Impossible Hermaphrodites: Intersex in America, 1620–1960

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In 1840 the *Boston Medical and Surgical Journal* published an article about a purported hermaphroditic who had lived some years as male and some as female. The author, a physician, described the subject’s ambiguous features: long, black hair arranged in a “feminine mode,” a face with “masculine coarseness” but with “a feminine complexion,” facial hair like a man, but earrings like a woman. Rumor had it that s/he performed the copulative functions of either sex. Despite the ambiguity of indicators, the doctor expressed no doubt about his subject’s sex and portrayed “him” as unequivocally disingenuous, as the perpetrator of a “case of imposture.” Although the individual presented herself as female, the doctor pronounced her male.1

What are we to make of this perplexing person? Was she a woman attired in men’s clothes, as so many supposed and she herself insisted? Was she truly a man, equipped with “male organs entire,” as two doctors observed? Did the “piece of dead flesh” she referred to on her body make her female or male? Why did she variously live life as a woman or a man? Why did the doctor feel entitled to pronounce her male, even as she presented herself as female?

This essay explores the changing definitions and perceptions of “hermaphrodites” from the colonial period to the early twentieth century.3 Over the course of the three centuries, most medical observers would have agreed that hermaphrodites did not exist in the human species and that patients with confused or ambiguous external and internal reproductive organs were not really hermaphrodites, but cases of “mistaken sex.” Indeed, by the mid-twentieth century, “corrective” surgery for such anatomical ambiguity became routine in this country, to make infants’ genitalia look “normal” and match their supposed “true sex.” But this essay is concerned less with the medical history of surgical procedures or the professional history of doctors than with the cultural history of how American doc-

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2 Ibid., 146.

3 The term “hermaphrodite” has been replaced by “intersexed” among laypeople and medical practitioners. In this essay I use the historical term to avoid presentism.
tors and laypeople regarded bodies and identities that fell outside their conceptual boundaries of normal female and male categories. What did it mean to be male or female? Who had authority to answer that question, and what were the criteria? The essay is organized chronologically as well as thematically, for the classification of hermaphrodites, impossible though the status was thought to be, changed over time. Each section explores the evolving determination of the biological and social foundations of sexual identity and the anxiety, expressed differently in different eras, over those cases that did not fit the ideal bipolarity.

Alice Domurat Dreger, in her pathbreaking book, *Hermaphrodites and the Medical Invention of Sex*, has termed the years 1871–1915 the “age of gonads” in France and England. By the late nineteenth century, European doctors argued that “true hermaphrodites” were those whose bodies (examined during autopsies) contained both ovarian and testicular tissue. All others, despite unusual conformations of external genitalia, were labeled as mostly female or mostly male (male pseudohermaphrodites or female pseudohermaphrodites), and hence the two-sex system could remain largely intact. I argue that in the United States the impetus to maintain a two-sex system increased in the late nineteenth century, though it began earlier. Before the technology required to analyze ovarian and testicular tissue developed, doctors focused on visual markers, particularly the penis and clitoris, though sometimes the vagina, uterus, and menstruation were offered as proof of womanhood. When biological cues proved inconclusive, medical men turned to social indicators—such as a person’s mannerisms, clothing, or tastes—to make their determination of sex definitive.

Physicians’ decisions involved factors, some medical, some social, that were linked to larger cultural anxieties. American doctors discussed their European colleagues’ case histories, read European medical textbooks, and used them to formulate their own conclusions about the impossibility of hermaphrodites. In what is now the United States the tendency to proclaim hermaphrodites “impossible” began long before the age of gonads, though it became more pronounced when the observation of gonads became important, here as in Europe. Embedded in both European and American doctors’ judgments, which labeled ambiguous bodies male or female, were traditional notions of femininity, masculinity, and, indeed, personhood as opposed to monstrosity.

Distinctive themes characterize each era’s understanding of hermaphrodites. The trope of the monster employed in early American texts persisted in new guises in the early republic and overlapped with the developing notion of the deliberately deceptive or shady character. In the nineteenth century especially, worries about gender deception and fraud merged with apprehension over racial constancy and the stability of bodies. Whether it was to ensure the legal status of men or women or to show that sex, like race, should be something uncomplicated, permanent, and easy to determine, nineteenth-century doctors insisted on certainty rather than ambiguity in gender designation. Later in the century, the frightening prospect of bodily metamorphosis fused with the worrisome possibility of homosexuality. Finally, throughout we confront the issue of choice; a binary system of sex, the ideal established and authorized by the biblical Adam and Eve, was rigid, and choosing an infrangible sex (despite indefinite and contradictory markers) was

4 Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* (Cambridge, Mass., 1998). I am not making implicit claims about European history; the increase in commitment to a two-sex system may have begun earlier in Europe too, but Dreger’s work focuses on the later period.
mandatory. Even if according to medical authorities hermaphrodites did not exist, the idea of one body exhibiting two sexes nonetheless raised a host of anxieties about gender and sex.

Technically, the doctors were right; no humans were like hermaphroditic earthworms, possessing two perfect sets of external and internal reproductive organs, capable of reproducing as either female or male. Hermaphroditus, the figure from Greek mythology whose male body was merged by the gods with the female body of the nymph Salmacis, found no counterparts in the mortal human world. But saying that hermaphrodites did not exist encouraged doctors and laypeople to insist on two and only two sexes, when not all bodies fit precisely into discrete male and female categories. True, most people have bodies with physical markers that are clearly male or female, but some have genitals, gonads, and genetic material sufficiently equivocal to make doctors and parents wonder to which sex they belong. Medical experts estimate that one of every two thousand people is born with questionable gender status, about the same ratio as those born with cystic fibrosis. Our gendered world forces us to put all people into one of two categories when, in fact, as the Harvard University biologist Anne Fausto-Sterling has suggested, we need to consider “the less frequent middle spaces as natural, although statistically unusual.”

Sex is social and historical, in large part a construction whose contours and boundaries have been imposed rather than simply discovered. Consider the analogy of race. Just as we think about race in black-and-white terms in the United States, so too we think about sex in exacting binary terms. African Americans, for example, have been considered “black” on the basis of the “one-drop” rule (any known African ancestry), which sought to define and police the boundaries between blacks and whites in the interest of white racial purity and supremacy. Although racism and discrimination persist, the one-drop rule has disappeared in the face of more just attitudes and practices, as Americans have redefined the color line in the United States in the previous half century. Today “multiracial” is an accepted identifier employed by increasing numbers to add nuance and complexity to our formerly rigid understanding of race.

Will a more complex understanding and classification of sex find similar respectability? How distinct are the boundaries of sex? And how should those with nonconforming bodies be treated? How small must an infant’s penis be before a doctor decides the child should be surgically remade as a girl? Does an unusually large clitoris transform a girl into a boy? Is someone with a penis and a uterus male or female? What about a person with breasts and testicles? Where do we place those who have both XX and XY chromosomes in this rigid taxonomy of sex? Intersex bodies have always existed, but they have been rendered invalid and invisible historically, for the boundaries of personhood have forced them into a conventional bipolar male/female division.7

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5 On the incidence of intersexuality, see Dreger, Hermaphrodites and the Medical Invention of Sex, 40–43. Anne Fausto-Sterling, Sexing the Body: Gender Politics and the Construction of Sexuality (New York, 2000), 76.
6 F. James Davis, Who Is Black? One Nation’s Definition (University Park, 1991). Sex is not like race in all respects; it has a greater claim to a basis in biology. Nonetheless, as we shall see, the rigidity of the sexual binary goes beyond the realm of biology into the realm of culture.
7 On contemporary medical attitudes toward intersex births, see Suzanne J. Kessler, Lessons from the Intersexed (New Brunswick, 1998). Identifying and living as intersexed is becoming a more viable option for some adults. For newborns with ambiguous genitalia, intersex activists advise parents to choose a traditional sex, based on best estimates of what will help the child be most comfortable with his or her body. When the child matures physically, she or he can choose to maintain the original assignment, live as the opposite gender, or identify as intersexed. See the Intersex Society of North America Web site for comprehensive resources: <http://www.isna.org> (Jan. 31, 2005).
The insistence on a strict male/female dichotomy should not be understood as a medical conspiracy, though doctors played an enormous role in delineating the boundaries between the two sexes and bestowing on that division the imprimatur of science. Those living with ambiguous bodies generally shared the binary ideal and sought to blend in, if only because survival demanded it. Forced to choose a sex, however, they did not always adhere to the sex they chose. Nor did they always endorse or accept doctors’ suggestions for surgical correction, particularly when such surgery required an adult to change gender.

The determination to make intersex bodies look like normal male or female bodies reached its apogee in the work of the psychologist John Money of Johns Hopkins University in the mid-twentieth century. Money believed, erroneously, that one’s sense of gender identity was malleable until eighteen months of age. He therefore concluded that those born with ambiguous genitalia could have their sex surgically and hormonally assigned as infants without negative consequences. Once their bodies were surgically shaped to approximate typical male or (usually) female figures, the children would develop personalities happily matched to their assigned sex, Money claimed, if the assignments were supported by proper rearing and a parental commitment to the chosen gender. Money was wrong. Many children thus altered never felt at home in their assigned sex. Some never knew their medical history, as doctors advised parents and relatives to keep the matter secret. When they found out, some changed genders as adults. Others struggled to accommodate life with surgically altered sexual organs that had been severely compromised as well as with a deep sense of shame induced by enforced secrecy. Intersex activists are currently challenging Money’s presumptions and protocols about “normalizing” procedures. As Alice Dreger, chair of the Board of Directors of the Intersex Society of North America (ISNA), put it, “Why perform irreversible surgeries that risk sensation, fertility, continence, comfort, and life without a medical reason?” ISNA’s efforts are making headway, but they are far from complete. At a recent meeting of the Section on Urology of the American Academy of Pediatrics, several leaders in the field cautioned against invasive cosmetic surgeries, while others continued to advocate early aggressive operations.

