⁴⁶ For examples of a "rhetoric of progress" in these reports, see. Kessler, *Lessons from the Intersexed*, 74.
- ⁴⁷ Cf. Fausto-Sterling, *Sexing the Body*, Table 4.1-3.
- ⁴⁸ Kessler, *Lessons from the Intersexed*, 53.
- ⁴⁹ Fausto-Sterling, *Sexing the Body*, 86.
- ⁵⁰ Fausto-Sterling, *Sexing the Body*, Table 4.2, 88-91; cf. also Kessler, *Lessons from the Intersexed*, 61.
- ⁵¹ Fausto-Sterling, *Sexing the Body*, Table 4.1, 82-83; cf. also Kessler, *Lessons from the Intersexed*, 53-54.
- ⁵² Fausto-Sterling, *Sexing the Body*, 86.
- ⁵³ Cf. also Kessler, *Lessons from the Intersexed*, 71: "Although two-thirds of the 345 patients were judged by the physicians as having a good- or satisfactory-looking penis, a group of researchers who have examined hundreds of boys and men with hypospadias claims that the 'surgery never produces a perfectly normal penile appearance.' In this typical sample, adult males with hypospadias had on the average more than three surgeries."

⁵⁴ Cf. also C. Chase, "Surgical Progress is Not the Answer to Intersexuality," in *Intersex in the Age of Ethics*, 147-159: 151-154.

⁵⁵ Cf. P. Califia, *Sex Changes: The Politics of Transgenderism* (San Francisco: Cleis Press, 1997), esp. 192, 207-209.

⁵⁶ Cf. Kessler, *Lessons from the Intersexed*, 73

⁵⁷ There are a number of first-person narratives from the intersexed available on the internet. One can start at: <http://www.angelfire.com/on/otherwise/more.html> and scroll down to find a few links, as a beginning.

⁵⁸ T. Alexandra, "Silence=Death," *Chrysalis (Special Issue on Intersexuality, 1997)*, 47-50.

⁵⁹ L. Melson, "New Perspectives on the Management of Intersex," *The Lancet* 357/9274 (June 30, 2001), 2110, reports new research by C. Minto and S. Creighton of the University College Hospitals in London on the complications of neonatal clitoroplasty. Cf. also Kessler, *Lessons from the Intersexed*, 64-68.

⁶⁰ Cf. also N. K. Alizai, D.F. Thomas, R.J. Lilford, A.G. Batchelor, and N. Johnson, "Feminizing Genitoplasty for Congenital Adrenal Hyperplasia: What Happens at Puberty?" *Journal of Urology* 161/5 (1999), 1588-1591.

⁶¹ Cf. Kessler, *Lessons from the Intersexed*, 90.

⁶² Cf. Kessler, *Lessons from the Intersexed*, 61-64.

⁶³ The intersexed have begun to organize themselves into an effective political and medico-ethical voice. In 1992, Cheryl Chase founded the Intersexed Society of Northern America, the first of its kind group dedicated to advocacy, education, research and outreach. Other similar support groups, some taking their inspiration from the ISNA, have since grown around the world. Groups have been formed in Canada, New Zealand, South Africa, Germany, England, Asia, Australia and Japan. They include the Androgen Insensitivity Syndrome Support Group (US, UK, Australia), Workgroup on Violence in Pediatrics and Gynecology (Germany), Intersex Support Group International, Ambiguous Genitalia Support Network, United Kingdom Intersex Association, Survivor Project, Turner Syndrome Society, Support and Education Exchange for Klinefelters Syndrome, and the MAGIC Foundation (a CAH support network), to name just a few. These groups represent grass-root efforts to connect, inform, share experiences, educate each other — to build community.

Fundamental to their success has been the growth of the internet, allowing people to communicate with unprecedented speed and access across countries and continents. Interestingly, this information exchange has met with some concern in the medical establishment. A recent article published in the *Journal of Pediatric Surgery* (1999, 36/8 [August 2000]) looked at 300 sites and found "only 45 represented 8 unique sites offering medical information. Five of these sites conformed to recommendations in 2 standard pediatric surgery texts, whereas 3 offered misleading information or information that did not conform to text recommendations." The authors concluded, "Parent-oriented information regarding intersex anomalies is difficult to find on the Internet. Over one third of sites containing medical information failed to conform to standard pediatric surgical recommendations for treatment. Pediatric surgeons should help parents effectively use Internet information." Specific websites that offered an alternative to standard protocols were of critical concern to the authors. This became a reason for suggesting that pediatric surgeons intervene and control information made available to the parents. It seems efforts by the intersexed to educate parents of other

intersexed children about alternatives available to them run contrary to the will of these authors (and, by extension, the Journal's editors and the discipline of pediatric surgery).

⁶⁴ S. Kessler & W. McKenna, *Gender: An Ethnomethodological Approach* (Chicago: University of Chicago Press, 1978).

⁶⁵ A. Fausto-Sterling, *Myths of Gender*, 2nd rev. ed. (New York: Basic Books, 1992).

⁶⁶ H. Devore, *FTM: Female to Male Transsexuals in Society* (Bloomington: Indiana University Press, 1997).

⁶⁷ Diamond and Kipnis, "Pediatric Ethics."

⁶⁸ Wilson and Reiner, "Management of Intersex."

⁶⁹ E. Howe, "Intersexuality: What Should Careproviders Do Now?" in *Intersex in the Age of Ethics*, 211-223.

⁷⁰ Cf. ISNA guidelines on their website <http://www.ISNA.org>.

⁷¹ Fausto-Sterling, *Sexing the Body*, 113.

⁷² Kessler and McKenna, *Gender*, 153-55..

⁷³ Fausto-Sterling, *Sexing the Body*, 76-114.