

AMBIGUOUS BODIES AND DEVIANT SEXUALITIES

*hermaphrodites, homosexuality, and
surgery in the United States, 1850–1904*

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ABSTRACT While the necessity of normalizing surgery on intersexed individuals is a topic of ongoing debate in the 21st century, the origins of surgery as a therapeutic practice for ambiguous or unusual genitalia lie in the 19th century. The first report of corrective surgery published in the United States appeared in the *American Journal of the Medical Sciences* in 1852, but surgery did not immediately replace more traditional social prescriptions designed to fit hermaphrodites into a dimorphic model of human sex. Only after homosexuality became a matter of discussion in American medical journals did the frequency of normalizing surgeries increase. This paper explores the connection between physicians' increased interest in preventing "abnormal" sexual behavior and their insistence that interventionist surgeries were the most appropriate means of treating cases of hermaphroditism.

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IN 1903, A 20-YEAR-OLD WOMAN approached Dr. J. Riddle Goffe, a New York gynecologist, for an examination. The woman, whom he identified only as E.C., had an interesting blend of sexual characteristics: she had facial hair and a vagina—though Goffe could find no internal generative organs—and a clitoris that resembled a penis in size and shape. E.C. wanted this structure removed; she claimed that she found it “annoying” and that “it made her different from other girls.” Goffe obliged by removing her clitoris and using its skin to expand her vagina. Eight months later, he examined her again and marveled at her physical recovery and her buoyant mood (Goffe 1903).

From these clinical details, Goffe’s report appears to be straightforward and not at all unusual. There is little to distinguish this from approximately 110 other reports of hermaphroditism (to use a 19th-century term) that American physicians published in medical journals between 1808 and 1904.¹ Indeed, Goffe’s report was significant not so much for its content as for its context: he published in the midst of profound changes in how physicians explained and classified different forms of sexual behavior and gender expression. E.C. and the issues her anatomy raised for Goffe therefore provide an entry into an exploration of the complex relationship between the medicalization of homosexuality and the perceived need for normalizing surgeries on patients with ambiguous genitalia.

In some ways, the medical history of hermaphroditism and the medical history of homosexuality are parallel stories. Hermaphroditism and homosexuality raised similar questions about gender categories and behaviors; hermaphrodites were an abnormality in a society that thought nearly exclusively in terms of absolute sexual dichotomies, and legal and medical authorities alike struggled to identify what hermaphrodites really were and what rights they might possess. As Jennifer Terry (1999) has noted, homosexual intercourse was a direct challenge to a binary system of human sex in which “men and women, as opposites, were thought to be naturally attracted to one another” (Dreger 1998). It was this double challenge—first to dimorphic sex, then to normal sexual behavior—that led late-19th-cen-

¹This tally, from a survey of U.S.-published articles listed under *hermaphroditism* or *hermaphrodites* in the *Surgeon General’s Index*, First through Fourth Series, represents individual publications, but does not necessarily reflect the number of individual patients examined. Different physicians may have written about the same patient, for example, and some physicians or publications included descriptions of more than one patient. Both these sorts of publications were infrequent, however, and effectively balanced each other out. The tally does *not* include translations of foreign articles, reprints from foreign journals, or papers duplicated verbatim in multiple American journals (though it does include multiple publications about the same patient). Including papers published in foreign journals pushes these numbers considerably higher—the Second Series, for example, lists well over 200 papers under *hermaphroditism* alone. I have also excluded articles on animal or experimental hermaphroditism and cases of ambiguous sex listed under cross-referential topics such as *gynandria* or *hypospadias* from this count. I have left out *intersexuality* in particular (though it seems counterintuitive), because the term does not appear in the *Index* until the Fourth Series, which reflects its appearance in medical literature beginning in the 1930s.

tury physicians to believe that surgery—whether reconstruction or outright removal of the sexual organs—was a necessary treatment for hermaphroditism.

