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'But We Have to *Do Something*': Surgical 'Correction' of Atypical Genitalia

KATRINA ROEN

Bodies are not neutral pages waiting to be inscribed with the same message by the same means.
(Holmes, 2002: 88)

This article engages critically with a selection of recent clinical publications, questioning the assumptions underpinning cosmetic surgical intervention for atypically sexed infants. The approach of this work is informed by feminist and queer theorizing that challenges claims about gender as fixed and knowable (Butler, 1993; Fausto-Sterling, 2000), and about the sexed body as a kind of coat rack (Nicholson, 1994) upon which gender may be placed. Attention is paid to the ways in which bodies are understood through the surgical endeavour (Braun, 2005; Budgeon, 2003; Davis, 1995), although the central focus is on providing an analysis of specific clinical publications, through which clinicians write about their views and practices regarding surgery with intersex infants.

Queer Subjects and Clinical Practices

Clinical work with intersex children largely rests on normative understandings about sexual difference: sex is assumed to be organized into a binary framework

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and children whose sexual features do not fit that framework are understood to require 'corrective' surgery or surgical procedures designed to 'repair' the atypical features. A queer reading of such surgical practices would suggest that the binary framework is a fantasy that can never be fully attained and that, as long as surgeons seek to (re)produce the reality of binary sexes, they inevitably keep producing queer embodied subjects. As Holmes writes, the irony of intersex surgery is that, rather than eliminating abnormality, such 'surgery *creates . . . abnormality*' (2002: 121, italics mine).

A queer reading gives rise to possibilities of reclaiming rather than shaming and opens up questions about the very notion of 'corrective' surgery.¹ '[A] queer body . . . throws into question even the possibility of surgical and hormonal "correction"' (Turner, 1999: 474). Despite the well-meaning aims of clinicians who seek to produce normative sexed appearance, queer subjects may refuse such normalization, emerging from long and painful periods of 'treatment' to proclaim their queerness, to argue articulately and defiantly that they have subverted the medical intention to normalize – metaphorically or literally displaying their scars as evidence that medical practices produce queer embodied subjects.

As long as surgery is used to erase difference or to 'correct' atypicality, people who have undergone such surgery will read its effects on their bodies in unintended ways, perhaps queering the surgeon's intentions, perhaps refusing to hide their scars in shame, perhaps reclaiming notions of queerness and monstrosity. Although not writing about intersexuality, Stryker makes a relevant comment in seeking to reclaim monstrosity, writing: 'As we rise up from the operating tables of our rebirth, we transsexuals are something more, and something other, than the creatures our makers intended us to be' (1994: 242).

Our critical understanding of the role that medicine plays in producing queer subjects feeds into the reclaiming of monstrosity: the monster as a sign, a warning, a reminder that where health practices seek to police the bounds of normativity, danger lies ahead. The monster 'resists the values associated with what we choose to call normality and becomes instead a focus of normative anxiety' (Shildrick, 2001: 163).

Other authors have also presented critical approaches to intersex, indicating the possibilities of intersex as a basis for identity claims and/or political challenges (e.g. Chase, 1998; Morland, 2005; Preves, 2003; Valentine and Wilchins, 1997). A key challenge confronting anyone working in this area is the rift between postmodern understandings that 'take the body as the site *par excellence* for exploring the construction of different subjectivities' (Davis, 1997: 4) and modernist discourse where 'the body represents the hard "facts" of empirical reality' (Davis, 1997: 3). It is this rift that lies at the centre of debates around the

way to make sense of intersex, and the way to work with intersex infants in clinical contexts.

Clinical Outcomes

For the past 15 years there have been increasingly vocal, articulate, politicized and academic critiques of the particular set of surgical practices that are founded on John Money's now infamous work (Money, 1955). It would appear that Money argued so convincingly for clinicians' ability to create girls and boys through cosmetic alterations that decades of treatment practices have been based on his theory. Yet now that the very basis for his theory has been exposed as flawed – with the publicity surrounding the 'John/Joan case' (Diamond and Sigmundson, 1997) (where an accident during circumcision led to a decision to surgically reassign the child and raise him/her as a girl) – it is interesting to watch with wonder how clinical texts reflect on this highly controversial practice. My review of some of the most recent clinical literature in this area suggests that, while a few clinicians are articulating concerns about the cosmetic surgery, many are reiterating old understandings. Typically they gesture towards the fact that some challenges have arisen, and then they dismiss those challenges within a sentence or two, going on to reiterate and reinforce the dominant clinical practice (American Academy of Pediatrics, 2000; Hrabovszky and Hutson, 2002).

