Medical histories, queer futures: Imaging and imagining 'abnormal' corporealities

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Once upon a time, queer bodies weren't pathologized. Once upon a time, queer genitals weren't surgically corrected. Once upon a time, in lands both near and far off, queers weren't sent to physicians and therapists *for being queer* – that is, neither for purposes of erotic reform, gender assignment, nor in order to gain access to hormonal supplements and surgical technologies. Importantly, when measures to pathologize queerness arose in the 19th century, they did not respect the now-sedimented lines that distinguish queernesses pertaining to sexual practice from those of gender identification, corporeal modification, or bodily abnormality. These distinguishing lines – which today constitute the intelligibility of mainstream LGBT political projects – simply did not pertain. The current typological separation of lesbian and gay concerns from those of trans, intersex, and genderqueer folks aids in maintaining the hegemony of homonormative political endeavors. For those of us interested in forging coalitions that are attentive to the concerns of minoritized queer subjects, rethinking the pre-history of these queer typologies is a necessity. This paper is an effort at this rethinking, one particularly focused on the conceptual centrality of intersexuality to the development of contemporary intelligibilities of queerness.

It is necessary to give some sort of shape to this foregone moment. It exists prior to the sedimentation of modern Western medical discourse and practice. It is therefore also historically anterior

to the rise of a scientific doctrine of sexual dimorphism. To paraphrase Foucault's famous assertion in his prologue to the diaries of 19th century French hermaphrodite Herculine Barbin: folks have not always been forced into one of two ostensible 'true' sexes, but were at one point perceived as simply *having two* (Foucault 1980, p.vii). With this assertion, Foucault counterposes a notion of queer corporeality – that is, a body comprised of both male *and* female elements – as pre-dating a dimorphic system of bodily intelligibility. The rise of sexual dimorphism establishes a rubric for understanding bodies that offers only two, strictly opposed understandings of what a body can be: male *or* female. The epistemological ascendancy of sexual dimorphism means that the queer understanding of intersexuality that Foucault indexes is gradually place under erasure. The sexually mixed body becomes an epistemic impossibility. It is necessary, then, to ask after the agglomeration of forces, techniques, and objects that have worked to fabricate this impossibility.

In order to orient and guide this inquiry, I privilege two phenomena that concatenate in a manner that attests to this profound shift in the logic of understanding sex, sexuality, and the 'abnormal' body: the medical construal of the intersexed body and the professional popularization of reproducible imaging techniques. Intersexed infants – that is, infants born with non-standard genitalia and/or reproductive organs – are frequently interpellated within a medicalized, pathological understanding of their bodies as well as captured by imaging technologies, from the camera to the X-ray to the ultrasound. We can think of these seizures of the intersex body as composite parts of the same apparatus of capture. Following Giorgio Agamben's gloss on Deleuze and Guattari's theorization of the apparatus of capture (1987, pp.424-473), we can think of it in broad terms as 'literally anything that has in some way the capacity to

capture, orient, determine, intercept, model, control, or secure the gestures, behaviors, opinions, or discourses of living beings' (Agamben 2009, p.14). Imaging technologies work in conjunction with biomedical etiologies of sex as an apparatus of capture that reworks the legibility of queer corporealities in order to render them compatible with a strictly dimorphic understanding of sex/gender. The interpellation of the intersex body by biomedicine is enabled and supported by the visual documentation of sexed aberrance, insofar as this documentation is made to function as evidentiary proof of sex and sex disorder. Photographic technologies are put to work in the service of biomedical understandings of the constitution of sex, and every attempt is made to fix the meaning of the image so as to confirm – and *only* to confirm – diagnosis of pathology and the supposed rectitude of assignation of sex.

A brief account of how queer corporealities were understood prior to this dovetailing of Western medical authority and photographic technologies will help us grasp the import of this shift in intelligibility. In this 'once upon a time', this long moment prior to the rise of medical authority in the metropoles of the West, bodies were understood according to a schematic of sex 'inversion' formulated by the second century Roman physician Galen of Pergamum. This understanding of how bodies are sexed demonstrated considerable staying power throughout subsequent epochs. Within the Galenic schema, intersex bodies were perceived as composed of *both* male and female elements – located *between* genders, as it were (Laqueur 1990, p.135). This understanding of sex is what we could term bimodal, rather than dimorphic. Imagine a vertical line as the hierarchy of sex, with the male as the apotheosis and the female as the base, and varying degrees of hermaphroditism located between the two. One's position within this schema is