Because hermaphrodites violated traditional sex categories and gender expectations by the very shape of their genitals, it is not surprising that their sexual behaviors drew physicians' attention in the same way their manner of dress, their occupation, or their name captivated curious doctors. Physicians had taken note of hermaphrodites' sexual lives even in the early part of the 19th century, well before the introduction of homosexuality to medical literature. In 1808, Dr. William Handy examined a hermaphrodite with a penis, testicles, labia, and an overwhelmingly feminine personal presentation, and he was surprised to discover that "there has never existed [in this person] an inclination for commerce with the female" (Handy 1808). Other reports throughout the century took similar note of hermaphrodites' physical attractions. Physicians often alluded to sexual attractions by mentioning marital status, and both were among the criteria physicians used to determine their patients' true sex. Pointing out hermaphrodites' sexual behavior, then, was not new, and such references were in fact quite common.

At the same time, physicians had only limited means for treating hermaphrodites—that is to say, for establishing them within a dimorphic anatomical and social norm—and they responded to these medical anomalies with social prescriptions. For example, physicians would inform their patients that they were not men as they had previously believed, but women, and that they should behave accordingly by wearing dresses and quitting their jobs, for example. These instructions were not easily enforced, however, and there is little reason to believe that hermaphrodites changed their customs or habits simply because a doctor told them to. Social solutions were temporary at best, and depended entirely upon patients' own willingness to conform to one set of gender roles or the other. Many hermaphrodites likely continued about their normal ways unimpeded.

Only in 1852, when surgeon Samuel D. Gross published an account of what he claimed was the first corrective surgery on a patient of ambiguous sex, did a second possibility for managing hermaphroditism appear in medical journals. Gross had performed the surgery in 1849 on a three-year-old girl whose parents were concerned when she developed "boyish" interests—she had abandoned "dolls and similar articles of amusement" for "boyish sports." Upon examination, Gross discovered that she did not have a penis or a vagina, but possessed a small clitoris, an indentation covered by an imperforate membrane, and testes. Gross removed her testes, and when he examined her again he was pleased to note that her interests had returned to more feminine pursuits—he claimed she found "great delight in sewing and housework" and that her "habits [had] materially changed and [were] now those of a girl" (Gross 1852).

The need to uphold standard gender roles figured prominently in Gross's justifications for performing the surgery. More important, he also speculated about the girl's future sexual activity. He claimed that surgery would remove "that portion of the genital apparatus which, if permitted to remain until the age of

puberty, would be sure to be followed by sexual desire.” An operation would spare the child the otherwise inevitable humiliation of attempting sexual intercourse with a male only to have penetration be unsuccessful and embarrassing. (He did not, however, describe any attempts to open her “indentation” or to create a vagina.) But his concern for this particular patient was indicative of a larger concern with the sociosexual consequences of hermaphroditism: he claimed that it could lead to moral and social degradation and, if left unattended, could lead “to the ruin of character and peace of mind.” He argued:

A defective organization of the external genitals is one of the most dreadful misfortunes that can possibly befall any human being. There is nothing that exerts so baneful an influence over his moral and social feelings, which carries with it such a sense of self-abasement and mental degradation, or which so thoroughly “maketh the heart sick” as the conviction of such an individual that he is forever debarred from the joys and pleasures of married life, outcast from society, hated and despised, and reviled and persecuted by the world. (Gross 1852)

The editors of *Beck's Medical Jurisprudence*, published 11 years later, likewise claimed that the operation Gross performed was a preemptive strike against a pubescent development of sexual urges “which could only be productive of evil” (Beck and Beck 1863). From these comments, it is clear that Gross and the editors all regarded corrective surgery as a means of curtailing immoral sexual behavior as well as a means of correcting hermaphroditism. The first surgery on a hermaphrodite, then, was also the first successful attempt to control hermaphrodites’ sexual behavior in the name of maintaining social propriety.

Although Gross expressed hope that his case would provide an example for future physicians faced with similar patients, surgery did not fully replace existing practices of prescribing social behaviors. Indeed, of the 41 reports of hermaphroditism published from 1852 to 1879, only three mentioned surgery as a treatment option: Gross’s report; one published in 1868 in which a woman requested the removal of what turned out to be a testicle; and a third from 1869 detailing an operation to correct hypospadias (a condition in which the urethra opens on the underside or at the base of the penis instead of at the tip) in a child with a penis and labia (Gross 1852; Avery 1868; Logan 1869). For the most part, physicians during this period still recommended exile, buying a new, gender-appropriate wardrobe, or other social solutions to establish hermaphrodites within normal dimorphic sex and gender paradigms; the efficacy of these recommendations remained dependent on patients’ willingness to follow them.