Clinical literature has repeatedly cited the lack of good outcome studies as a key problem faced in this area (MacDougall and Creighton, 2004). The argument goes: without good clinical evidence showing what works and what doesn't work, the best we can do is carry on with the current treatment. Evidence of outcomes produced by intersex adults who are dissatisfied with their surgery is taken as a political statement that does not have any weight as clinical evidence. The vast majority of intersex adults appear to be quiet on the matter and no news is understood to be good news. Silence is assumed to signal contentment.

But a more careful reading of clinical literature will tell us that poor outcomes in clinical studies have been reported over a period of at least 30 years. Christopher Woodhouse refers back to a study in the mid 1970s: 'In looking at the long-term follow-up of 16 women . . . Lattimer's group concluded in 1976 that the results of vaginoplasty were so poor that operation should not be done before puberty' (2004: 302). Twenty-five years later, a team of gynaecologists and clinical researchers reported the results of their outcome study. This study followed up 44 adolescents who had undergone 'feminizing genital surgery' in childhood. Eighty-nine percent of the genitoplasties 'planned as one-stage procedures required further major surgery' (Creighton et al., 2001: 124); 41 percent of the people who

took part in the research were assessed as having a ‘poor’ cosmetic result from their surgery. These researchers state that their study ‘prompts a re-evaluation of cosmetic genital surgery in children’ (Creighton et al., 2001: 125).

With outcome studies that show poor clinical results, plus repeated reports of dissatisfaction from intersexed adults, how is it that this cosmetic surgery is still being carried out on infants? To address this question, I want to examine the epistemological underpinnings of the treatment.

Epistemological Foundations

There are numerous arguments about why cosmetic treatment is worth carrying out on intersex infants, despite the risks it poses. The central aim is generally articulated in terms of the benefit of treatment to the child (and, later, the adult) concerned. Some of the key arguments include:

- The child needs visible evidence that is consistent with broad understandings about sexual anatomy: a girl does not have a phallic structure, a boy does have a phallic structure. This is seen as important for their psycho-social/gender identity development.
- The child will face humiliation and bullying if the genitalia look noticeably atypical.
- The parents will be traumatized at the sight of atypical genitalia.
- The parents will struggle to explain the atypical genitalia to babysitters and family members.
- The child may be subject to sexual abuse if their genitalia are not ‘corrected’.
- The boy needs to be able to urinate while standing: this is seen as important for his psycho-social development; his being accepted by others as a boy; his taking up a masculine gender identity.
- Some argue that it is better to make the surgical change early in life so that (i) the child won’t remember; (ii) the child will set off from the start on an unambiguous gender path.²

Taken as a whole, the arguments that are used to assert the value of cosmetic modifications to intersexed infants’ bodies can mostly be distilled into a fairly ‘popularized’ set of understandings about sex and childhood: girls need vaginas, boys need penises, children who are ‘different’ get a hard time from their peers, and children are vulnerable to being neglected or abused by adults. This is

consistent with Liao's observation that psychological discourse on sex differences closely follows popular understandings, and thus science 'reinscrib[es] the sexual difference story, again and again' (2005: 428).

The epistemological rift that arises through the persistent reliance of clinical approaches on popular understandings about gender and about the body, becomes apparent when these approaches are read against postmodern theorizing. Here, postmodernity 'is marked by the return of the "others" of modernity . . . [that] emerge as counter-subjectivities' (Braidotti, 2002: 117). Instead of binary masculinity and femininity being promoted and reiterated through scientific knowledge about the physical body, notions of binary gender are problematized and the relationship between 'gender identity' and the body is reconceptualized (Budgeon, 2003; Fausto-Sterling, 2000). The quest to know about the intersex person through biomedical tests during infancy is disrupted by understandings of *embodied becoming*, whereby intersex people may come into being despite, rather than because of, medical intervention. The understanding that the infant's body is something that can be operated *on* to produce a 'girl' or a 'boy' is challenged through the argument that the body may be understood 'not as an *object* but as an *event*', in which case 'the body cannot simply be altered or transformed to converge with particular versions of the self' (Budgeon, 2003: 35). That this epistemological tension exists – between most clinical practitioners and postmodern theorists writing about intersex – underpins the present article. The primary focus of the remainder of the article is, however, on the ways in which clinicians write about intersex and early cosmetic genital surgery.