How nonconforming bodies are treated is a historical question. In America they have been marked as “other,” as monstrous, sinister, threatening, inferior, and unfortunate. We might imagine other possibilities, perhaps drawing on the pathbreaking work in the new history of disability, which invites scholars to ask how ambiguous bodies became “abnormal” bodies. Difference, including the sex characteristics of nonconforming bodies, need not carry the stigma of inferiority or monstrosity. The rush to classify intersex persons as male or female—or forcibly to make them male or female—can be seen as evidence of a social construction that demands historical explanation. The proposition that a person’s sex might range more broadly and variably along a continuum between the two poles of conventional male and female embodiment forces us to denaturalize sex. We are thus


challenged as historians to analyze how and why a rigid male/female dichotomy was enforced, how it assumed unquestioned status as biologically natural, and how it affected those whose anatomy did not conform as well as those whose bodies were considered normal. This essay therefore considers how the criteria and the authority for judging ambiguous bodies changed over time, even as the anxiety over ambiguity persisted and the binary sexual ideal endured. How Americans have understood and handled nonconforming bodies reveals not merely the hidden history of intersex, but the process by which Americans defined and naturalized the norms of sex and gender.

Early Americans placed hermaphrodites in the broader category of monstrous births, a catchall that included all kinds of birth anomalies. Monsters, few doubted, were sent by God as signals and warnings. Puritan theologians agreed on the doctrine of providence; if God ordered the universe, every unusual event had divine significance. Sometimes God sent subtle signs; at other times, presumably depending on the importance of the occasion, his messages were more obvious. Mary Dyer's unfortunate malformed baby was one such blatant expression, understood to be a dramatic expression of God's censure. Dyer had been a follower of Anne Hutchinson (a woman expelled from the Massachusetts Bay Colony for criticizing established clergy, expounding the doctrine of “grace in the heart,” and testing the limits of female autonomy in matters of faith), and she later became a Quaker. In 1637 Dyer gave birth to a terribly misshapen baby that John Winthrop, the colony's governor, described:

it was a woman child, stillborn, about two months before the just time, having life a few hours before; it came hiplings till she turned it; it was of ordinary bigness; it had a face, but no head, and the ears stood upon the shoulders and were like an ape’s; it had no forehead, but over the eyes four horns, hard and sharp; two of them were above one inch long, the other two shorter; the eyes standing out, and the mouth also; the nose hooked upward; all over the breast and back full of sharp pricks and scales, like a thornback; the navel and all the belly, with the distinction of sex, were where the back should be, and the back and hips before, where the belly should have been; behind, between the shoulders, it had two mouths, and in each of them a piece of red flesh sticking out; it had arms and legs as other children; but, instead of toes, It had on each foot three claws, like a young fowl, with sharp talons.10

The Reverend John Cotton suggested that Dyer conceal the birth. He saw “a providence of God in it . . . and had known other monstrous births, which had been concealed, and that he thought God might intend only the instruction of the parents, and such other to whom it was known, etc.” But God apparently wanted all to know, for even during labor, about two hours prior to the birth, Winthrop ascertained, the bed shook violently, and Dyer's body emitted a “noisome savor.” Such shaking and the foul smell indicated that Satan lurked nearby. Most of the women attending Dyer “were taken with extreme vomiting and purging” and were forced to leave.11


Though Winthrop assigned blame to Dyer only tentatively (he never explicitly tied her unsuitable religious leanings to the stillborn baby), other Puritans and their contemporaries saw a direct correlation between monstrous births and dangerous opinions. In a sixteenth-century English text dealing with such deliveries, the conclusion was unequivocal. These births, it explained,

signifie the monstrous and deformed myndes of the people mysshapened with phantastical opinions, dissolute lyvynge, licentious talke, and such other vicious behavoures which mounstrously deformed the myndes of men in the syght of god who by suche signes dooth certifie us in what similitude we appere before hym, and thereby gyveth us admonition to amende before the day of his wrath and vengeance.

Dyer no doubt indulged in all four sins specified: fantastic opinions, dissolute living, licentious talk, and vicious behaviors such as her claim of revelations, or supernatural communication. As a result, she received God’s explicit physical condemnation in the figure of the malformed child. The account of Dyer’s daughter’s birth by the Puritan minister Thomas Weld concurred: “Then God himselfe was pleased to step in with his casting voice . . . by testifying his displeasure against their [Dyer’s and Hutchinson’s] opinions and practices, as clearly as if he had pointed with his finger.”

Winthrop’s horrific description of Mary Dyer’s baby conformed to other colonial portrayals of birth anomalies. Aristotle’s Master-Piece, the most popular and often-reprinted medical manual in the colonies and the definitive word on matters of reproduction and genital anatomy, included accounts of creatures born with composite animal, human, and mythic features. The book detailed a case in 1393, for example, when a woman copulated with a dog, producing a beast that resembled the mother from the waist upward and the dog, with paws and a tail, from the waist down. (See figure 1.) The Master-Piece included a similarly composite hermaphroditic creature, thus explicitly linking inhuman monsters and hermaphrodites. The “monster,” as the Master-Piece termed it, was born in 1512 in Ravenna, with a horn on the top of its head and two wings; it stood on only one foot, which had talons like those of a large bird. It had “the Privities of Male and Female, the rest of the Body like a Man, as you may see by this Figure.” The creature is not specifically labeled a hermaphrodite, but the description of its “privities” conforms to the colonial understanding that a hermaphrodite had both male and female genitals.

Monstrous births of all sorts had gendered explanations; for example, their irregularities were often attributed to maternal imagination. According to another edition of the


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Master Piece, a pregnant woman’s thoughts or impressions could cause a birth anomaly. If a pregnant woman saw a rabbit, for instance, her child might be born with a harelip, the manual cautioned. “Some Children are born with flat Noses, wry Mouthes, great blubber Lips, and ill-shap’d Bodies; and most ascribe the reason to the Imagination of the Mother, who hath cast her Eyes and Mind upon some ill-shap’d Creature.”

For similar reasons, the Master Piece advised women to abstain from sex during the menstrual period. “Undue copulation,” the book explained, was “unclean and unnatural.” The “issue of such Copulation does oftentimes prove Monstrous, as a just Punishment for their Lying together, when Nature bids they should forbear.” Women and men were both to blame for bad coital timing, though most of the onus was put on women to prevent such activities; a woman should know her body’s condition and, if necessary, refuse her partner. Whoever was to blame, the Master Piece made clear that one cause for monstrous births was divine: “Because the outward Deformity of the body, is often a Sign of the Pollution of the Heart, as a Curse laid upon the Child for the Parents Incontinency.”

In early American medical texts, authors usually discussed hermaphrodites in relation to monstrous births. The discussion of monstrosity typically included three questions:

14 Aristotle’s Master Piece, Completed in Two Parts: The First Containing the Secrets of Generation in all the Parts Thereof (London, 1700), 17. By the early nineteenth century, doubt about maternal imagination as an explanation for unusual births began to creep into doctors’ accounts, though the tone of many articles suggests that the idea had not been completely dispelled. See, for example, Thomas Close, “Singular Monstrosity,” Boston Medical Intelligencer, Sept. 13, 1825, p. 71. The idea flourished again in the late nineteenth century, in the context of attacks on it. See Michel Middleton, “Cases of Malformation: with Reflections on Congenital Abnormalities,” American Journal of the Medical Sciences, 55 (Jan. 1868), 69–76.

15 Aristotle’s Master Piece (1700), 40, 35.
“What is the cause of monsters? Whether they are possessed of life? Whether a perfect monster can be considered a human being?” *Aristotle’s Master Piece* maintained that those conceived by “natural means,” as opposed to an “unnatural” union between a woman and a beast, “tho their outward Shape may be deformed and monstrous; have notwithstanding a reasonable Soul, and consequently their Bodies are capable of a Resurrection.” The same theological and medical questions were asked about hermaphrodites. Most writers acknowledged the humanity of those born “imperfect monsters,” in which only part of the body, such as the genitals, was affected, and lamented the sorry fate that befell “perfect monsters,” which resembled “brute animals” and were deemed more monstrous than human.  

The first case of ambiguous sex that has been found in early American sources did not engage any concerns about monstrosity, maternal imagination, or the ensoulment of hermaphrodites, for in 1629 an adult, Thomas/Thomaisine Hall, came to the attention of the Virginia General Court for dressing “in weomans apparel.” During the investigation into this matter, other issues came to light. Rumor had it that Hall had had sex with a maid, “greate Besse.” According to the historian Mary Beth Norton, a clear determination of anomalous sex would have been required to assess that act: For Thomas, it would have been considered fornication, a not uncommon offense in seventeenth-century Virginia, but for Thomaisine, it might have meant very little (for same-sex liaisons were condemned primarily when they involved men), or it might have been construed as an “unnatural act.” The court was determined to ascertain Hall’s true identity: Was he a man or a woman? The case demonstrates the potential fluidity of gender in the early modern period. We see both Hall’s flexible, laissez-faire perspective and the authorities’ attempt to impose precise gender rules that would reflect and announce Hall’s equivocal condition.

Hall explained his history to the court. Having been baptized a girl, Thomaisine, she lived as a girl at home near Newcastle upon Tyne until she was twelve years old. She was then sent to her aunt’s residence in London, where she spent another ten years. When her brother was pressed into military service, Hall decided to cut her hair, don men’s clothes, and become a soldier. Upon returning to Plymouth from military service, according to the court’s deposition, “hee changed himselfe into woemans apparel and made bone lace and did other worke with his needle.” After a while she decided once again to put on men’s clothes and came to Virginia as an indentured servant. Here, despite Hall’s status as a bound laborer, s/he continued to cross back and forth between the genders.