concordant with one's degree of bodily heat, that amorphous something said to force what were conceived of as analogous genital and reproductive structures out, rather than allow them to remain internal. The more heat one possessed, the nearer one was to this male apotheosis; the less, the closer to the female base (Laqueur 1990, pp.26-28). Heat was equated with bodily perfection, reinscribing a not unfamiliar schematic of sex hierarchy. It is important to note, however, that within this system of somatic intelligibility, intersex bodies were considered legitimately mixed, rather than dissimulating or obfuscating an underlying true – that is, male or female – sex. Thomas Laqueur has deemed this mode of intelligibility a 'one-sex' model, and this model served as foundation for both pre-modern and early-modern research on the biology of sex. Laqueur persuasively articulates how it was that early modern anatomical discoveries were incorporated within, rather than disruptive of, this precedent conceptual understanding. When ovarian structures were discovered, for instance, they were construed as internal analogues of the testicles, not rendered as markers of an incommensurable difference between the sexes (Laqueur 1990, p.10). This began to shift gradually in the late 1830s, with the introduction of the notion of a 'spurious' hermaphrodite by British physician James Young Simpson. Spurious hermaphrodites 'possessed genitals that were "approximate in appearance" to those of the opposite sex, whereas true hermaphrodites had a mixture of male and female organs' (Karkazis 2008, p.36). The concept of genital dissimulation – that is, of genital structures that would seem to signal one's status as belonging to an intermediate sex – is introduced as the lynchpin of a process of interrogation in a move that renders queer corporealities as nothing more than the proposition of a riddle of sex to be solved by medical practitioners, framed here as privileged interventionists

capable of discerning the *true* – that is, male or female – sex that lay hidden beneath these dissembling genitals.

Simpson's invention of the spurious hermaphrodite was elaborated upon by T.A.E. Klebs (1876, p.718), who reconfigured the taxonomy for intersex bodies, articulating three divisions: the male pseudohermaphrodite, the female pseudohermaphrodite, and the true hermaphrodite. Sex, in this classificatory schema, was determined by the gonadal tissue present in one's body, regardless of genital configuration or the varying presence or absence of secondary sex characteristics. Given that only one form of intersex conditions (what is called 'mixed gonadal dysgenesis') results in the copresence of ovarian and testicular tissue in the gonads, nearly all intersex bodies came to be seen as 'pseudohermaphroditic' (Foucault 1978, p.ix) as bodies masking an underlying true sex. This ushered in what we can call the Reign of the Gonads, the tissue present therein the mighty arbiter of one's sexed ontological status, the revelator of biological and social being. Essentially, if one had ovarian tissue, one was a woman; conversely, if testicular tissue, one was a man. This notion of gonadal true sex wholly disregarded the rest of one's bodily configuration as well as, and perhaps more importantly, their subjective desires. The gonadally-based notion of true sex was most forcefully articulated by Two British physicians, George F. Blacker and Thomas William Pelham Lawrence, who published an article in the 1896 volume *Transactions of the Obstetrical Society of London,* wherein they deploy Klebs' taxonomy to almost fully expunge the medico-historical record of instances of 'true hermaphroditism' and couple this expungment with a call for microscopical examination of gonadal tissue in cases of doubtful or ambiguous sex (1896).

This diagnostic shift and concomitant purging signals more than a move away from the one-sex model and its discursive

admittance of a certain degree of sexed mixity. It also marks the consolidation of medical authority in matters of gynecology and obstetrics, as well as a movement away from the primarily female institution of midwifery. With midwifery, which exists (both historically and currently) in a significant sense beyond the stranglehold of biomedical intelligibility, the solution in instances of intersex births hinges on what we now call the performative. When faced with sexed mixity, a preferred gender of rearing is selected by the parents and then ostensibly consistently enacted and encouraged. In the absence of surgical and hormonal maneuvers to intervene in sex constitution, the success of this assignation was judged along the lines of dress, comportment, gestural habit – all techniques of recurrent and quotidian subjective constitution currently examined beneath the rubric of performativity. As such, this method of gender assignation prefigures what I consider a non-institutionalized mode of dealing with intersex bodies. This method, given its absentation from corporeal intervention and reconstruction, is one potentially much less damaging, psychosomatically, than the prevailing mode of treatment that recommends infant genital surgeries that are often botched and repeated numerous times, which result in both pain and desensitization, and that are coupled with the recommendation of lifelong hormonal regimens. Particularly invasive treatment protocol, given that the ostensible necessity of these treatments is not a matter of bodily wellness, but rather shaped fundamentally by *social and aesthetic* concerns that fear the disruptive potential of these queer bodies.