Arguments for cosmetic genital surgery carried out early in life appear to be based more firmly on popular understandings about sex and childhood than they are based on sound studies showing reliably good long-term outcomes from the surgery. Arguments for such surgery rarely reflect an understanding of changing societal views on gender and sexuality. It has become increasingly clear that the usual rationales for these highly contentious surgical practices will not stand up to scrutiny. There is a problem here, but little agreement about where, exactly, that problem is located.

In reviewing clinical literature that proposes how clinicians might best work with children born with atypical genitalia, I have been particularly interested in texts published after the exposure of Money's John/Joan case as fundamentally flawed.³ Any texts published within the past few years have necessarily been touched in some way by a realization that there is a problem here – but that problem gets cast in different ways by different authors. For some years, clinicians have been focusing on 'problems' of diagnosis and of surgical technique. These problems are understood to exist at a level that can readily be addressed by

clinical advances and through scientific research. The problems are located at the heart of clinicians' areas of expertise and overcoming these problems becomes part of a scientific quest.

Some clinicians have also conceded that there are 'problems' at the level of relationships – parents need support to relate to their atypically sexed children, and clinicians need to build supportive (rather than deceptive) relationships with their patients. And so recent texts have moved away from the old model of deception and secrecy. But beyond the acknowledgement of these problems that relate to the specialisms of clinicians, there is little engagement with challenges to the ideas underpinning the surgical gender assignment of children. Challenges at an ethical level are typically met with oversimplified appeals to parents' informed consent. Challenges at a conceptual level – questioning the very assumptions underpinning cosmetic genital surgery – are rarely taken up. When they are taken up, there is often a piecemeal approach relating to one body-part⁴ at a time; and the conceptual issues are reduced to an evidence-crunching exercise about what works according to outcome studies.

What is interesting about the ways in which clinicians currently engage with the problems inherent in intersex surgery is the way that notions of self – of the intersex subject – are broken down into manageable components: the body (that can be operated on); the psyche (that needs to be better understood); and the political voice (that is not often acknowledged as offering anything substantive to thinking about the treatment of intersex children).⁵ In the texts I review, the relationship between surgical sex assignment and psycho-social considerations is peculiarly slippery. Texts that support early surgical assignment have long cited Money's thesis, that is, they suggest that surgery is intended to aid psycho-sexual development. So the psychological issue is pictured as coming first, and the surgical response is understood as *aiding psycho-sexual development*. Yet the decades of work that have raised concerns about the psycho-social and sexual functioning *effects* of the cosmetic surgery have brought about a situation where, in many cases, the surgery is still performed, but a psychologist is brought in to help the patient and their family to cope with the *psycho-social effects of the surgery*.

Here, psycho-social 'issues' are the poor cousin to surgical answers. The reasons for undertaking surgery are purportedly psycho-social and many of the problems with surgery relate to psycho-social effects. Even though the conceptual model underpinning the 'need' for treatment hinges on a very delicate relationship between the surgical and the psychological, the actual relationship between surgical and psychological decisions is largely scripted in ways that conceive of surgically operating as 'doing something' to help the child and not operating as 'doing nothing'.

But We Have to Do SOMETHING

I will now focus on specific clinical texts that have been selected on the basis of being published in the past five years and reflecting the work of key clinicians working in this area, primarily in British or European settings.⁶ The texts considered represent a purposive sample that ranges across a number of clinical specialties, but particularly clinical psychology and surgery. This is a sample of texts that we would expect to be at the forefront of current, specialist clinical approaches in this area.

In 2003, a definitive statement was published on behalf of the British Association of Paediatric Surgeons (Lawson Wilkins Paediatric Endocrine Society and European Society for Paediatric Endocrinology, 2002). This working party acknowledged the shifting approach to working with intersex children but, rather than taking a radical stance and suggesting that surgery might be delayed until the young person concerned is able to contribute to the decision, these authors argue that: 'There are . . . so many specific issues related to the different diagnostic groups that . . . a policy [of routinely delaying surgery] would seem to be too prescriptive' (Rangecroft, 2003: 799).

While key commentators such as these reiterate generic endorsements of 'corrective surgery', when the surgical procedures are broken down into their components, the story changes slightly. I will consider clitoral surgery, penile surgery and vaginal surgery separately.