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18 McIlwaine, ed., *Minutes of the Council and General Court of Colonial Virginia*, 195. I use male pronouns when discussing Thomas Hall’s life as a man and female pronouns when Hall lived as a woman. When the sources are unclear, I use neutral language.
When asked “wether hee were man or woeman,” Hall answered, “both man and woeman.” Perhaps Hall was a hermaphrodite, as suggested by Hall's description of his/her genitals as encompassing “both” male and female characteristics and the fact that those who viewed his body were unclear about which category Hall belonged in. Hall claimed s/he was “both” and added that s/he “had not the use of the mans parte.” S/he made clear that there “was a peecce of fleshe growing at the . . . belly as bigg as the top of his little fin". When a group of female examiners saw the piece of flesh and asked if “that were all hee had,” s/he answered, “I have a peecce of an hole.”

Rather than encouraging Hall to choose one or the other gender according to which predominated, a solution consistent with scripture-based laws as interpreted by Talmudic commentaries and consonant with early modern European customs, the court acknowledged Hall's self-description as a person embodying both sexes. It decreed that henceforth s/he be required to wear a paradoxical costume consisting of “mans apparel, only his head to be attired in a Coyfe and Crosscloth with an Apron before him.” No longer would Hall be permitted to operate freely in the world, switching between the roles of man and woman as circumstances allowed and opportunities afforded. Nor would s/he be able to maintain privacy and blend in with the populace. Instead, Hall would live publicly as an inconclusively gendered being, at once male and female.

The court chose such a sanction, I believe, not to endorse uncertainty, but to preclude future acts of deception, to mark the offender, and to warn others against similar abomination. The dual-sexed Hall embodied an impermissible category of gender. The ultimate impossibility of clear classification resulted in a solution that, ironically, confounded social conventions. The court's punishment, making Hall a public spectacle, seems harsh today when courts debate the humanity and legality of labeling and exposing repeat sex offenders who have completed their prison terms. In Hall's milieu, a judgment mandating the simultaneous performance of both genders must have been devastating, radically limiting Hall's personhood—not only could Hall no longer switch between living as a man or as a woman, s/he could not live solely as a man or solely as a woman. Unfortunately for historians, we do not know what became of Hall after the decision, as s/he disappears from the public record. We can only imagine that for the rest of his/her life, unless s/he worked off the indenture and changed location, Hall was marked as a creature of indeterminate sex, a ludicrously attired object of disgust, amusement, or pity.

The Virginia court's decision contradicted earlier and later legal and medical attitudes toward persons of ambiguous sex. Early European treatises on hermaphrodites emphasized legal regulations. Using as guides both Jewish Talmudic law and canon and civil law influenced by ancient Latin sources, early European medical manuals typically addressed the legal issues that hermaphrodites or their parents might have faced. All such precedents required that a hermaphrodite choose one sex. For example, the 1741 English treatise *A Mechanical and Critical Enquiry into the Nature of Hermaphrodites*, by the physician James Parsons, outlined the standard regulations. Despite his contention that human hermaphrodites did not exist, Parsons listed each possible legal question, from whether a hermaphrodite should be given a male or female name at birth to whether or not a hermaphrodite should be allowed to marry or divorce. The answers to most questions required that

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19 Ibid.
20 Ibid.
21 Norton similarly argued that the verdict was unprecedented and that Hall was probably lonely and “perhaps the target of insults or assaults.” See Norton, *Founding Mothers and Fathers*, 196.
hermaphrodites choose one sex. Parsons stated unequivocally: “Predominancy of Sex . . . ought to be regarded; but if the Sexes seem equal, the Choice is left to the Hermaphrodite.” Unlike later medical practitioners, Parsons was willing to entrust this vital decision to laypeople.

Parsons’s discussion of the practical issues confronting those with indistinct genitals seems to contradict the bulk of the book, which is devoted to persuading readers that hermaphrodites do not exist. He defined a hermaphrodite as “an Animal, in which the two Sexes, Male and Female, ought to appear to be each distinct and perfect, as well with regard to the Structure proper to either, as to the Power of exercising the necessary Offices and Functions of those Parts.” For Parsons a true hermaphrodite possessed entire “perfect” male and female organs, with each performing its usual sexual and reproductive functions. Thomas/Thomasine Hall would not have qualified as a hermaphrodite, according to Parsons, as his/her genitals were not perfectly and doubly formed. Parsons maintained that hermaphrodites could be found among earthworms, snails, and some reptiles, but not among humans.

All the examples in his 1741 treatise on hermaphrodites, Parsons argued, were truly women with enlarged clitorises or (less frequently) men with small penises that hid in bodily folds and were often accompanied with undescended testicles. His book examines each case of human “double Nature” that he had encountered from the early Greeks onward, proving the allegations mistaken. Parsons joined a long tradition of doctors who discussed hermaphrodites; since the fourteenth century medical men had been interested in the subject and had proffered theories about it. Some insisted that hermaphrodites were possible; others, like Parsons, maintained that it was folly to imagine the factual existence of what they saw as purely mythical beings.

The mistakes arose, Parsons suggested, from ignorance of human anatomy, particularly female anatomy. For Parsons, the clitoris was the primary culprit in the many erroneous identifications of hermaphrodites. So few even knew about the female clitoris, he said, that it was no wonder that “at the first sight of a large Clitoris, divers odd Conjectures should arise.” Parsons was right. Few medical men considered the clitoris in any detail. Nicholas Culpeper, the English author of the 1655 manual The Compleat Practice of Physick, had compared the clitoris to the penis: “[it] suffers erection and falling as that doth; this is that which causeth Lust in women, and gives delight in Copulation, for without this a woman neither desires Copulation, or hath pleasure in it, or conceives by it.” Most early midwifery manuals found in America offered scant reference to the clitoris and even less discussion of its purpose. In Dr. Alexander Hamilton’s 1790 textbook, Outlines of the Theory and Practice of Midwifery, for example, the organ is mentioned on only 2 of the book’s 307 pages. Similarly, William Smellie’s 1786 text, An Abridgement of the Practice of Midwifery, notes the clitoris only twice, in a list of female anatomical parts. William Cheselden briefly alludes to it in 2 pages of his 350-page book on human anatomy and barely

22 On Jewish law regarding hermaphrodites, see Alfred Cohen, “Tumtum and Androgynous,” Journal of Halachah and Contemporary Society, 38 (Fall 1999), 62–85. “Tumtum” referred to people whose indistinct genital organs made it impossible to determine their sex; “androgynous” to those whose organs had both male and female characteristics. See also Sally Gross, “Intersexuality and Scripture,” Theology and Sexuality, 11 (Sept. 1999), 65–74. James Parsons, A Mechanical and Critical Enquiry into the Nature of Hermaphrodites (London, 1741), xxxiv.

23 On the role of medical men in ascertaining the cause of marital problems, such as impotency, possibly due to intersex conditions, see Michael R. McVaugh, Medicine before the Plague: Practitioners and Their Patients in the Crown of Aragon, 1285–1345 (Cambridge, Eng., 1993), 200–207.
hints at its significance, explaining in one sentence that it “is a small spongy body, bearing some analogy to the penis in men, but has no urethra.” In an 1802 midwifery manual, Thomas Denman wrote, “The clitoris is little concerned in the practice of midwifery, on account of its size and situation.”

But if clitorises in general were insignificant, a clitoris deemed too large was seriously troublesome. Large clitorises (unfortunately common in African nations, according to Parsons) could lead to “two Evils; the hindering [of] the Coitus, and Women's abuse of them with each other.” Parsons was not alone in his anxiety; sixteenth-century French medical writers had highlighted this troubling potential of female sexuality as well, suggesting that women with large clitorises could give sexual pleasure to other women. One such doctor described the clitoris in 1597 as “that part with which imprudent and lustful women, aroused by a more than brutal passion, abuse one another with vigorous rubbings, when they are called confricatrices.”

The conflation between alleged hermaphrodites and women having sex with other women was muted in American writings, perhaps because the clitoris itself was hardly mentioned. Early editions of *Aristotle's Master-Piece* implicitly blamed the clitoris for mistaken cases of hermaphrodites by including the perspective of Pliny, the first-century Roman scientist and author. Pliny believed that there were no such beings as hermaphrodites. He assumed that errors of sex assignment were simply due to “unexpert Midwives, who have been deceived by the evil conformation of the parts, which in some Male Births may have happened to have had some small protrusion, not to have been discerned . . . and on the contrary the over far extension of the Clytoris in Female Births, may have occasioned the like mistakes.” In Pliny’s view, as later in Parsons’s, there were no hermaphrodites, only cases of mistaken sex.

The 1806 edition of *Aristotle's Master-Piece* (titled *The Works of Aristotle*) offered the fullest explanation of the clitoris in relation to hermaphroditism. Like Culpeper’s text, it spoke of the clitoris and penis as homologues: “The next thing is the clitoris . . . [which] in the same manner as the side ligaments of the yard [penis] suffers erection and falling in the same manner, and both stirs up lust and gives delight in copulation.” No longer occasioning mistakes in identifying hermaphrodites (though that explanation would recur throughout the nineteenth century), the clitoris determined which sex a hermaphro-

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dite should choose. Referring to the clitoris as the “seat of lust,” the book advised that a hermaphrodite should be considered female if sexual pleasure derived from the clitoris, or male if from the penis. The manual also recommended that a hermaphrodite be considered as either a man or a woman depending on “which member is fittest for the act of copulation.”

