# Re-membering a Queer Body

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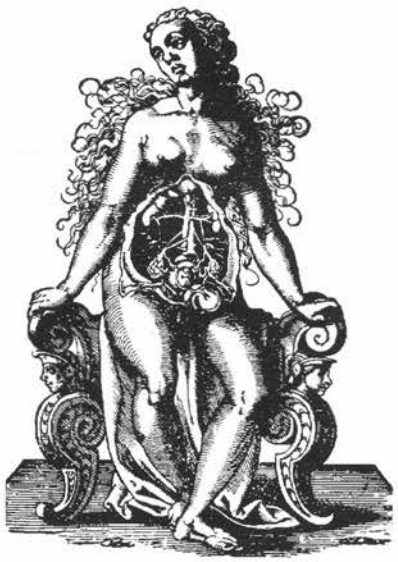
In the spring 1993 issue of *The Sciences*, Brown University geneticist Anne Fausto-Sterling, citing the work of John Money, indicates that approximately four percent of the population is, to some degree, intersexual: they either possess physical characteristics of both officially recognized sexes or they have chromosomes which indicate a sex which are 'contradicted' by their physical appearance.[1] In Toronto, the four percent figure translates into roughly 88,000 people. Yet little has been written about intersexuality, although its concerns often intersect with those of feminist and queer theory. This paper deals with feminist issues in patriarchal medicine and its relation(s) to intersexuality (and intersexuality's inherent ability to challenge arguments for the 'natural' basis of heterosexuality).

Sex is generally understood as the biological basis for assertions of gender: i.e. the body is the incontrovertable facticity which cannot be denied. The starting point of this paper, the one I could not proceed without, is that **sex**, while I agree that it is located in/on the body, is not absolute—that is to say that sex is not clearly defined, not something which all bodies adhere to simply and easily. Sex is also constructed, not only at the ideological level of gender, but at the physical/biological level of bodies and surgery. The frequency with which intersexuality occurs, in which species it is more prevalent, its causes and manifestations and its variances are studied so that *all* traces of intersexuality in humans can be erased. Texts and research dealing with intersexuality make no provision for intersexuality to exist except as a pathological condition. Instead of using the knowledge to designate a space in which intersexuality constitutes a sex or set of sexes which is consistent with the forms that the human body may take—just as male and female are presently seen as medically consistent configurations of human form—the knowledge is used in order to make diagnoses which effect, not merely closure on the sexes as bimorphic and complementary, but also lead to the erasure of physical states that challenge this vision of human existence.

> To understand the **problem** of intersexuality, it is necessary to understand how **normal** sexual development occurs and how this process may be **disturbed**.[my emphasis] (Edmonds 1989:6)

By common definition a female body is one capable of reproduction and



not possessing a penis while a male body possesses a penis and is not capable of gestation. However, when it comes to 'managing' intersexed children, it is the *size* of the phallus[2] that counts:

> Choice of gender identity thus depends on the external genitalia and the possibility of future coital adequacy. When the sex assignment is definitively made, the gonads that conflict with the assignment should be electively [according to whom?] removed. (Emans and Goldstein 1990:62)

This means that when a genetically male child (XY) is considered incapable of achieving 'normal' heterosexual activity as a male, he will be reassigned as female even though the micropenis would be functional (i.e. sexually sensitive and able to carry semen and urine).

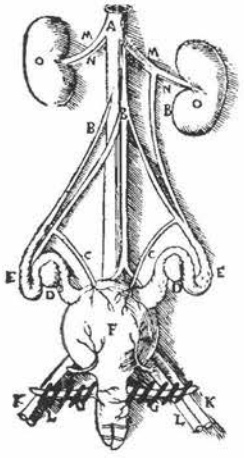
In this paradigm female bodies are not understood through any positive attributes but are defined only through lack of a penis. Indeed, the possibility of fertility in a genetic female (XX) — and not the adequacy of the phallus — justifies the removal of the phallus/clitoris.[3]

> It should be emphasized that '46,XX' persons with CAH[4] are females and are potentially fertile. Thus, regardless of the appearance of the external genitalia, the sex assignment should be female. (Emans and Goldstein 1990:58)

The removal of the phallus/clitoris in both male and female intersex 'cases' results in bodies which, regardless of their genetic constitution or initial appearance, conform to the most important definition of the female: absence of the penis. This system of treatment sees fertility as the most important defining factor of an XX body and the least important defining factor of an XY body (for which the main issue is adequacy of sexual performance). Furthermore, this system takes heterosexuality as an a priori imperative. The contradiction in this logic is that XY intersexes revised to be 'female' will be infertile even though fertility is used to validate the removal of a phalloclit[5] from an XX intersexual.[6] This contradiction is why I am insisting that there is no positive definition of female bodies in medicine. Ultimately, fertility is irrelevent to femaleness while potency remains an essential feature of maleness.