Taming the Monster: Clitoral Surgery

The focus of decades of surgical 'advances' has been on making a large clitoris look less protruding. While there are critical versions of the development of this surgery (Chase, 2002; Kittay, 2006), let us begin by considering a recent retelling of the history of such surgical procedures, published in a clinical context:

The history of clitoral surgery is . . . characterized by a variety of techniques . . . mostly aimed at reducing clitoral size. Development of surgical techniques has also been influenced by concepts of clitoral and sexual function. . . . Many surgeons in the 1950s considered that the clitoris was *unnecessary for normal sexual function* and, therefore, clitorectomy could be performed. (MacDougall and Creighton, 2004: 121, italics mine)

MacDougall and Creighton go on to describe a variety of approaches to clitoral reduction, concluding that 'it is still unclear which technique, if any, is optimal' (2004: 121).

As this account states, early methods involved removing the clitoris altogether, while recent methods have refined ways of making the clitoris smaller or making

it protrude less, hopefully without damaging clitoral sensation. A 2001 survey of European and Mediterranean countries' practices found that clitorrectomy was currently performed in 27 of the 125 centres surveyed (Riepe et al., 2002). Despite this alarming finding, experts publishing in the field now commonly write about clitoral reduction rather than removal.

What the authors of the above excerpt choose not to say is that the use of clitorrectomy in Western medicine has not only been founded on a notion of the clitoris as 'unnecessary for normal sexual function', but that the clitoris has often been regarded as in excess of – and threatening to – heteronormative, female sexual function. What they are carefully not saying is that clitorrectomy was *seen as necessary to enable normative female sexual functioning* – not just that clitorrectomy could be performed without jeopardizing normal sexual functioning. By retelling the historical story in a way that elides medical attempts to instate particular kinds of normative feminine sexuality, these authors claim innocence for medical colleagues who have practised (and may even currently practise) clitorrectomy. That the development of techniques for reducing clitoral size was 'influenced by concepts of clitoral and sexual function' rather understates the case. In the final sentence quoted, the assumption that there might yet be an optimal technique for reducing clitoral size is seen to persist. Such assumptions dictate what kinds of choices might be available to those for whom clitoral reduction is a possibility.

Even those of us with only a basic understanding of the effects of scar tissue on sensation will be unsurprised to read that these various surgical attempts produce less than optimal results in terms of sexual sensation. The argument that the latest techniques *must* be producing better results crumbles with outcome studies showing otherwise (Creighton et al., 2001). The most recent publications of surgeons specializing in this area highlight the continued lack of knowledge about female sexual functioning at a level that might usefully inform this kind of genital surgery (Carmichael and Alderson, 2004; Creighton, 2004; Woodhouse, 2004).

From his knowledge of genital surgery with adults, Woodhouse writes:

There is some evidence that surgery even to reduce the size of the clitoris in adults impairs sexual sensation. . . . If such damage can occur when operating on the comparatively large adult clitoris, it is likely that the same, or worse, damage may occur when such surgery is done in infants. (2004: 302)

Taking this a step further, Crouch writes: 'If the clitoris is functionally normal at birth but simply enlarged, it is questionable whether surgery that irretrievably impairs function is acceptable' (Crouch et al., 2004: 138).

Despite the substantial concerns being raised, the Working Party represented by Rangecroft does little more proactive than urge a cautious approach to clitoral reduction:

While the operation of clitoral shaft resection . . . seems logical, and is probably an advance on total clitorrectomy . . . there is no evidence that the retained glans functions well in sexual/orgasmic terms. Indeed there is some emerging evidence to the contrary. . . . Further revisional procedures in adolescence are common and may do further sensory damage. . . . There is a strong case for no clitoral surgery at all in lesser degrees of clitoromegaly. (Rangecroft, 2003: 799)

Here, Rangecroft and colleagues do acknowledge probable sensory damage, yet they still only seem concerned to extend the range of the clitoral size not requiring surgery. The logic of reducing clitoral size goes unchallenged. The importance of retaining sexual sensation for a child who happens to be born with a particularly large clitoris is overlooked.

In contrast to Rangecroft and colleagues, Woodhouse prioritizes the doctor's duty to do no harm:

. . . it seems correct, on the basis of a doctor's obligation to do no harm, to limit the surgery on the genitalia to that which is necessary for physical health. . . . With even the limited outcome results available today, it is difficult to justify clitoral reduction . . . in infants. (2004: 306)

From these excerpts emerges a picture of a number of key experts, working in different hospitals, carrying out different practices, according to their own points of view. As has long been the case with surgery on intersex infants, there is the opportunity for maverick clinicians to try out their own theories about what might work: some use clitorrectomy, some do not; different surgeons make different judgements about how big a clitoris needs to be to warrant surgical reduction.