The recommendation that both sexual satisfaction and reproductive capability be criteria for choosing sex in doubtful situations should be highlighted. Both factors gave hermaphrodites decision-making power over their bodies, a principle that later physicians did not embrace. Parsons too had recommended that hermaphrodites choose a sex, saying explicitly, “Predominancy of Sex . . . ought to be regarded; but if the Sexes seem equal, the Choice is left to the Hermaphrodite.” Though not overtly stated, the choice he and others advocated was of one sex exclusively. No one ever suggested that hermaphrodites switch back and forth between the sexes, as Hall had done in Virginia. In fact, in the nineteenth century, the worrisome prospect of hermaphrodites changing sex inspired doctors to choose for hermaphrodites, especially if they seemed unable or unwilling to choose for themselves.

Later eighteenth- and nineteenth-century medical writers echoed Parsons’s doubts about the existence of hermaphrodites among humans. Yet many writers tried to have it both ways. “Perfect” hermaphrodites could exist in the human species, some insisted, but they were extremely rare; most so-called hermaphrodites were, as Parsons presumed, women with elongated clitorises erroneously judged to be penises. In Samuel Farr’s 1787 medical jurisprudence textbook, published in America in 1819, “perfect” hermaphrodites were defined as those “partaking of the distinguishing marks of both sexes, with a power of enjoyment from each.” Whereas Parsons had required a perfect complement of parts able to “exercise[e] the necessary Offices and Functions of those Parts,” Farr explicitly pushed the definition a crucial step further by adding “a power of enjoyment.” Hermaphrodites had to have both sets of organs and be able to use either one for sexual satisfaction. Could a hermaphrodite derive sexual pleasure as both a female and a male? That seemed impossible to most medical writers, though they revisited the question repeatedly throughout the eighteenth and nineteenth centuries. More than one nineteenth-century commentator also wondered if hermaphrodites would be able to impregnate themselves. But medical men were sure the answer was no. No such instance had ever been found.

By the mid-nineteenth century, some American doctors had become familiar with the sorting and stabilizing efforts of Isidore Geoffroy Saint-Hilaire, author of *Histoire des anomalies de l’organization*, published in 1832–1836 and soon excerpted in English in Theodric Romeyn Beck’s prominent medical jurisprudence textbook of 1838. Geoffroy Saint-Hilaire argued that hermaphroditism, per se, did not exist; as Beck translated the passage, “the external organs (as a penis and clitoris) have never been found perfectly double.” Geoffroy Saint-Hilaire believed that anatomists had resolved the debate about

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hermaphroditism once and for all; he concluded that “it is anatomically and physiologically impossible.” Echoing Farr and Geoffroy Saint-Hilaire, John North, author of a two-part article on hermaphroditism and other “monstrosities” published in America in 1840, also denied the existence of perfect hermaphrodites. “Although we see many instances of true hermaphroditism in the animal and vegetable kingdoms,” he remarked, “no such cases have ever existed in the human subject; no human hermaphrodite, in the proper sense of the term, has ever existed; not a single so-called hermaphrodite in man has even been capable of performing the sexual functions of both sexes.”

The repeated assertion that no true hermaphrodite existed and the concomitant avowal that one could scientifically uncover a person’s actual sex suggest anxiety about the possibility, to quote Thomas/Thomasine Hall’s phrase, of being “both” a man and a woman, and specifically, as we shall see, of having sex with members of both sexes. If people could not be both male and female, then doctors would proclaim what sex they really were, and, increasingly, medically imposed surgical intervention would shape the appearance of ambivalently sexed persons’ genitals.

In the nineteenth century, as doctors professionalized, they published their medical/legal cases in newly established journals and medical jurisprudence textbooks. These writings typically described the ambiguous physical condition of patients, their marital, parental, racial, and class status, and the doctors’ opinions as to their true sex. We need to read these publications carefully as cultural texts, because it is here that we see the evolution of hermaphroditism as a medical condition, even as the early modern motif of monstrosity lingered. Doctors brought their assumptions—both medical and social—with them as they examined each patient. As they denied the possibility of perfect hermaphroditism among humans, they leaped to an additional, faulty conclusion: the impossibility of anything other than perfect (that is, conventional) male or female embodiment. Such logic went unquestioned. Doctors’ understanding of femininity, masculinity, and personhood thus shaped their perception of the possibility of hermaphrodites and ultimately reinforced the binary ideal.

The most benign nineteenth-century term used to designate persons of indeterminate sex was “hermaphrodite,” but other labels were frequently applied as well: “hybrid,” “impostor,” “unfortunate monstrosity.” Doctors used similar derogatory descriptors for various genital incongruities. In an article on malformations of the male sexual organs, for example, one doctor referred to “these mortifying and disgusting imperfections.” The story of James Carey, who lived in Philadelphia in the 1830s, illustrates the enduring, painful plight of the “hermaphroditic monster.” We learn about Carey at his death, through the autopsy report written by the celebrated artist James Akin.

According to Akin, Carey lived his entire life as a man, but the account describes a creature more beastly than manly. Akin went to great pains to prove the veracity of his narrative, appending signatures by attending doctors confirming the shape of James Carey’s genitals as well as his general demeanor. Akin recounted Carey’s sad and pitiful life for readers. A self-imposed recluse, in particular dread of exposure, Carey vigorously guarded

his privacy and shunned any interaction with people beyond that necessary to make a living. Akin writes,

Conscious that busy intermeddlers might surprise him sleeping, and when in a state of nudity, discover his strange malconformation, he continually girded his pantaloons securely about his loins, and when thus shielded, he would confidently retire to rest, conceiving the vestment a fortress of impregnable strength to protect him.

Figure 2. A popular pamphlet by James Akin, Facts connected with the Life of James Carey, bore this cover. The pamphlet detailed the reclusive life, work habits, grooming, and personality of Carey, who lived in Philadelphia in the 1830s. A focal point was an autopsy report, introduced by a poem that illuminated doctors’ bewilderment with Carey’s body:

Facts reveal’d by Goddard’s knife,  
Sheds light upon the M.D. strife,  
For centuries contended.  
That Nature steady in her plan,  
Confus’d not sexual forms in man,  
Her systems pure intended.  
But Carey’s life, outre and strange!  
Illustrates nature’s freaks in change;  
Virility affected, ------  
Devoid of ducts, of glands, and muscle  
Physiologists stare! Their wits bepuzzle,  
At wond’rous Facts detected!

Image from James Akin, Facts connected with the Life of James Carey . . . , 1839.  
against all infractions during repose, . . . or changing his apparel, he would resort to every preventative for guarding against sudden obtrusion, determined to punish with promptitude infringements of the curious, who should violate his sanctuary.

Carey is portrayed as a stooped hunchback, “exhibiting features of a grotesque melancholy aspect.” His eyes were dull, his nose flat, “not unlike the lesser Ouran Outang.” He emitted “preternatural discharges” from his nose, which could cause severe nausea or vomiting among onlookers. Akin's description, supported by documentation from those who knew Carey as well as from doctors who witnessed the postmortem, described a most distressing and pathetic character. He remained chaste throughout his lifetime; indeed, Carey showed an “incorrigible aversion” to women and never committed, in Akin’s words, “debasing earthly drudgery in commerce with the sex.” Given his indistinct genitals, perhaps this was for the best, Akin suggested.

While nineteenth-century doctors continued to debate whether a true hermaphroditic condition existed, there lingered in their gradual medicalizing of this condition an older, harsher interpretation of monstrous malformation. As in the report on James Carey,

33 James Akin, Facts connected with the Life of James Carey, whose eccentric habits caused a post mortem examination (Philadelphia, 1839), 3, 1.
34 Ibid.
many doctors and other commentators never entirely abandoned this motif and slipped deprecating words of monstrosity into medical descriptions of their patients.

By the antebellum period, a new scientific, medical discourse dominated by professional physicians emerged. As scholars of medical history have pointed out, this was precisely the time when American physicians established themselves as a professional body. American doctors began attending medical schools in greater numbers, and they shared their cases with colleagues in newly instituted medical publications. Doctors wrote about a variety of cases involving unusual genital presentations, including elongated penises, urethral strictures, vaginal fistulas, and hypertrophied clitorises. Even the cases that did not specifically focus on hermaphroditism offered doctors the opportunity to compare one patient’s presentation with another. In making comparisons, doctors often referred to, and denied, hermaphroditic conditions. In the surgeon-general’s catalog index, the most comprehensive index of published medical articles from the seventeenth to the twentieth centuries (series 1–5), there are over one thousand citations for “hermaphroditism” in the nineteenth century, several hundred of which refer to cases in America. Another twenty-seven hundred cases are listed under “genito-urinary,” many of which overlap with conditions described elsewhere as hermaphroditic. I have examined foreign cases reprinted or referenced in American journals as well, as their inclusion indicates that nineteenth-century practitioners shared knowledge, though such sharing could take the form of challenges and disputes.

Doctors acquired cultural authority slowly and unevenly. Medical pronouncements did not always have the powerful influence they have today. Nonetheless, even in the eighteenth and nineteenth centuries, doctors possessed knowledge that laypeople lacked, and people sought doctors’ advice to relieve themselves of painful suffering from injuries and diseases. Nineteenth-century medical journal articles, not unlike today’s essays, can be read as conversations among doctors; they endorsed or rebutted each other’s work. They frequently referred to previously published cases to buttress their own opinions. The cases concerning hermaphroditism were no exception. Doctors cited much earlier precedents, for example, to prove to their colleagues that hermaphrodites did not exist, despite the cases of confused sex that they continued to see. The patients they evaluated, then, were really men or women, and doctors could publish their unusual cases to prove their points and validate their medical authority.