Summarily speaking, in the epochs preceding the consolidation of modern medical authority in matters of sexed and sexual irregularity and abnormality (that long moment of Galenic bodily intelligibility spanning from the 2nd to the 19th century), the

treatment of intersex bodies is one of both juridical and informal (but *not* medical) gender assignation and subsequent performative conscription to a social (male or female) gender. It is not yet one of dimorphic corporeal truth. Prior to the 1800s, sex was a sociological, rather than an ontological, category. In large part, this is because the body was not yet construed as an epistemological object with its own truth to tell, a truth only able to be discerned by medico-scientific specialists in anatomy. This particular mode of corporeal objectification was not salient until the advent of Enlighment-era scientific positivism, which sought – through close anatomical analysis of both living beings and increasingly available corpses – to establish biological facts *from the body up* rather than viewing the body as merely *reflective* of larger cosmological truths. While intersex bodies certainly presented enfleshed signs that bespoke an unusual corporeality, comprised of elements that are conventionally perceived as neither wholly male nor female – for instance, large clitorises, blind vaginal canals, hirsutism, small breasts, and the presence of descended testicles in vulval folds – these elements were not yet orchestrated into a full diagnostic symptomatology constitutive of a medically classifiable entity.

How, then, do these queer corporeal signs come to constitute, in the 19th century, a symptomatology? T he constitution of the calibrated perception of the clinician is the hinge. This finely tuned mode of perception is not simply comparative, but wholly engendered by a drive to articulate an original and natural order, to achieve an exhaustive, clear, and complete reading of the body, with no ambiguity or ineluctability. This intense clinical gaze is considered to be isomorphic with the transparent and fully denotative language of diagnosis and disease, which together guarantee the truth complex of medical science. It is in this way that 19th century medicine

shrugs off its speculative yoke and becomes an explicitly positivist endeavor. Further, this isomorphism calls into being a certain stranglehold on what had heretofore been posited as the caprice of nature. The notion of the natural irregularity or error of nature is done for. Nature can no longer produce *Homo sapiens* that are anything other than male or female. In keeping with this, there are no more mysterious, unusual, monstrous, or wondrous bodies. Rather, these bodies are now seen as merely deformed, and the richness of their possible meanings are sacrificed to a eugenic conception of etiology hat takes, as its standard-bearer, that phantasm known as the 'normal body'. The normal body becomes the gauge for the exacting articulation of somatic pathology, that which all bodies are measured against. Within this schema, intersex conditions come to be seen as desperately in need of intervention, conceptualized as disordered, and thus privy to the infinitesimal explorations and discourses on both the etiology of hermaphroditism and the recommended courses of action relevant to diagnosis.

In keeping with this transition, the intersex body must be recuperated to a position *within* the diagnostically mappable realm of the natural, not perceived as special or preternatural. This recuperation happens by way of the near-erasure of the possibility of a diagnosis of 'true' hermaphroditism, the elaboration of a discourse on pseudo-hermaphroditism, and the divvying up of what appears to be aberrance within a pre-given conceptual schematic predicated on sex dimorphism in order to secure the correlation between the medical gaze and the language of diagnosis. Shortly, we'll look at an example from the late 1800s that vividly dramatizes this process, wherein the body of an intersex patient is photographed and presented as diagnostic evidence of a discernible 'true sex' to a council of gynecologists.

We can think of this process as a sort of *significatory kidnapping*, wherein the intersex body loses its sexually mixed and, to a large extent, ineluctably wondrous and monstrous status and is instead submitted to a clinical gaze that intently maps this queer corporeality with the intent of discerning, once and for all, its *true* sex, as well as the etiological path of this abnormal development. For with the death of the notion of the true hermaphrodite, we also witness the beginning of an increasingly fine-tuned diagnostic machinery that will refine the taxon of sex abnormality into multiple categories. The queer body is ensnared within the scientific logic of sexual dimorphism, and as a result has a new subjective truth mapped onto its flesh. The guarantor of this truth is the denotative language given to the medical gaze that 'circulates within an enclosed space in which it is controlled only by itself' (Foucault 1994, pp.30-31), a gaze that fantasizes and fetishizes its autonomy, unaffectability, and powers of adjudication, and is only aided in this endeavor by an imaging technology once imagined to be fully denotative, entirely commensurate with the real: the camera. The 'enclosed space' that Foucault writes of indexes the construction of a distinct medical realm that is centralized in its structure and sovereign in terms of its knowledge-production. Within this contained realm, medical knowledge is produced not through a doctor's encounter with a patient, nor through a confrontation between 'a body of knowledge and a perception' (1994, p.30), but through establishing a realm where an endless feedback loop is created between medical observation and medical judgement and adjudication. Medical professionals build a world wherein only they may knowingly investigate and observe the body and declare their theorization of what is observed as diagnostic truth. The first level of observation is constantly and continuously mapped homologously to the second