Sarah Creighton attempted to establish an evidence base for either carrying out, or not carrying out this cosmetic surgery. She reviewed more than 70 studies that have investigated sexual function among those who have undergone childhood clitoral surgery. Only three studies were found to have sound methods and to consider, in detail, the psycho-sexual function of intersex women after genital surgery. These studies all found that participants were less likely to experience orgasm than were women who had not undergone clitoral surgery (Creighton, 2004).

One of the factors that is often mentioned in relation to both clitoral and vaginal surgery is the probability that such surgery in infancy requires follow-up operations in adolescence and/or adulthood. It is now acknowledged by some key commentators that even excellent, state-of-the-art surgery done presently is likely to require follow-up surgery. Furthermore, the way that surgery was done in infancy influences what can be done – what needs to be remedied – what tissue

there is to work with when surgeons attempt to do further work with the adolescent or adult. Surgeons now recognize that they can make things difficult, not only for the intersex patient, but for themselves when they come to do follow-up surgery. In this context, the relative importance of performing vaginal and clitoral surgery in infancy, rather than later in life, begins to look a little different.

Girls Don't Need Vaginas

With the shifting tide of thought on intersex surgery in infancy, reducing an enlarged clitoris is now more routinely seen as necessary than producing a vagina. The discussion about whether or not girls actually need vaginas has reached the point where even the *relatively* conservative commentators advise: 'Since early vaginoplasty confers no obvious benefit in a young girl, there would seem to be a strong case for delaying it until the onset of menstruation possibly makes it mandatory' (Rangecroft, 2003: 799).

Creighton also argues that 'the vagina is not necessary for a young girl prior to menstruation or sexual intercourse' (2004: 329). This claim runs counter to the formerly held belief that the girl and/or her carers would become aware of the absence, would raise questions about the child's sex and that this would interfere with her gendered psycho-sexual development.

Thomas goes further to state: 'No prepubertal girl requires a vagina and misguided attempts at aggressive correction . . . are at best doomed to failure and at worst may compromise subsequent attempts at vaginoplasty in adult life' (2004a: 50).

Female genitalia inevitably throw up dilemmas of presence and absence: we know from literature on intersex and on designer vaginas that what now seems to alarm people most is what *is* there, not what is *not* there. Simone Weil Davis observes that, before the advent of the designer vagina, 'the "scandal" of a woman's genitals [was] supposed to be due to what *isn't* there, not what *is*' (2002: 9).

Perhaps it is not a lack that is threatening but an excess. The fact that even if no pathology exists, there *is* something there – namely, a vulva with labia, a clitoris, and so on, a marginal site occupying both the inside and the outside, an abject space . . . (Kapsalis, 1997: 89)

Questions of genital appearance – and the extent to which this is a physical concern or a psycho-social concern – do not have easy answers. We may theorize this in terms of abjection and marginality, or in terms of functionality, but it remains enormously difficult to translate such ideas into clinical practice. Despite the promising claims about girls not needing vaginas, the 2001 survey of European

and Mediterranean centres treating children with CAH (congenital adrenal hyperplasia) showed that most centres were still carrying out surgical vaginal construction in early childhood (Riepe et al., 2002: 199). Data from 125 centres showed vaginoplasty being carried out between the ages of 0.1 and 18 years, with a median age of 2.5 years.

The most optimistic conclusion to be drawn from the texts reviewed is that the practice of vaginoplasty on girls is being revised and, in some places, surgery is only carried out once the patient is old enough to be engaged in the decision-making process.

Hypospadias 'Repair'

While ambiguously sexed children do tend more often to be assigned as female, there is a substantial proportion of atypically sexed children who are treated as boys and who undergo penile surgery early in life for primarily cosmetic reasons. A review of recent clinical texts concerning 'hypospadias repair' surgery is offered here, with a view to understanding what clinicians regard as key issues in crafting a more typical looking penis out of a hypospadiac penis.

Hypospadias is a congenital 'disorder' consisting of (i) atypically positioned urethral meatus, (ii) a curvature of the penis, and (iii) an atypical distribution of foreskin (Woodhouse and Christie, 2005). Approximately 80 percent of people with hypospadias may be assessed as 'requiring a single-stage repair' while 20 percent are described as possibly 'requir[ing] two or three operations' (Woodhouse and Christie, 2005: 22). In practice, however, complications with the initial surgical procedures can lead to many more operations being performed. Hypospadias may present in such a mild form that only a clinician experienced in this area of work would regard the penis as atypical. Alternatively, the atypicality can be sufficient that the genitalia appear ambiguous, raising questions about the child's sex.