Physicians who proposed surgery also often found that their patients had different ideas about their bodies. Physicians could no more force patients to undergo surgery than they could force them to wear trousers instead of dresses, and as a result, patients often shrugged off their uncommon bodies as harmless and went about their business as usual. One example of this stands out in particular: in 1880, 46-year-old Mary O’Neill approached Dr. Edward Swasey at the

New York Hospital for the Ruptured and Crippled for a truss to contain a double hernia (Swasey 1881). Upon examining her, Swasey discovered two labial tumors that were connected to cords resembling spermatic cords and suspected that they were testicles, even though he also found “nothing in feature, form, or deportment to suggest that she is not a woman.” He offered to remove the tumors, but O’Neill refused and left the hospital with her truss.

Swasey accepted O’Neill’s decision without moral or medical criticism, in contrast to many of his surgical colleagues who believed that surgery was necessary to alleviate a pathetic condition or to prevent the possibility of hermaphrodites engaging in sexual activity. The potential futility of suggesting an operation to an unwilling patient did not stop surgically minded physicians from trying, however; from 1880 to 1904, the suggestion of surgery appeared in 13 of 49 published case studies of hermaphroditism—almost five times as many references as between 1852 and 1879, and in three fewer years. This increase may in part reflect other factors, including advances in surgical techniques (such as more effective anaesthetics and the introduction of antiseptic and aseptic methods) and the rise of gynecology and urology as medical specialties. Doctors who encouraged surgery for patients with ambiguous genitalia did not cite these factors in their published work; instead, the justifications that surgeons offered after 1880 suggest that, like Gross, they found hermaphrodites’ sexual behavior to be a serious threat. It is no coincidence that surgeries increased in frequency after homosexuality began to be discussed in medical journals. Physicians tacitly agreed that surgery was a potential means of correcting sexual ambiguity while also preventing sexual depravity.

It was this emphasis on sexuality as a legitimate reason to promote surgery that distinguished American medical responses to hermaphroditism from those of their European counterparts. European doctors also performed normalizing operations and were aware that their hermaphroditic patients may have harbored sexual attractions. As Alice Dreger (1998) has detailed, French and British physicians “seem to have made something of a habit” of removing errant gonads or sex organs from their patients. Likewise, French experts on hermaphroditism expressed a keen interest in theorizing their patients’ sexuality, and although British experts were not as inclined towards psychoanalyzing hermaphrodites’ sexual tastes, they agreed that “testicles naturally meant desire for women, and ovaries naturally meant desire for men” (Dreger 1998). American physicians shared this assumption but conflated hermaphroditism with homosexuality to a far greater degree. As a result, a medical distaste for homosexuality played a much more prominent role in physicians’ prescriptions of surgery in the United States than in France or Britain.

From their first appearance in American medical literature, homosexuals had been included in the broader category of sexual inverts—a category that encompassed transvestites; women who smoked, whistled, or preferred sports and masculine dress; and men who were “fond of looking in the mirror” or who had

effeminate voices (Chauncey 1989). Hermaphrodites' behavior fell under the rubric of sexual inversion because of their ambiguous genitalia, but this was not the only connection between homosexuality and hermaphroditism. In their effort to understand homosexuality and to identify what could be done to correct it, physicians and sexologists employed the term "psychical hermaphroditism." How else to accurately describe patients who looked like one sex but behaved like the other in their sexual lives than to claim their bodies were of one sex and their minds of the other? Furthermore, the same causal explanation applied to both phenomena. Physicians struggling to identify the causes of hermaphroditism turned to embryology and developmental biology for answers. Embryonic bisexuality, cellular differentiation, and Ernst Haeckel's insistence that ontogeny recapitulated phylogeny all appeared in medical reports of hermaphroditism with varying degrees of relevance and accuracy (e.g., Cochran 1878; Cummings 1883). Harry Oosterhuis (2000) noted that physicians and sexologists invoked these same explanations in their analyses of homosexuality. Whereas early 19th-century physicians had regarded hermaphrodites as a curious and disturbing anatomical puzzle to be solved (and often explained by causes such as conception on a state line or startling a pregnant woman), introducing the language of development redefined hermaphroditism and homosexuality as the results of a biological process gone horribly wrong. Both hermaphrodites and homosexuals, therefore, were biological deviants from a dimorphic, heterosexual norm; treating their condition consisted of normalizing the outward behavioral and anatomical effects of that process.