The possibility of swindle and deceit looms large in nineteenth-century discussions of hermaphroditism. Certainly crossing the gender divide, as Hall had done, was risky. Rumors might spread, and the suspicion that one was not who one claimed to be, or who one was assumed to be, could be hazardous. Scholars have asserted that the 1830s and 1840s saw a particular anxiety about the dangers of deception. At a time of increasing geographic mobility and urbanization and the development of new impersonal commerce...

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36 See, for example, Thedric Beck’s discussion of a 1459 case involving a person with a female body but a man’s “nature” who impregnated a woman. Beck mentioned the case to suggest an exception to the rule that supposed hermaphrodites lacked sexual desire. Beck and Beck, Elements of Medical Jurisprudence, 125.

37 Karen Halttunen, Confidence Men and Painted Women: A Study of Middle-Class Culture in America, 1830–1870 (New Haven, 1982); James W. Cook, The Arts of Deception: Playing with Fraud in the Age of Barnum (Cam-
cial networks, new opportunities emerged to remake one's self and perhaps to deceive others. The "self-made man" might be a confidence man or—shockingly—even a woman. Changing one's gender was the ultimate dishonesty in this mutable world.

Had they been given the opportunity, nineteenth-century doctors would never have forced the seventeenth-century Hall simultaneously to present as male and female. They were intent on deciding patients' sex definitively. In their zeal to achieve sexual certainty, doctors did not hesitate to judge their patients' gender performance as mistaken, if not deliberately fraudulent. The account of the unnamed person with whom I began this essay, an individual who had lived some years as male and some as female, typifies mid-nineteenth-century medical discourse on hermaphrodites; the themes of dishonesty and sexual promiscuity lurk in what were otherwise dispassionate and clinical medical cases. Foremost in the narrative is the subject's shiftiness, as if bodily ambiguity meant that the person's word also lacked clarity and could not be trusted. The subject presented herself as female, but recall that the doctor pronounced the presentation a "case of imposture" and continually referred to the subject as male. Nevertheless, the doctor noticed that the subject's style of walking was so feminine that "no one could avoid the suspicion that the individual was a woman in male attire." In fact, what had brought the subject to public notice was an arrest for being a female disguised in men's clothing. From the jail she was transferred to the almshouse, where the doctor was sent for to help the superintendent with the examination. Rumors had apparently spread about the prisoner. She was known as a hermaphrodite, and the doctor learned that "stories were current of his performing the copulative functions of either sex."38

The examining doctor used the masculine pronoun "he" throughout his account, thus making his own evaluation of the case evident, although the "hermaphrodite's" words, as nearly as they can be ascertained from this account, suggest that she identified herself as a woman. "He" was bashful, according to the doctor, and did not want to submit to a medical examination because "he" said he "was menstruating." The doctor's inability to accept the patient as female, despite her own wishes, led to incongruities, the very ambiguity (a man menstruating, for example) that the doctor was trying to avoid by categorizing the patient as male. The superintendent tried bribery and threats to persuade the patient to submit to either the doctor's or the superintendent's examination, but to no avail. Finally, she acceded to an exam by a female inmate.39

The woman inspector declared that "the female organs predominated," and so the patient (still called "he" by the doctor) settled into one of the female wards. She maintained that she had been raised female, and that she had worked as a kitchen maid and as a female circus performer. While at the almshouse, she worked in traditionally female

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38 F[lint], "Hermaphroditism," 146. We do not know where or when this person was arrested. Laws against cross-dressing multiplied in the mid-nineteenth century. Beginning in the 1840s, cities of every size and in every region of the country enacted rules requiring behavior that followed conventional gender norms; such laws often focused on gender fraud and targeted women who sought male advantages, such as employment. New York City, for example, first imposed a law regulating cross-dressing in 1845, making it a crime to assemble "dressed" in public places. The law was later amended to allow for masquerade balls. See William N. Eskridge Jr., Gaylaw: Challenging the Apartheid of the Closet (Cambridge, Mass., 1999), 24–30, 338–41. Biblical injunctions against cross-dressing preceded and justified civil law. Deuteronomy 22:5 (AV) states, "The woman shall not wear that which pertaineth unto a man, neither shall a man put on a woman's garment, for all that do so are abominable unto the Lord thy God."

39 F[lint], "Hermaphroditism," 146.
jobs, such as washing clothes. She said that she had no “inclination” toward either sex romantically. Regarding her genitalia, she referred to herself as having “a piece of dead flesh hanging down.” She worked for a few weeks at the almshouse but then contracted pneumonia and died.40

The doctor, with a colleague, eagerly performed an autopsy, confirming his own suspicions that the deceased was not a woman. He “found male organs entire and well developed, and no semblance whatever of those of the female.” The other doctor present at the autopsy recognized the deceased as a person who had once appealed to him for a certificate authenticating his male organs. Apparently, having been repeatedly harassed for being a woman dressed in men’s clothes, she sought the means to prove, via a doctor’s certificate, that she did indeed possess male genitalia. She had told the magistrates before whom she appeared that she dressed as a man “to avoid the importunities of the sex.” In other words, too often sexually harassed as a woman, she dressed as a man. The subject was apparently adept at procuring funds as either sex. While living as a man, s/he successfully convinced “benevolent ladies” that s/he did so to avoid the male advances so commonly made to women. They took pity, offered sympathy, and contributed to his/her financial aid. Were those “benevolent ladies” the victims of a con artist? The doctor’s written evaluation of the case encourages that interpretation.41

Given the pervasive suspicion of supposed hermaphrodites in many medical accounts, it is perhaps unsurprising that these descriptions also betray white middle-class anxieties about both class and race. Statements in the medical narratives that subjects were poor or in an almshouse, for example, often suggested that either laziness or dishonesty had landed them there. One patient suffering from a malformation of his urethra was introduced to journal readers as a famous pickpocket, originally from Holland, who spent many years of his life in a New York State prison. He was said to have exaggerated his symptoms (pain in the kidneys and scant urinary void) to acquire greater medical benefits from his native country. (See figure 4.)42

Similarly, a Boston medical journal reported the case of Mary Cannon, a woman admitted to the charity ward of Guy’s Hospital in London who had lived many years of her life as female and many as male. She had held numerous working-class jobs (toiling in a brickyard and as a milkman, greengrocer, and maid), and the doctor noted that “her habits and manners were rude and bold, sometimes indicating a degree of derangement.” “Suspicion hung about her,” the doctor noted, particularly concerning her sexual proclivities; while she was a maid, the other female servants never accepted her, and “care was always taken to provide for her a separate bed.”43

Embedded in many of the medical accounts were worries going beyond the threat of dishonesty and illicit sexual relations to the far more troubling threat of inexplicable sex-

40 Ibid. This recalls the response that Hall provided authorities in seventeenth-century Virginia, that s/he had “a peece of fleshe growing at the . . . belly as bigg as the top of his little finger.” Perhaps the similarity is coincidental, or perhaps the Hall story had circulated and become “urban legend” or a source for ambiguously sexed persons’ self-descriptions. This case bears many similarities to the seventeenth-century Hall case. Both subjects were raised female, worked at traditionally female occupations, referred to “a piece of flesh,” and endured invasive genital scrutiny from “experts.” See Melwaine, ed., Minutes of the Council and General Court of Colonial Virginia, 194–95.
41 F[lint], “Hermaphroditism,” 146.
ual transformation. As if individuals’ shifting back and forth between the genders at will was not bad enough, doctors reported startling cases of people suddenly, and involuntarily, changing their sex. In 1850 a Boston medical journal reported the case of a fourteen-year-old who had been born female and christened Rebecca, but whose body altered into that of a boy. His father successfully petitioned the court to have the child’s name changed to William. Similarly, the *Medical Examiner* in 1839 reported the mysterious masculinization of an eighteen-year-old woman. At her birth, there had been some doubt as to the girl’s sex, but the “gossiping females” present at her birth decided that her organs of generation looked more female than male. Although as a child she engaged in “manly sports and the labours of the field,” she wore female attire and lived as “Elizabeth.” When she turned eighteen, however, her body changed. She was nearly six feet tall and had begun to grow a beard. Old enough to make her own decisions about sexuality, she abandoned her old name and female identity, lived as a man, and married a woman.44

The unnerving possibility that individuals could suddenly change sex paralleled the early national preoccupation with race, racial categories, and the possibility of changing racial identity. In the early republic, as Americans sought to find social and political order in their unsettled national life, the potential transmutation of race raised serious questions. In 1796 Henry Moss had become a celebrity widely recognized in print as an American-born man of African descent who in middle age somehow turned white. Another man, James, from Charles County, Maryland, lived for fifteen years “a black or very dark mulatto colour,” and then white spots began to appear. Gradually increasing, the spots grew until he had become entirely white, except for a few lingering dark spots on

Figure 4. The text accompanying this picture of a New York “pickpocket” in the *New York Medical and Physical Journal* remarked that the subject, a man named Robinson, was thought to have exaggerated his symptoms of kidney pain and scanty urine discharge in order to receive medical benefits from his home country of Holland. The picture is typical of medical journal illustrations. *Image from the New York Medical and Physical Journal, July–Sept. 1826. Image published with permission of ProQuest Information and Learning Company. Further reproduction is prohibited without permission.*

his cheekbones. His child, the article duly noted, was born with white spots, suggesting that the offspring’s transformation might come soon.45