Hypospadias surgery is carried out with a view to creating a penis that is more typical in appearance and that enables the patient to urinate in a standing position. Here, the intended cosmetic effect of surgery (to normalize the appearance of the penis) and the functional effect of surgery (to ensure that the flow of urine is smooth and to enable urination while standing) are clearly intertwined. The cosmetic element and the functional element are intertwined in the common-sense understandings about masculine gender identity that underpin the rationale for this surgery. The science and expertise of surgery become invested in producing an ideal of masculinity rather than employing practical means to address a practical concern.

As with intersex surgery broadly, the continued use of ‘hypospadias repair’ surgery has been criticized because it is typically carried out during infancy or early childhood, because of reported cases of complications that have led to multiple surgical procedures being carried out over a number of years, and because the resulting scarring and emotional impact is sometimes severe enough that the harm caused appears to outweigh any good that might have been done.

Despite the criticisms and complaints made by people who have undergone such surgery, and despite the acknowledgement among surgeons that hypospadias repair can lead to ‘complications’, even very recent publications continue to hold this surgical practice in high esteem and describe it as a highly advanced and successful: ‘with the advent of new operative techniques, suture materials and postoperative dressings, the results of hypospadias surgery in general has become almost excellent’ (Adayener and Akyol, 2006: 247).

Despite this clear enthusiasm for hypospadias surgery, it is also acknowledged that it does not always work well, sometimes leaving patients with severe problems. ‘Repeated attempts at surgical repair of hypospadias may leave the penis scarred, hypovascular and shortened. . . . complex hypospadias cases [are] often referred to as hypospadias cripples’ (Amukele et al., 2005: 1540).

Even when the surgery does not lead to complications, patients may not be happy with the outcome because, as surgical techniques have developed, so have patients’ expectations risen (Woodhouse and Christie, 2005). Indeed, even authors who consider the surgery to be ‘almost excellent’ also write about the process by which any individual surgeon may attain that point of success – a process that inevitably sacrifices a number of patients to the surgeon’s initial errors. It is suggested that surgeons go through their own learning curve with hypospadias treatment, so that patients at the start of that curve are more likely to have troubles than patients who reach the clinician later.

The learning curve for hypospadias surgery is rather long. [Other surgeons have] reported high complication rates, in the early years of their study. . . . [Similarly], we had more complications in the first half of our study. Seven complications out of 11 occurred in the first 5 years. (Adayener and Akyol, 2006: 250)

In a field of surgical practice that is primarily for cosmetic gain, that is carried out on non-consenting minors, that requires a high degree of surgical expertise and specific experience with the particular type of surgery, and that not uncommonly leads to ‘complications’ requiring follow-up surgery, it would be reasonable to imagine that surgeons are motivated to ensure consistent and high-quality practices. The practices of concern include the surgical technique itself, as well as the processes of decision-making necessary for such surgery to be carried out at all

and to be timed appropriately in the child's development. With this in mind, Woodhouse and Christie carried out a small survey of 34 surgeons who regularly do hypospadias operations. This survey paid some attention to the decisions that surgeons make (such as at what age to operate) and their rationales for those decisions. Woodhouse summarizes the surgeons' responses to this questionnaire:

The opinions expressed did not always seem to be based on the medical evidence and were sometimes self-contradictory. Some surgeons felt that having the child in nappies was helpful, while others thought it to be a disadvantage. Penile size and anaesthetic risk were used to support surgery at all ages. The contradictions were even more marked when surgeons were citing the psychological reasons for their choice. It would appear that surgeons use an often spurious psychological reason to support their personal prejudice. (Woodhouse and Christie, 2005: 26)⁷

This is the critique that one surgeon (Woodhouse) and one clinical psychologist (Christie) offer in relation to the most recent practices of surgeons who regularly carry out hypospadias operations. That some of the rationales for early surgery appear spurious and inconsistent raises the possibility that what underpins the practice is at least partly something that could not be articulated in the survey – something that the respondents might have been skirting around. Such unstated rationales might include a desire to play out a particular masculinist role, as a surgeon (Davis, 2000), and seeking to improve on what nature has produced (Haiken, 1997). Similarly, unstated rationales might include a desire to work with infants in order to avoid the resistance that atypically sexed adolescents or adults might present (Chase, 2002). The critique offered by Woodhouse and Christie not only highlights concerns about the consistency of practice and the rationales that underpin important decisions, but it also points to the complex relationship between the surgical and the psychological.