The medicalization of hermaphroditism, already concerned with gender boundaries, became entangled in the medical profession's redefinition of homosexuality as a matter of sexual object choices, and therefore fell doubly victim to the perceived need to define appropriate sexual and social behaviors. In 1896, Dr. Samuel E. Woody refused to operate on a 20-year-old patient who presented herself as a woman. She claimed to have had sexual attractions to both males and females, and that she had "copulated with males with success and satisfaction," though at the time she was attracted mostly to women. Woody described her anatomy, which included a clitoris that "became" a penis "on titillation," testicles, a small vagina-like pouch, and possibly a uterus, and concluded that his patient was not a woman, but a young man. Yet to Woody, the patient's dual sexual attractions posed an additional problem: regardless of her true sex, she could not possibly be heterosexual. He saw this as a telling commentary on hermaphrodites' sexualities in general and took his interventionist duty one step further than simply refusing to operate. He asserted that because they were "so ill-fitted for the generative function and so prone to psychical perversions and moral degradation, such cases should be castrated in early life." Under this reasoning, physicians had a moral obligation to correct their patients' bodies to forestall inevitable tendencies towards sexual deviance, even if it meant complete removal of their sexual organs.

Woody's arguments appeared only five years after urologist G. Frank Lydston proposed surgical treatments as a means of curtailing homosexual behavior (Terry 1999). Lydston believed that homosexuality was a form of perversity caused either by a defective brain or defective genitals, but he also believed these perversities could be corrected permanently. Correcting the defective gonads, whether by complete removal or by replacing them with "better" ones, should therefore eliminate homosexuality, just as Woody argued that castrating hermaphrodites would prevent them from ever having erotic attractions. Indeed, Lydston reported success in eliminating homosexuality in men by transplanting a testicle from a heterosexual man into a homosexual man (who then, according to Lydston, began to feel sexual attractions toward women), and he likewise claimed that ovariectomy and clitorectomy were an effective means of preventing the expression of lesbian sexuality. In addition, he explicitly linked homosexual behavior with physical abnormalities. Lydston included "sexual perversion with defect of genital structure, e.g., hermaphroditism" as one possible form of "congenital, and perhaps hereditary sexual perversion," and opined that

it is often difficult to draw the line of demarcation between physical and moral perversion. Indeed, the one is so often dependent upon the other that it is doubtful whether it were wise to attempt the distinction in many instances.

But this does not effect the cogency of the argument that the sexual pervert is generally a physical aberration—a *lusus naturae*. (Lydston 1889a, 1889b)

By Lydston's description, then, homosexuality and hermaphroditism—representing the moral and physical sides of sexuality respectively—were both deviant conditions. The sexual pervert, regardless of the exact nature of his or her perversity, was a trick of nature, and stood in clear contrast to normal sexuality. Lydston's language indicates that physicians intent upon eliminating sexual inversion constructed a direct connection between homosexuality and hermaphroditism through both the categories they invoked to describe their patients and the surgeries they claimed could normalize them.

This equation of the two conditions also problematized surgery as well—Goffe's 1903 treatment of E.C., for example, drew criticism from Fred J. Taussig, a St. Louis gynecologist. Again, E.C. appeared to be a woman; she had a vagina and a clitoris that resembled a penis—a fairly mundane set of characteristics as far as hermaphrodites went. Even her sexual desires suggested femininity: she confided in Goffe that she had "never had any girl love affairs or been attracted passionately to any girl, but has been attracted by boys." Goffe, thus convinced that he had before him a woman with an enlarged clitoris, asked her if she would prefer to be a man or a woman. She answered that she wished to be a woman, and Goffe performed the surgery that "placed the young patient safely in the ranks of womankind, where she desired to be."