Conversely, there were disturbing instances in which whites were rendered black—as when light skin darkened among white victims of yellow fever, a disease that raged through eastern cities in the 1790s. Or when white U.S. sailors, captured by Barbary pirates, risked reductions to servility and, some feared, actual physical blackening in North African prisons. One case recorded an elderly white woman’s skin turning entirely black for over a year, evidently as a result of her grief at the violent death of her daughter and grandchildren. Doctors described “black matter” even in the skin of whites, suggesting that, although “it seldom discoulours our [white] skin,” the possibility of such transmutation existed, as the elderly woman’s case proved. With southern manumission, emancipation in the North, and the growth of the free black population, opportunities for racial mixing inspired intense white efforts to stiffen measures that controlled and separated African Americans.46

In the nineteenth century, as northern blacks figuratively turned white through emancipation, women threatened to turn into men—again, figuratively—as they claimed the political rights of citizenship reserved to white males. One response of those most fearful of chaos and most committed to established structures of power was more stringent classification of such categories as race and sex, based on the conviction that such divisions were embodied and essential. African Americans were thus defined as inferior and servile in their very essence, rendered so, not by circumstance, but by nature itself, and women were judged unequal to the task of public citizenship—the domain of white males—because of the essentially dependent nature of their sex.47

Significantly, though medical men wanted to ensure the permanence of each person’s sex, uncertainties regarding the criteria for womanhood or manhood flourished. The following case illustrates the consequences of deception and the rewards of male privilege. What was seemingly easy to ascertain turned out to be quite debatable. In March 1843 Dr. William James Barry of Hartford, Connecticut, examined a twenty-three-year-old man, Levi Suydam, of nearby Salisbury. Apparently, the Whigs of Salisbury had presented Suydam to the town’s board of selectmen to be acknowledged as a freeman and property holder able to vote in the upcoming election. (Connecticut had a property requirement for voting until 1845.) As the election was closely contested, Suydam’s petition was challenged. The opposing party did not dispute that Suydam owned sufficient property; it

47 For early American efforts to establish a biological basis for “racial difference,” see Samuel George Morton, Crania Americana; or, A Comparative View of the Skulls of Various Aboriginal Nations of North and South America, to which is Prefixed an Essay on the Varieties of the Human Species (Philadelphia, 1839).
objected on the grounds that “he was more a female than a male, and that, in his physical organization, he partook of both sexes.” Women were, of course, unqualified to vote—both legally and (it was believed) biologically.48

The close physical scrutiny that Suydam endured recalls the examinations imposed on Thomas/Thomaisne Hall in the seventeenth century, except that, consistent with the professionalization of medicine, the experts were now town physicians rather than midwives or community leaders. Suydam’s first intimate inspection revealed that he was indeed a man and thus eligible to vote. The doctor found a penis, an underdeveloped scrotum, and one small testicle. Dr. William Barry pronounced him a “male citizen, and consequently entitled to all the privileges of a freeman.” But Dr. Barry’s examination was not the last. A few days later, on election day, a Dr. Ticknor challenged Suydam’s admission as he came forward to vote. Dr. Barry intervened, explained his findings, and invited Dr. Ticknor to examine Suydam privately. Dr. Ticknor concurred with Dr. Barry, confirmed that Suydam was a man, and so reported to the selectmen. Identified as a male by the presence of male genitals, however diminished, and authorized by two doctors, Suydam voted, and according to Dr. Barry’s account, the Whigs, who had presented Suydam initially, won by only one vote.49

A few days after the election, an apparent ruse was revealed. It was discovered that Suydam bled monthly. According to Suydam’s sister, a Mrs. Ayers, who regularly washed his clothes, there was no doubt that Suydam menstruated, though not as heavily as most women. Dr. Barry requested a meeting with both Suydam and Dr. Ticknor to reevaluate the situation. Suydam admitted that he bled and submitted to an inspection. This time, Dr. Barry’s examination was far more rigorous, assessing both Suydam’s physical attributes and his social qualities.

Likely influenced by his knowledge of the bleeding, Dr. Barry now became impressed with Suydam’s “feminine” features. Barry drew attention to the fact that Suydam was only five feet two inches tall, had light hair, a fair complexion, and, notably, a beardless chin. He also had narrow shoulders, wide hips, and “well developed mammae, with nipples and areola.” Somehow, these signs of womanliness had escaped Dr. Barry’s notice at earlier examinations, when he apparently checked only the genitalia. Dr. Barry now deduced from these secondary physical attributes that, despite the presence of the male organs, Suydam exhibited “in short, every way of a feminine figure.” Even Suydam’s genitalia looked different on second inspection. Dr. Barry inserted a female catheter into the opening through which Suydam urinated. The catheter entered a space (not his penis), which Dr. Barry now understood to be “similar to the vagina, three or four inches in depth.” Dr. Barry inquired further and discovered that at Suydam’s birth a doctor had surgically made this opening.50

Suydam had amorous desires for men and, according to many observers, “an aversion for bodily labor, and an inability to perform the same.” Others had noticed his “feminine propensities,” which included a “fondness for gay colors, for pieces of calico, comparing and placing them together.” By the conclusion of Dr. Barry’s account, there seemed to be

49 Ibid., 308–9, esp. 308.
50 Ibid., 308–9, esp. 309.
no reason to doubt that, although Suydam perhaps “partook of both sexes” and although he had voted as a man, he leaned toward womanhood both physically and socially and was more female than male. Suydam’s earlier efforts at maleness could be interpreted as duplicitous, leading to the worst kind of voter fraud. Detecting and exposing such deception was exactly what doctors wanted their science to accomplish.

Yet if many wished for an ideal clarity and definitude, the real world of the nineteenth-century United States was muddy and slippery, and Americans exhibited a paradoxical attitude toward confidence men, impostors, shady entrepreneurs, religious frauds, and cross-dressing women. Though such individuals were conventionally deplored, tales of their supposed exploits were eagerly circulated. Among the most popular accounts of women’s passing as men was an often-republished novel, The Female Marine, about a woman pretending to be a man, written by a man pretending to be a woman. In the book, Lucy Brewer goes off to fight in the War of 1812, serving as a sailor aboard the USS Constitution. She displays resourcefulness, self-reliance, and mobility—characteristics commonly deemed male that this female marine appropriates to deal with her extraordinary predicament. But after scenes of danger, suspense, and near discovery, Lucy returns to acceptable female dress and sensibility and marries an appropriate suitor, whom she had met during her masquerade. All’s well that ends well in The Female Marine, as characters revert to their true natures, aligned with prescribed categories of gender and sex. The chaotic world of gender impersonation settles into one of blissful morality, and Lucy accepts the conventions of the cult of true womanhood.

In deciding the sex of their patients, doctors sought similarly happy endings, hoping to see their patients embrace at least one element of womanhood (or manhood): marriage. The early cases of interventionist surgery on genitalia were designed to make the genitals serve the doctor’s perception of patients’ sexual and marital requirements. One case, in 1833, involved a twenty-three-year-old woman who arrived in Dr. John Warren’s Boston office with a “natural malformation of the generative organs.” She had no vagina and requested the creation of an artificial passage. We do not know why she wanted this surgery. Warren’s description of her hints at normative heterosexuality. He mentions that she was “well-constituted” with normal breasts and clitoris, but no vagina or uterus could be found. Proceeding through her rectum, the doctor was able to create a vaginal opening three inches deep and wide enough to admit a finger. After days of profuse bleeding, fever, and pain, followed by dilation of the opening, the wound healed and seemed to remain open. In fact, the doctor reported that “something like labia” formed. At her next appointment he noticed “a sanguineous discharge resembling the catamenia,” and he thought he could distinguish “something like an uterus.” The case ends there with the surgical construction of a (normal) woman who bled, could be penetrated, and, the doctor suggested, could bear children.

The impulse to ensure a patient’s future marital prospects is obvious in the following case, though this doctor’s interventions were harshly criticized. In 1849 a three-year-old girl came under the care of Dr. Samuel D. Gross, professor of surgery at the University of Pennsylvania. Following is a description of the patient’s condition and the doctor’s intervention.

51 Ibid., 309, 308. This phrase recalls Samuel Farr’s definition of a hermaphrodite as one “partaking of the distinguishing marks of both sexes.” See Farr, Elements of Medical Jurisprudence, 13.
of Louisville. For the first two years of her life, the patient had been “regarded as a girl,” but at the age of two a strange metamorphosis began. Gradually she started to “evince the tastes, disposition, and feelings of the other sex.” In other words, she began to reject her dolls and “became fond of boyish sports.” The doctor commented that in every other way this girl was healthy: she had long dark hair, dark eyes, perfectly formed hips and chest, arms and legs, and a lovely face. But upon closer examination, the doctor found what was likely the root of her troubles: ambiguous genitals.54

Dr. Gross located neither a penis nor a vagina. Expecting a penis because of the girl’s propensity for boyish sports, he discovered instead what he took to be a small clitoris, a “cul-de-sac” instead of a vagina, and, growing inside the labia, one testis on each side. If her testicles had been allowed to mature to puberty, Dr. Gross speculated, they might spur sexual desire, which could lead to a “matrimonial connection.” And since the marriage could not be consummated by way of penetration, Dr. Gross thought it best that the testicles be surgically removed. The case, then, turned, not on the little girl’s present propensity for “boyish sports,” but on her future marital prospects. After the operation, Dr. Gross happily reported, her “disposition and habits” returned to those of a girl, and she took “great delight in sewing and housework” rather than “riding sticks and other boyish exercises.” He said that he had seen the girl several times because she lived in his neighborhood and that she appeared to be developing normally. In fact, her mind was “uncommonly active” for a child her age.55

For Dr. Gross the single most important justification for the surgery was his young patient’s future marital prospects. He could not bear the thought that she would be unmarried. The doctor assumed that when the testicles matured, they would arouse a sexual interest, and the girl would seek satisfaction. But with whom? Sex with a man would be doomed, the doctor implied, because without a proper vagina, penile penetration would not be possible. He mentioned that impregnation was similarly unfeasible. Might Dr. Gross have been worried that the testicles this girl possessed could lead her, in fact, to pursue a female sexual partner? A small clitoris, even if incapable of performing penetration, combined with testicles, might so incline her, Gross hinted, arguing that maturation of her testicles would “ultimately lead to the ruin of her character and peace of mind.” A man with no testicles would have no incentive to marry and would be “doom[ed] to everlasting celibacy,” according to Gross’s reasoning, but a woman with no sexual desire would still be marriageable.56 Better a woman with no sexual desire than a man unfulfilled, the doctor seemed to suggest.