Recent surgical texts on hypospadias often acknowledge the importance of psychological factors and the need for more knowledge in this area. The way that hypospadias surgeons conceptualize the relationship between surgery and psychological concerns is consistent with the treatment of intersex children in general. Thomas writes that: 'with advances in techniques and the consistently lower complication rates being achieved in specialist hands, attention is now focusing more on the subjective measures of, e.g. voiding function, cosmesis, psychosexual outcomes and patient/parental satisfaction' (2004b: 471).

Thus, psychological issues are presented as a fine-tuning consideration, only to be attended to once the details of the surgery have been fully examined. The way that the psychological is conceptualized reduces all questions about sexed embodiment and emotional well-being to a functional level, whereby the nuanced difficulties faced by at least some people who have undergone hypospadias

surgery cannot be adequately understood. Psychological concerns are not in any way positioned so that they may bring the use of surgery into question. Further, psychology is conceived of in a fairly functional way: it can identify issues and offer interventions, rather than providing insight into the experience of the child who undergoes hypospadias surgery.

Recent work on patients' perspectives on their hypospadias surgery has revealed a discrepancy between surgeons' and patients' ideas about what counts as a good cosmetic result from hypospadias surgery. Apparently, surgeons' views were based on what they knew to be achievable surgically, while patients based their assessment on their desire to alter features that cannot currently be altered surgically (Mureau et al., 1996). This is now becoming acknowledged more widely (Marrocco et al., 2004). But, despite the evidence that patients' feelings about the outcomes may not reflect surgeons' enthusiasm for their surgical technique, authors continue to assert the importance of carrying out this surgery whenever possible, with the minor caveat that patients should be followed up so that any psychological issues may be detected:

Surgery for hypospadias has to be strongly pursued in as many cases as possible. In addition, we strongly recommend following up all hypospadiacs, independently of the severity of their genital malformation, through adolescence to early adulthood, to ensure early detection of subjects with impaired psychological profiles. (Mondaini et al., 2002: 81)

Here, quite clearly, 'psychology' is evoked as a catch-all concept that embraces anything that could happen to the patient after the work of the surgeon is done. Whether this patient is unhappy with their surgical result, angry about being operated on as a minor, or politically motivated and articulate in their critique of this surgical practice in general, their perspectives and feelings are reduced to 'psychological' concerns, rather than being understood to present a challenge to the very practice of this type of surgery.

This deployment of psychology does little to address the compartmentalizing effect that a focus on genital surgery has on one's understanding of intersex. Focusing in on specific elements of surgery – the presence of the enlarged clitoris, the absence of the vagina, the appearance of the penis – rapidly means losing sight of the intersex subject. Ironically, in the attempt to provide intersex children with bodies that are intelligible (Butler, 1993), bodies that enable them to enter girlhood or boyhood as coherent subjects, the surgeon inevitably becomes fixed on the alteration of tiny portions of bodily tissue, and the whole subject almost disappears from the text altogether.

Yet considerations of the materiality of intersex infants' bodies and the work of surgeons crafting genital tissue inevitably bring us back to questions of the moral, the social: whom do the intersex people featuring in these texts *become*? In what ways is the intersex person in clinical texts agentic?

Agency and Becoming

Only very recently have we seen the emergence of clinical texts that sensitively and comprehensively engage with the intersex person as a whole subject whose agency and becoming are clinically relevant. Very few clinical texts take a nuanced psycho-social focus and begin to consider the intersex child as agentic.⁸ One good example is the work of Carmichael and Alderson, who discuss the ways in which intersex children may choose to disclose information to others about their being intersexed, or having a particular medical condition.

We may consider that the intersex person's agency centres on his/her development as an embodied subject – the process of becoming 'belongs' to the intersex person even though 'what gender' s/he becomes has been heavily mediated by others. This is not about agency as choice but it is about agency in the sense that the process of becoming is potentially empowering. This experience of becoming – this process of working through medical treatments and childhood experiences and being able to look back as an adult, reflecting on who one has become and what it was like along the way – is something that clinical psychology research is starting to consider (Alderson et al., 2004). Early findings in this area do picture intersex adults as whole subjects, with a degree of agency, whose experiences can feed back usefully into clinical practice.