level of judgement and knowledge production. It becomes very difficult to intervene in the truths created by this closed epistemic loop, and the utilization of photographic technologies within medicine only enhances the supposed veracity of the knowledge produced.

This is the relatively long back-story that is necessary in order to read this first photograph (see figure 1) documenting the abnormal or aberrant genitals of Eugenie Remy. This image, which circulated among medical professionals in France in the late 1800s, was initially published as part of a paper on hermaphroditism given by gynecologist Fancourt Barnes of the British Gynaecological Society in 1888. The photograph features the body of an intersex person, who had been raised and was living as female, with h/er skirts pulled up to the waist, exposing the genitals, where a physician's hand gingerly holds up what appears to be a micro-phallus. The upper body and face of this 'living specimen' are out of focus, while the doctor's hand and the genitals of the hermaphrodite are positioned both clearly and centrally.

This image entered into an intensely contestatory field of medical discourse, and was accordingly read in widely varying manners. Hot topic these genitals were, eliciting arguments that recursively referenced both Simpson's conception of spurious hermaphroditism dependent on the contradiction of genitalia with other physiognomic features which spoke one's real sex, as well as ones that presaged the entrenchment of Kleb's gonadal taxonomy. Barnes himself recommended male sex assignment, arguing that this 'living specimen' was clearly male on account of 'the undoubted existence of a well-formed prepuce and glans penis [and] the imperfectly formed urethra running down from the tip of the glans and passing into the bladder' (Dreger 1998, p.20). While Barnes was

arguing for sex assignation based upon the apparently male formation of the genitals, utilizing the framework provided by Simpson privileging the genital configuration as evidentiary of true sex, other conference attendants registered protests regarding his method of rectal examination, the relative femininity or masculinity of the 'specimen's' facial structure, and the amount of body hair present. These counterarguments were taken into consideration by the attending members, resulting in a highly divisive resolution wherein the physicians in attendance essentially agreed to disagree. Dreger writes that they were 'dramatically unable to decide what they had seen and felt, incapable of agreeing on the nature of sex and its proper diagnosis' (1998, p.23). Counter-intuitively, perhaps, the inconclusiveness of this meeting precipitated *not* a reconsideration of the now entrenched doctrine of univocal sex in cases of hermaphroditism, but an increasingly fervent search for a 'true' material determinant, resulting in the full-on entrenchment of gonadal determination.

Given this intensely contestatory field, what is there to make of the actual photograph? What *do* these genitals signify? It is obvious that they are meant to testify in some way. The image reads as a scene of capture, the physician's tastefully cuffed hand raising the enlarged clit to facilitate a clearer view of the genital surface, the hiking up of Remy's skirts, the obfuscation of h/er face. Through what eyes, however, can this photograph work as evidence of something other than undecidability? How would it be that that image spoke in order to unify agreement as to Remy's true sex? Undoubtedly, it would first need to be coupled with that endless and transparent clinical discourse of which Foucault wrote (1994, p.29) – a precise and rigorously descriptive discourse that maps and fixes the seen. This is provided by Barnes' attached paper, and his succinct

utilization of descriptors coded as masculine. This attempt at incorporeal transformation – that is, a naming that effects a shift in perception without material reorchestration – ultimately results in dissensus.

So what exactly does this image depict? The 'naughty bits' of the intersex body are rendered spectacular while the person replete with said 'naughty bits' is desubjectivised – in the blurring of h/er face, s/he becomes subjectively unidentifiable. The image, in its intent focus on Remy's genitals, definitively testifies to a burgeoning drive to document congenital sex deformity – but it also does much more than this. If we turn away from the apparatus composed of the camera, the doctor, and the 'deformed' genitals of the intersex subject – all of those signifiers working in conjunction to produce the medical intelligibility of the intersex body – and instead focus on the frame of the image and what it absents, we can begin to parse some of the other work being done here. The demonstrative hand of the physician signals two pointed disappearances – that of his body and face. What do these absences mean?