Intersexual bodies, in the medical framework, are abnormal insofar as the

the 'true' sex is obscurred by some malformation of the external genitalia and/or the gonads and reproductive organs. The medical presumption is that by relying on the scientific criteria which distinguishes male from female, the 'true' sex of intersexed bodies can be revealed. In addition, because of the issue of phallic adequacy and because "...the surgery nec-



essary to convert to female is simpler..."[7](Edmonds 1989:14) even in a chromosomally male body, a phallus which cannot meet the medical criteria to become a certifiable penis will be removed.

> It is true that penises come in all sizes, as do hands and feet... In the case of the microphallus, however, the organ is definitely too small to permit satisfactory copulation. It is, therefore, fairly common to recommend to the parents that they raise such a baby as a girl. This is, of course, a very difficult decision for them to make, and they must be given all the information needed to understand the rationale of the decision. (Money 1968:40)

The rationale is, of course, primarily functional and also assumes that a dominant, heterosexual mode of penetrative sex is the only appropriate one. There is no allowance made for intersexed persons to grow up in the bodies they possess so that they can eventually decide for themselves what 'normal' sexual function is. The recommended surgical procedure assumes that the normal male sexual role is to insert a penis of acceptable size into the apropriate receptacle (i.e. a vagina — which can be constructed for those not born with one).

Heterosexist, functionalist medicine furthermore assumes that if one *is* born with a vagina, the appropriate sexual activity will be as receptor and not penetrator. Thus, when a body which has been designated female (either through chromosome testing or anatomical standards) possesses a phallus, the surgical procedure remains roughly the same as that for treating the micropenis: remove the phalloclit in a process of either partial or total clitorectomy.

When I underwent surgery in 1975 a procedure known as 'clitoral recession,' in which the midsection is removed and the glans reattached to the base, had come into practice and was used in my case. Although I consider the surgery to be a serious amputation in which a perfectly functioning body part is stolen, D.Keith Edmonds takes the procedure more lightly:

> Preservation of the glans has become **fashionable** in an attempt to preserve clitoral sensation.... The clitoral skin is incised along its lenght on the dorsal surface, carefully opening the sheath of the corpora to preserve the neurovascular bundle and shelling out the remainder of the corpora.... The corpora having been excised, the glans is then sutured onto its base. [my emphasis] (Money 1968:62)

In addition to the similarity of the surgical procedure involved in the removal of a micropenis, the interests of heterosexual 'normalcy' are being similarly served. The assumption is that a body which possesses 'female' reproductive organs and a vagina must *not* be a body which is also capable of assuming the sexual privilege of penetration usually reserved for males. After all, if the phalloclit grows large enough, the lines between heterosexual and homosexual behaviour could be severely blurred and the heterosexual matrix would be severely threatened.

The patriarchal desire to protect the rightful place of the phallus and a societal tendency to value largeness in the male penis cannot be overlooked in a diagnosis of intersexuality. It is, after all, this patriarchal framework which demands that the female body a) must not possess a penis and b) is pathological if it does possess a penis.

What to do about the clitoris which threatens to assume the rightful place of the penis is made easier by falling back on chromosomes: regardless of how (en)large(d) the clitoris is, an XX karyotype will define it as a clitoris rather than as a penis. Depending on the anxiety level of the surgeons involved, the the phalloclit will be remedied by varying degrees of surgical intervention ranging from partial amputation of the phalloclit to its complete exturpation. The complete removal of the clitoris is no longer a favoured mode of treatment but that doesn't mean that it never happens in current practice:

> Currently few physicians perform [total] clitorectomies and when they do such operations usually follow the perceived "failure" of one of the less drastic procedures. A commonly cited reason for performing a clitorectomy after clitoral reduction or recession is the presence of painful erections and/or cosmetic dissatisfaction. In the latter case surgeons complain that the clitoris remains too large and visible.[8]

Whether or not clitorises are still *completely* removed or 'only' reduced or recessed, it remains valid to question who has the right to decide what a 'normal' female body looks like, or for that matter, what a 'normal' male body looks like.