Taussig (1904) expressed his dissatisfaction with this course of treatment in the *American Journal of Obstetrics and Diseases of Women and Children*, where Goffe

had initially published his report. While he was not as explicitly anti-homosexual in his reasoning as Woody, Taussig likewise argued that physicians needed to intervene to control hermaphrodites' sexual desires. He explained that sexual urges were socialized behavior and argued "that the patient in this case had the sexual desires of a woman must, therefore, be looked upon, more as a result of her education, of suggestion and imitation than as in any way conclusive evidence of her true sex." Taussig also thought it likely that E.C. had undescended testicles, in which case her sexual desire was definitely misdirected. If she had testicles, she should rightly have been attracted to women, and it was Goffe's duty to ensure that E.C. did not act upon her attraction to other men. With this in mind, Taussig found Goffe's treatment inappropriate. Although he did not offer a moral condemnation of homosexual behavior as had Woody, Taussig's fears reflected the medicalization of homosexuality as a deviant condition. Homosexuality, like ambiguous genitalia, stood on the wrong side of the divide between normal and abnormal.

The disagreement did not end there, however. In a second set of articles, published in the *Interstate Medical Journal* in 1904, Goffe defended himself against Taussig's criticisms (Goffe, Taussig, and Neugebauer 1904). He acknowledged that he asked E.C. if she would prefer to be a man or a woman, but he claimed he did so as the final stage of his examination after having already concluded she was female. By asking what E.C. would prefer, he argued, he was merely obtaining her consent for the operation, not allowing her to base her decision upon her sexual tastes. Such an act would clearly be detrimental to both the patient and society at large, since she was trapped between her sexual inclinations and her anatomy. At any rate, Goffe stated, this point was now irrelevant, as E.C. was menstruating at the time of her follow-up examination, thereby proving his judgment correct.

Taussig dismissed this as unimportant to the discussion at hand (Goffe, Taussig, and Neugebauer 1904). He claimed that while it was all well and good that Goffe had turned out to be correct, there was no way he could have known this at his initial examination. Goffe had therefore taken quite a risk, as Franz Neugebauer (Europe's leading authority on hermaphroditism) had published many examples of patients with the same presentation who turned out to be men. Waiting until the patient had either ejaculated or menstruated, or examining the mature gonads through laparotomy, Taussig continued, were the only fail-safe means of determining sex. Aside from this, however, Taussig had nothing else to say, given that Goffe had assessed E.C. accurately, and he closed by claiming that he only wished to provoke discussion, not to criticize. There appears to have been no further public discussion between the two physicians.

By 1904, then, normalizing surgery was already justifiable for its supposed ability to reestablish hermaphrodites within the boundaries of dimorphic sex, both physically and behaviorally. The recognition that hermaphrodites' bodies could dictate—and, more to the point, misinform—sexual desire was already

present in Gross's 1852 report, yet surgery did not immediately catch on as the preferred treatment for non-dimorphic bodies. Physicians concerned about hermaphrodites' liminal state promoted surgery as an appropriate intervention with apparent urgency only after the introduction of homosexuality into American medical literature. Again, between 1852 and 1879, only three physicians even mentioned surgery in their reports of hermaphroditism, and only two performed it—compared to 13 discussions of surgery between 1880 and 1904.

This suggests that simply knowing surgery was possible could not convince physicians that it was the best means of treating or correcting hermaphrodites. After 1880, when abnormal genitals became strongly associated with abnormal sexual behavior (as was evident in medical terminology and explanation, as well as in moral belief), surgeons began to express interest in more invasive ways of enforcing standard sexual categories. Discomfort with homosexuality, therefore, was among the most pronounced influences that contributed to the establishment of surgery as a necessary medical treatment for hermaphroditism in the early 20th century. While the refinement of surgical practices and techniques may very well have contributed to physicians' overall willingness to perform increasingly complex and intrusive gynecological and abdominal surgeries, understanding the rising popularity of genital surgeries in the late 19th and early 20th centuries requires first understanding the assumptions about gender, sex, and sexual behavior that informed medical practice. Reconsidering the link between the medicalization of homosexuality and of hermaphroditism, then, offers a new perspective from which to explain how these assumptions contribute to physicians' eagerness to promote normalizing surgery as a therapeutic option in the 20th and 21st centuries.

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