Dr. Gross believed he made the right decision for this patient who, to him, stood as, not “a boy or a girl, but a neuter.” He hoped to ensure that she would not be “forever debarred from the joys and pleasures of married life, an outcast from society, hated and despised, and reviled and persecuted by the world.” Dr. Gross considered his surgery a success, and he published his account in a leading medical journal. He claimed no regrets about performing the surgery and maintained, three years later, that he had done the best

56 Ibid., 388, 390. Gross may have operated to satisfy the parents’ wishes, but the justification he provided in the case report emphasized the girl’s marriageability.
for the girl and her parents. Dr. Gross recognized the radical nature of his medical intervention, but despite finding no precedent for it, he defended his operation, stating that it was “perfectly just and proper, and vindicated upon every principle of science and humanity.”

Not everyone agreed. Whereas other practitioners might have concurred with Gross in considering “dreadful” the “defective organization of the external genitals,” the journal’s editor found the surgery barbaric. In a postscript to Dr. Gross’s account, the editor sarcastically quipped that doctors might just as well administer prussic acid to those afflicted with malignancy, so preposterous, dangerous, and potentially deadly was this intervention. That the editor singled out Gross’s operation is telling; most surgery at that time was horrendous, as doctors typically operated without anesthesia, could not control infection, and lost many surgical patients. Francis Wharton and Moreton Stillé, authors of a medical jurisprudence text, were similarly horrified. They held that such an operation “removes merely the external.” In a response more characteristic of today’s intersex activists, they urged readers to avoid surgery, arguing that “it does not necessarily extinguish the sexual instinct, nor deprive the person of ‘his only incentive to matrimony,’ and finally, in no way relieves him from the odium or aversion with which the malevolent or ignorant may regard him.” Yet Gross had his supporters. In an article on morphology of the sexual organs, one doctor suggested genital surgery for “persons with organs so imperfectly formed.” Seeking to alleviate “the sufferings to be apprehended from ungratified sexual desires, . . . and for the timely prevention of such sufferings,” the author cited approvingly Gross’s surgical removal of his patient’s testicles.

By the second half of the nineteenth century an irony, visible in the case that opens this essay, had emerged in the medical reporting of so-called hermaphrodites. Most doctors’ accounts published in leading medical journals argued that hermaphrodites did not exist in the human species, and that all so-called cases were simply patients whose sex, male or female, had been mistaken. Yet, incongruously, medical men clung to the term, further refining it to justify their pronouncements of one sex or the other. The classification schemes devised by European physicians became more detailed and ultimately, as Alice Dreger has argued, centered on the gonads, both sets of which (testicles and ovaries) were required to label someone a true hermaphrodite. Since most believed such precise dualism was impossible, doctors had to figure out what combination of organs (along with what conduct) determined true sex. Despite surprisingly little medical agreement on exact criteria, it became the doctors’ prerogative to proclaim sex, even if their assessments contradicted how their patients had lived their lives.

Doctors recognized that their verdicts had profound significance. Indeed, Theodric Romeyn Beck, author of a leading medical jurisprudence textbook, asserted, “The decision may be important in deciding the employment in life of an individual, the descent of

57 Ibid., 387, 389, 388.
59 See, for example, Horatio R. Bigelow, “The History of Hermaphroditism,” New England Medical Monthly, 4 (Oct. 1884–1885), 1–7. American doctors shared the confusion of criteria with their European colleagues, yet all were determined to fit people into two distinct sexes, despite contradictory evidence. See Dreger, Hermaphrodites and the Medical Invention of Sex, esp. 83–109.
property, and the judicial decisions concerning impotence or sterility.” To facilitate such judgments, Dr. E. Noeggerath commented in the *American Journal of Obstetrics*, “the testimony of competent medical authority is very essential for the correct and intelligent solution of the legal question at issue.” Thus, with the best of intentions, doctors described the facts of their patients’ lives—analyzing their physical bodies, personalities, and behaviors—to prove that they were decidedly *not* hermaphrodites and were really one sex or the other, despite ambiguous or mixed genitalia.60

In 1863, for example, during the Civil War, a Dr. B. Cloak examined an injured twenty-one-year-old soldier with the intention of returning him to duty. When he discovered the man’s indefinite sex organs, Dr. Cloak took on the case for further evaluation. The patient, M.B.H., had lived as a man, though his sexual performance as a male was severely limited. He told the doctor that he “may have had something like an erection once or twice.” He had no sexual desire but once had a nocturnal emission. He had little or no beard but shaved anyway. Ever since he was fifteen years old, he had suffered from what seemed to be a bloody discharge each month, accompanied by back pain, dizziness, and discomfort in his groin. As significant, according to Cloak, M.B.H. could sing soprano as well as bass, enjoyed the company of women more than that of men, had rather full breasts for a man, and exhibited “nearly an equal blending of the male and female natures.”61

Despite the blending of natures, Cloak ultimately concluded that M.B.H. was not a hermaphrodite but had a “preponderance of woman.” Why did Dr. Cloak feel compelled to make that determination, defining what was not only ambiguous but contrary to M.B.H.’s performative life as a man? Cloak may have been looking for sex organs that were perfect and complete; since M.B.H.’s were not, the doctor could declare that he was not a hermaphrodite, but then he had to evaluate other biological and social indicators to render a decision as to M.B.H.’s sex.62

According to Dr. Cloak, the patient was mistaken in living as a man and fighting in the Civil War. The doctor implied that M.B.H. ignored his “preponderance of woman” and that he should have lived as female. He bled every month, could sing soprano, enjoyed female companionship, and had no sexual desire: What better indicators of womanhood? When doctors insisted that their patients had lived lives incorrectly as the wrong sex, they could not help but imply that the mistake had been intentional. Dr. Cloak wrote of M.B.H. as if he were deceitful: M.B.H. “has always passed” as a man, he reported. Even Cloak’s discussion of his patient’s expressed sexuality read as if the doctor doubted M.B.H.’s every word: “The statement, if true, that he has no sexual desire, is another evidence” that M.B.H. was truly a woman.63

The pen-and-ink drawings accompanying the journal article, however, undermined the doctor’s diagnosis. (See figure 5.) We do not know the accuracy of the artist’s rendition, but M.B.H. appeared to be predominantly male, his singing ability notwithstand-

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Perhaps M.B.H. was unaware that his penis had no urethra, and that the curious opening he exhibited was, according to Dr. Cloak, “no doubt a rudimentary vagina”; the bloody discharges, surely menstruation. The doctor speculated that if M.B.H. would submit to exploratory surgery, doctors would even find “a womb in its proper position.” M.B.H. was considered to be a woman in part because “she” had little sexual desire. A patient’s sexual desire (or lack of it) was a factor in the medical determination of true sex, and as the century progressed, doctors increasingly considered it, particularly if they were debating surgery.

Ensuring heterosexual sex, particularly intercourse, with or without accompanying sexual desire, became progressively more important for doctors. When sexual inversion became the scientific explanation of homosexuality in the late nineteenth and early twentieth centuries, hermaphrodites were seen as in danger, according to the historian Christina Matta, of coupling with the “wrong” sex. For example, in 1903 doctors encountered a patient who challenged their preference for heterosexuality. E.C., a twenty-year-old “pseudohermaphrodite” (typically this means one who has the external organs of one sex

Ibid., 73. This drawing is unusual in that it depicts the entire person and not just the genital region. In addition, it shows rarely included props such as a chair. Theodric Beck recounted a similar case in 1834 that highlighted sexual desire in the medical decision to assign gender. The person had undeveloped breasts and the voice and mustache of a man, as well as “strong sexual desires.” After thirty-three years of living as a woman, “he” was told by doctors that he was actually a man, and he “then assumed the male attire.” See Beck and Beck, Elements of Medical Jurisprudence, 120.
but the internal organs of the other), arrived at Dr. J. Riddle Goffe’s office in New York because a genital “growth,” as she called her enlarged clitoris, was “a great annoyance.” “It made her different from other girls, and she wanted it taken out,” the doctor recorded. The growth was prominent: three inches in length and three and a half inches in circumference. Goffe complied with her request. Like Dr. Gross, Dr. Goffe also received harsh criticism, not because he performed genital surgery, but because some thought he had made the wrong call. Dr. Fred Taussig suggested that what Goffe removed was not a clitoris at all, but that he had misread the patient’s symptoms and had excised “his” penis. Even the editor of the journal that published Goffe’s account disagreed with Goffe’s assessment, subtitling the article, “Operation for Removal of the Penis,” when throughout the essay the organ was consistently called the clitoris. Goffe had been convinced that the patient was a woman, despite heavy beard growth, thick eyebrows that met over the eyes, no breast development or menstruation, and a clitoris three inches long.65

Why didn’t Goffe assume E.C. was male? The secondary sex characteristics seemed to point in that direction. Perhaps Goffe wanted to place the patient “safely in the ranks of womankind” because he had inquired into E.C.’s love life. He wrote, “She has never had any girl love affairs or been attracted passionately by any girl, but has been attracted by boys.”66 E.C. needed to be a woman because she had been romantically inclined toward boys. If Goffe had considered her clitoris to be, in fact, a penis, then by classifying E.C. as male, the doctor would perhaps have encouraged same-sex relationships.