Carmichael and Alderson offer a view of the future that not only focuses on medical advancement, as many other texts do, but also considers the socio-political context:

In the future, this patient group will include individuals who have chosen not to undergo surgery, along with those who have opted for any of the range of surgical interventions available. Over time, changes in healthcare technologies and hopefully societal tolerance of difference will alter the specific pressures upon children and their families. (2004: 175)

These two psychologists are trying to envisage the reality of intersex people's lives and the possibility of agency. Perhaps this is the beginning of the kind of acknowledgement that is sought by the intersex person quoted in this excerpt:

You can't become a real person until the reality of your life is acknowledged. And if you're an intersexed person, you can't be real until you can say, 'I'm an intersexed person . . .' And no matter what path you take from that reality, it can't be surgicalized away. If you try and destroy that reality, you destroy big pieces of human beings. (Preves, 2003: 107, quoting 'Kiira')

This excerpt echoes Stryker's monster as well as Holmes's claim that the post-surgical body is necessarily queered despite medics' efforts to use surgery to produce normative bodies. Kiira's reference to destroying 'big pieces of human beings' is interesting in relation to questions about what particular body parts signify, and how specific, discrete parts can make the difference between feeling whole or feeling that life is not liveable. The 'big pieces' that are destroyed are

not physically big, nor are they necessary for the functioning of the organism, but they are big at the signifiatory level and without them the spectre of non-humanness or of unliveability creeps in.

In quoting Kiira, Sharon Preves (2003) is speaking to Butler's notion of intelligible humanness:

If I am a certain gender, will I still be regarded as part of the human? . . . Will there be a place for my life, and will it be recognizable to the others upon whom I depend for social existence? (Butler, 2004: 2–3)

While these are philosophical questions that can never be answered by clinical practice alone, some clinical work with intersex children engages with sentiments about humanness and liveability. This article concludes with some reflections on the work of two clinical psychologists who are specifically concerned with intersex children and the process of becoming.

Carmichael and Alderson offer one of the most comprehensive approaches to working sensitively with intersex young people, taking on board criticisms articulated by intersex adults, and envisaging multiple possibilities for the futures of intersex people. They emphasize the importance of 'not overloading the child with hospital appointments and interventions' (2004: 158), and they write of providing psychological support that is 'focused on the prevention of difficulties throughout medical care' (2004: 158). They address the point that parents may need more support and neutral information and time to make good decisions rather than deferring to doctors, and they discuss cosmetic surgery as an option, explicitly exploring the 'no-surgery option' (2004: 169).

Importantly, although their area of specialism concerns psycho-social issues, rather than surgical decision-making, they do discuss the ways in which children of various ages may understand, interpret and disclose to others information they are given about their or their siblings' intersex status. They write:

It should be recognized that an offer of surgery might inadvertently introduce the idea of difference to an adolescent. A desire to conform can increase pressure for surgery from adolescents or their parents, seeking to eradicate difference as soon as possible. (Carmichael and Alderson, 2004: 171)

Here, we can see the hopeful beginnings of an engagement with the complexities of clinical practice in relation to difference, normativity and embodiment.

Reading the clinical texts referenced in this article through the lens of (queer) theories of embodiment, it seems that regarding the body as an object that can be broken down into surgically alterable parts underpins the logic of early cosmetic genital surgery. Further, the roles played by surgery and psychology are structured by understandings of the body as a foundation upon which 'gender identity' might be built. There are opportunities, here, for shifting clinical practice

by conceptualizing the atypically sexed child as a whole, agentic subject and thinking of her/his embodiment as a process.

By developing such thinking, we may better support and extend the emerging critical work of clinicians who are part of multidisciplinary teams involved in surgically altering intersex children. This kind of critical, clinical work locates intersex people as agentic subjects in socio-political contexts and envisages non-surgical options for them. Through this work, some clinicians are beginning to support colleagues, intersex people and their families to explore non-surgical possibilities, thus fundamentally disrupting the assumptions upon which the routine practice of early cosmetic genital surgery is based.

Notes

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1. For a broader critical analysis of 'corrective' surgery for children, see Parens (2006).
2. For a fuller engagement with these arguments, from a clinical perspective, see Cohen-Kettenis and Pfäfflin (2003).
3. Colapinto's book *As Nature Made Him* came out in paperback in 2001 – much media furore preceded and followed its publication.
4. Other authors who comment critically on the way intersex people are broken down into body-parts include Dreger (1999, 2000) and Kittay (2006).
5. A clear exception to this is the work of Creighton et al. (2004); they explicitly describe seeking input from intersex adults as 'expert patients'.
6. The choice to focus primarily on this geographic location was a pragmatic one. Practices differ from clinician to clinician and from place to place, so it would not have enhanced the analysis to sample texts without paying attention to location as well (for which there was insufficient space in this article).
7. Here the authors use the term 'personal prejudice', presumably to refer to personal views (not based on medical evidence) on whether and when hypospadias repair surgery may best be undertaken.
8. Some who do include: Creighton (2004), Liao (2003) and Liao and Boyle (2004).

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