They visually index the physician's intellectual integrity, the non-interferential character of his observation and analysis. Put more simply, these absences establish this being as a modest witness. Donna Haraway (1997, pp.23-29) provides a thorough account of this disappeared modest witness, arguing firstly that modesty, as a trait of comportment, is a crucial underpinning of scientific claims to objectivism. I read this modesty as the primary mode of signalling a distinct lack of pomposity in cultures of science and medicine. Scientific method itself attempts to cap grandiosity and the triumph of the individuated genius, the great brain, procedurally in-building both a culture of empiricism and a logic of progressive supersession. The culture that produces the modest witness is one 'within which

contingent facts – the real case about the world – can be established with all the authority, but none of the considerable problems, of transcendental truth' (1997, p.23). The modest witness, produced by the Enlightenment-era scientific 'culture of no culture,' is constituted by the fundamental sameness of his subjectivity and objectivity. As Haraway writes, his modesty is

> the virtue that guarantees that the modest witness is the legitimate and authorized ventriloquist for the object world, adding nothing from his mere opinions, from his biasing embodiment. And so he is endowed with a remarkable power to establish the facts. He bears witness, he is objective, he guarantees the clarity and purity of objects. His subjectivity is his objectivity. (1997, p.24)

The modest witness, in the isomorphism of his subjectivity and objectivity, seems to be pure conduit – embodied only insofar as he is a ventriloquil medium, but in possession of a body, so unlike queer bodies (including women's bodies), that does not risk compromising his production of facts. In this capacity to possess a body that *doesn't matter*, the modest-witness is what Haraway calls 'self-invisible' (1997, p.23). He must inhabit the space of the unmarked, must be the witness who is never himself witnessed, never the object of a critical or incisive gaze. Thus, the modest witness is a ghostly figure, the producer of facts that do not, in fact, produce him. He is possessed of an ostensibly unsituated – that is, ostensibly universal – knowledge, secured through the erasure of the 'non-matter' of his (white, male, upper-class) body, through the construction of a scientific myth that assumes he adds nothing to the analysis that is derived from 'his mere opinions, his biasing embodiment' (1997, p.24).

To return to the hand that directs the sceneography here, while remaining otherwise disembodied – we follow it to the wrist, the border of the image severs, invisibilizing the physician, diffusing

medical authority, rendering it part of the miasmic milieu while sterilizing its violence. The corporeal absence of the modest witness is thus documented, his mastery, his literal factic grasp of the matter at hand, as well as the ostensible non-matter of his somatic matter.

There is another near-disappearance here – the face of Eugenie Remy. Moving beyond a hoary assumption of the supposed negation of essence implied by a lack of eye contact, a better mode of understanding what this facial blurring signifies is offered by Deleuze and Guattari's theorization of faciality. 'The face is a politics,' they plainly state in *A Thousand Plateaus* (1987, p.175). So let us ask, first, what this politics is and, secondly, what the pixellated blurring of *this* face might then mean.

Faciality – the politics of the face – is comprised of what they term a white wall/black hole system. Each of these components have attendant associations – the white wall prioritizes what Deleuze and Guattari term a despotic regime, shaped by an emphasis on signification; the black holes, an authoritarian regime, operating through an emphasis on subjectivation. The face, though, is composed of both, and thus the politics of faciality are comprised of both despotic and authoritarian elements, technologies of signification and subjectivation. 'The face' is not just any face, but a face that operates as a mastercode of sorts, one thoroughly Eurocentric and modern, that is, geopolitically and historically contingent. They write that the 'face is not a universal. It is not even that of the white man; it is White Man himself, with his broad white cheeks and the black hole of his eyes. The face is Christ' (Deleuze & Guattari 1987, p.176). The politics of the face, then, consists of and in the way that it marks a standard wherein all faces are intelligibly fixed through reference to their degrees of difference or deviation from this despotic signifier, this White Man face.