The clitoris which threatens to become a penis must be made to remain a clitoris and the penis which threatens not to become a penis must also be made into a clitoris. To reiterate, it is the absence of the penis which defines the female body, in the case of micropenises it doesn't matter that there is no vagina—it can be surgically constructed. Clitoral hypertrophy (the phalloclit) and micropenises are

different case scenarios, which on an individual basis will have even greater variances, and yet the outcome of being forced into a standardized 'female' body is the destiny of each case. Why? To maintain a stable place for the phallus—and by extension, for patriachal, phallocratic privilege.

Through the course of treatment of intersexuality, the male body, as it is commonly understood, remains stable. What defines the male body is the penis, its size and ability to achieve and maintain erection. By removing micopenises and phalloclits, male bodies continue to be those which possess 'viable' penises. Female bodies are, of course, not stable in this equation at all. Female bodies are not defined by the *presence* of a uterus, female bodies are not defined by the *presence* of a vagina and they are not defined through the *presence* of reproductive ability. Vaginas can be created for those who have had their micropenises removed and **if** they choose to have children later they can adopt them.

This is the medical (and cultural) understanding of what female bodies do not have, and must not have: a penis. The model furthermore assumes that any body which *does* possess a penis must either be designated 'male' or be surgically altered. If these options were not taken, if female bodies could run around with penises then perhaps male bodies could run around with vaginas...

Imagine the terror this scenario (a kind of gender terrorism in action), indeed a truly 'Queer Nature', must inspire in the minds of doctors who have learned so well what bodies are for (procreation and heterosexual penetrative sex). I thrill at the thought that one little phalloclit could wield so much power and cause so much anxiety—but then I re-member my dis-memberment which was/is the penalty exacted for causing such anxiety and I'm not grinning anymore.

Not that I would necessarily have kept my phalloclit. Not that I think my anger is some bizarre twist on Frued's castration theory. But I would have liked to be able to choose for myself. I would have liked to grown up in the body I was born with, to perhaps run rampant with a little **physical** gender terrorism instead of being restricted to this realm of paper and theory. In theory I can be many things. In theory I could have been many things. But physically, someone else made the decision of what and who I would always **be** before I even knew who and what I was.

## Notes

[1] An example of this is Testicular Feminization Syndrome, in which a person has a male genotype (i.e. 46,XY karyotype) and a body with a female genital appearance.

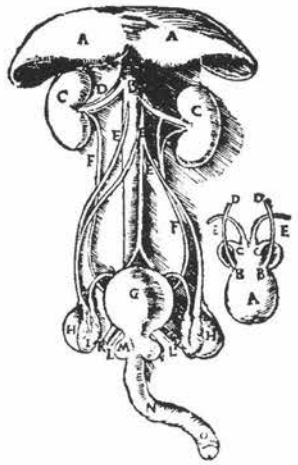
[2] In medical practice there is no distinction made between a penis and a clitoris until a body has been declared either male or female, until that time 'phallus' is used to designate the erectile organ which could be either a penis or a clitoris. This practice is grounded in the observance of genital development in embryos which, until about the sixth week of gestation have genitalia which appear the same.

[3] Note that I have made a distinction between a phallus and a clitoris because it is the designation of the phallus as *clitoris* which necessitates its amputation or removal.

[4] CAH is one of many possible intersex etiologies.

[5] I have created this term rather than describe the organ as a phallic clitoris because I don't want to describe it as an organ possessing phallic attributes - to do so assumes that the proper place of the phallus is on/of the male. Furthermore, to describe the organ simply as an 'enlarged' clitoris assumes that all 'normal' clitorises are somehow identical (having taken the body size of the owner into consideration). These clitorises are not *phallic*, they are phalluses in themselves, however decidedly different from the male penis. Therefore I have retained the adjoining 'clit' to make the point that in spite of the intersexuality of such bodies, they are related on physical, philosophical and experiential levels to female bodies not deemed anomalous. I am hoping to bring to the surface, the idea that part of what informs the need to erase these phalloclits is the patriarchal anxiety over the possible phallic power of all female bodies.

[6] In addition, for the XY individual who has been assigned a female sex, hormone treatment will be required throughout life otherwise there will be no pubertal activity and secondary sex characteristics will not be established (although menstruation is not likely even with hormones treatments because there is no uterus).



[7] The same sentiment is expressed as "It's easier to make a hole than build a pole" by Dr. John Gearheart in Johns Hopkins Magazine, Nov. 1993, 15.

[8] Fausto-Sterling, Anne, 1993b, "How Many Sexes are There?", unpublished paper prepared for The History of Science Meeting at Santa Fe, New Mexico.

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