When Goffe responded to criticism of his surgical decisions, he elaborated on the relationship between the determination of sex in ambiguous cases and homosexuality. A crucial step would be to examine the ovarian or testicular structure, he admitted. But, as examining them would require removing them (thus unsexing the patient), the next best thing would be to “make a study of the individual mental and emotional attributes from a physio-psychological point of view.” It was well known, he argued, that hermaphrodites born with a “duality of development” in their sexual organs turn out to be “sexual pervers, or . . . inverts.” And so, “the sooner they can be relieved of the duality and the anatomical features made to harmonize with the psychic the better it is for that individual and for society.” In other words, it was necessary to alter patients’ bodies to make their desires heterosexual.67

Another surprising and equally significant factor influenced Goffe: the patient’s wishes. When Goffe asked E.C. if “she preferred to be made like a man or woman, she said decidedly, ‘a woman.’” Dr. Goffe performed the operation on March 11, 1903. In this case, the patient’s desire—in both senses of the term, her own gender perception and her sexual attraction to men—matched the physician’s propensity to make bodies align with heterosexuality. With “that thing” (as she called it) removed and her vaginal opening enlarged, E.C. could be a woman. In a follow-up visit the following October, she described


66 Goffe, “Pseudohermaphrodite, in Which the Female Characteristics Predominated,” 757.

successful electric depilation of her facial hair. Examination of her vagina revealed vaginal walls that were “smooth and satisfactory in every way.” Goffe described her external genitalia as having “a perfectly normal appearance.” As important, Goffe said that she was “in a buoyant frame of mind,” and, indeed, we are left to assume that she lived happily ever after. Goffe had a further opportunity to silence his critics when he saw E.C. seven months later; she reported that she had begun to menstruate. Thus, he wrote, there could “be no further question as to the propriety of the operation I performed.”

Goffe’s case is unusual in the annals of intersex management, not because he wanted to guarantee heterosexuality, which was typical for doctors of the era, but because he asked the patient what she wanted and then complied with her wishes. As a result, he had to defend himself from critics who condemned what they saw as giving undue power to the patient. Taussig essentially accused Goffe of giving his patient the choice as to which sex she would adopt. The guidelines in Parsons’s 1741 manual—choose male or female according to the “Predominancy of Sex, which ought to be regarded; but if the Sexes seem equal, the Choice is left to the Hermaphrodite”—had eroded during the nineteenth century as doctors used their authority to rectify ambiguity. If doctors had been able to entertain the idea that hermaphrodites (however imperfect) existed, then perhaps they could have heeded what Theodric Beck described as “an old French law [that] allowed them great latitude. It enacted that hermaphrodites should choose one sex, and keep to it.” But since they doubted the very existence of hermaphrodites, doctors themselves needed to take charge, make the decisions, and remove all uncertainty.

Into the twentieth century doctors’ reports betray the tendency to distrust their patients’ words, particularly with regard to sexual desire. The tropes of the hermaphroditic monster and the deceiver lingered. In 1917 two leading New York physicians described a fifteen-year-old African American girl in terms that doubted her veracity while they highlighted the conflation of race, class status, and sexual uncertainty. Betty entered the hospital for “ulcerative affection of the external genitals,” which she attributed to a rape four months prior. After five weeks of treatment with mercury and iodide, with the lesions sufficiently healed, doctors noticed her atypical genital presentation and spent the next six months examining her physical and psychological health. “Betty is a dark negress of low intellectual type,” they recounted. “Her mental faculties cannot be called subnormal for the class and type that she represents.” Betty said that she was attracted to men, but according to the nurse in the hospital ward, she paid no attention to the men, and instead “she is very devoted to the females in the ward, fondling them whenever permitted and unchecked.” The doctors were more inclined to believe the nurse’s observations than Betty’s words. In fact, they cautioned, “her own statements have to be taken with reserve.”

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68 Goffe, “Pseudohermaphrodite, in Which the Female Characteristics Predominated,” 763; Goffe, Taussig, and Neugebauer, “Correspondence,” 315. On the controversy, see Geertje Mak, “‘So We Must Go behind Even What the Microscope Can Reveal’: The Hermaphrodite’s ‘Self’ in Medical Discourse at the Start of the Twentieth Century,” GLO, 11 (no. 1, 2005), 65–94.

69 Parsons, Mechanical and Critical Enquiry into the Nature of Hermaphrodites, xxxiv; Beck and Beck, Elements of Medical Jurisprudence, 129. Not all patients consented to surgery. One who had been living as a woman refused a recommended lengthening of her urethra and correction of a curved penis because surgery would necessitate entering the hospital as male. The doctor said: “He could not, of course, enter a female ward, being a male; nor, on the other hand, could he be put in the male ward still clad in the garments of the other sex, and these he objected to laying aside, as, he claimed, that he would not like to return to his home, even after an operation, dressed as a man after having passed so many years as a woman.” See James L. Little, “Spurious Hermaphroditism. A Case of Hypospadias, where the Patient, Mistaken for a Female at Birth, has Passed as such to the Present Time,” Illustrated Medicine and Surgery, 2 (1882), 180–82, esp. 182.
Betty’s accounts of her sexual experiences were inconsistent, the doctors believed; she admitted having been raped, but she also spoke of “her own sensations during intercourse.” Adding their own assumptions about black women’s sexuality, the doctors concluded that “her stories of rape by a white man only some months ago as her first sexual experience do not seem likely to be true in an individual of her race and age; sexual life usually begins much earlier.” Perhaps Betty’s presumed penchant for deceit should come as no surprise, since, according to these doctors, hermaphroditism was thought to occur alongside other “mental” problems, including “hysteria, epilepsy, psychoses, criminal tendencies, and abnormal sexual inclinations.”

Betty’s external genitalia appeared male, though one doctor who examined her considered “the penile mass as an extra clitoris and advise[d] its amputation.” (See figure 6.) The primary doctors disagreed. They believed that Betty possessed both a penis and a clitoris, and though they could not call her a true hermaphrodite, “which is so rare as to be almost unrecorded in the literature of the subject,” they suggested that she could hardly be any closer. They ultimately declared Betty to be “preponderatingly female because of the presence of a vagina and cervix, and in spite of the presence of a penis and of sexual impulses toward the female sex.” As we have seen again and again, the compulsion to choose one sex or the other led doctors to acknowledge the very inconsistencies (a woman with a penis) they hoped to avoid by insisting on a rigid binary of male or female. Doctors could see Betty, not as a hermaphrodite, but rather as a “pseudo-hermaphrodite” with “bisexual external organs” but single-sex reproductive glands (in this case, presumed ovaries because she menstruated, albeit irregularly) and “psychic hermaphroditism,” a reference to her sexual attraction to both men and women.

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71 Ibid., 11, 7.
In the early twentieth century, it was still all but impossible for a person to be labeled a hermaphrodite. Many of the themes surrounding hermaphrodites endured from the colonial period, including the tendency to employ the category in denying it. The motifs of monstrosity, deliberate deceit or fraud, and the potential for celibacy or nonheterosexual intimacy continued to capture doctors’ imaginations and arouse their anxiety. But other notions, such as blaming mothers’ harmful thoughts or questioning whether or not those born with unusual anatomies had souls, gradually receded.  

In 1741 James Parsons had insisted on the impossibility of hermaphrodites and argued that most so labeled were simply cases of women with enlarged clitorises. Both sets of genitals, in both form and function, could not be found in one individual, he argued. In 1787 Samuel Farr concurred, adding that alleged hermaphrodites should have a “power of enjoyment” from both sets of sexual organs but that such “perfect” hermaphrodites have never been found. Theodric Romeyn Beck focused in the 1830s on the penis and clitoris, agreeing with Isidore Geoffroy Saint-Hilaire that a penis and a clitoris had never been found in one person. Later in the century, the European physician Theodor Klebs stated that hermaphroditism should be classified by gonadal evidence, internal rather than external indicators, and American doctors followed his lead in looking for dual sets of ovaries and testicles. No matter how the factors shifted, perfect hermaphrodites could not be found; all people had to be really male or female.

If to be human means to be gendered in a binary way, then human hermaphrodites could not exist. On the one hand, doctors’ avowals of a two-sex model may have gendered their patients, rendering them more human in the eyes of medicine and the law, and thus less monstrous. On the other hand, doctors’ insistence on a bipolar system, sometimes surgically supplied, also made them far less likely to recognize the potential complexities of genital and sex presentation. By the 1950s, physicians understood the scientific importance of chromosomes and hormones, but they elevated external genital morphology as the single most important criterion in deciding how to treat hermaphrodites, firmly believing that, in spite of confounding indicators, social gender could be created to match genital morphology. As John Money, the leading researcher in intersexuality for the last half century, put it: “The chromosomal sex should not be the ultimate criterion, nor should the gonadal sex. By contrast, a great deal of emphasis should be placed on the morphology of the external genitals and the ease with which these organs can be surgically reconstructed to be consistent with the assigned sex.” This model, assuming the assignment of sex and stressing surgical convenience over all other considerations, has had lasting negative consequences. Intersex activists today recommend raising ambiguously sexed
children as male or female on a “best guess” basis and barring surgical intervention until after puberty, when sexual development may clarify the situation and when the individual is of an age to choose what, if anything, should be done. The activists are trying to undo the unyielding enforcement of a two-sex standard that, as we have seen, has been evolving for centuries.