Importantly, it is through this reference to the White Man face that faciality does the work of biunivocalization. Biunivocalization is a term specific to Deleuze and Guattari, and is used to make plain the power dynamics at work in processes of dichotomous thinking, wherein two terms are linked to one another through the act of defining one term according to the dictates of the other. Biunivocalization signals the process by which one term in a dyad overcodes or fixes the meaning of the other, so that the two terms become yoked together by what is ultimately a unitary, rather than a differential, logic – hence, *bi-uni*-vocal.

Deleuze and Guattari claim that we read utterances through reference to a signifying face that is always 'in biunivocal relation with another: it is a man or a woman, a rich person or a poor one, an adult or a child, a leader or a subject, "an x or a y"' (1987, p.177). It is through this biunivocal relation that the specificity of the face is transformed – biunivocal subjective positions become units of signifiance, units of intelligibility that combine and recombine, but always through an overcoded schematic hinging on degrees of derivation from the Christ face. Subjectivation works, then, through this process of (re)combination, and is comprised of a second aspect: whether or not a given face passes, that is, can be slotted into a given regime of biunivocal sense. Deleuze and Guattari write of the faciality machine's 'rejection of faces that do not conform, or seem suspicious' (1987, p.177). This rejection of the inassimilable is often followed by the creation of new divergence-types, new etiologies of deviance that more effectively subjectify that which seems, at first glance, inassimilable, improper – queer corporealities, for instance.

While the absence of the physician's face signals the invisibility of the modest witness, it also signals the diffuse omnipresence of the despotic signifier, the face that need not appear on account of its

entrenchment as standard-bearer. It can sustain invisibilization without risking disappearance – its lack of visibility is not commensurate with its illegitimacy or non-existence, but rather shores up its position as arbiter of the real, as mastercode. It is, even in its absence, always already present, its gaze and discourse provident of the exegesis for this image of capture, the mask that the viewer is expected to adopt as its own, constituted by its possession of the gaze that legitimately territorializes, not the body territorialized by the gaze. The modest witness is part of a larger machine invested in processes of identification, recognition, and identification, and the facial absence of the modest witness only further positions him as part of the 'abstract machine that has you inscribed in its overall grid' (1987, p.177). The face may not be present, but this does not in the least signal an attempt at what Deleuze and Guattari call becoming-clandestine, a fugitive refusal of the politics of faciality, a refusal of identitarian belonging secured by and through the signifiance of the face. In the instance at hand, the absence of the face is conjoined with a bodily absence, the authoritative and privileged gaze of the medical professional becoming that of the intended viewer at the same moment it signals the disembodiment and isomorphic subjectivity-objectivity of the modest witness.

This is decidedly not the case with the intersex body in question. The blurred face, in

concordance with this theorization of faciality, signals visually what we already either intuitively deduce, or have assumed given the contestatory field into which this image initially entered – a suspension of subjectivity, a liminal body, a body in limbo. While this photograph is historically poised on the cusp of conventions for concealing the identity of patients – a set of practices that began only in the late 19th century, gradually supplanting earlier portrait-style

images (Warner-Marien, 2002, p.42) – it is nevertheless important not to reduce the meaningfulness of subjective concealment to the level of ensuring patient privacy. If the face is a politics that overcodes the body, that forces the body to cohere beneath and with reference to the face, to form a coherent and unified appearance within a pre-given schematic of somatic intelligibility, then the blurring of the face is a visual strategy that decisively suspends subjective coherence. We know these genitals correspond to a person, there, present in the upper third of the image, but only tenuously does this person – as subject – exist. This is necessary, if the purposive function of the image is to perceptively dissect the genitals in order to adjudicate sex. The suspension of subjectivity enacted by the blurred face highlights the ambiguity of the corporeality pictured and, in so doing, posits the body as inhabiting the space of a caesura; a pause while proper subjecthood is recalibrated in concordance with the developing parameters of biomedical thought. There is a certain tension here between the ostensible function of the image (to prove Remy's 'true' sex) and the undecidability and ontological unsurety called up by this blurred face.

These tropes of the absent modest witness and the subjectively suspended intersex body abide throughout the twentieth century – let's look, for instance, at some shots from the Kinsey Archives at Indiana University, dating from the 1950s (see figure 2). The physician's hands have, in certain instances, been replaced by the hands of the patients themselves, while in others they are not only present in the image, but inserted in the patient, ostensibly documenting 'insufficient' vaginal depth. There are three other new introductions which seem to be heightened instantiations of the aforementioned tropes. The face is now either left entirely out of the

frame, cropped at the eyes, or blocked at the eyes by the ubiquitous black bar. In certain images metric sets are inscribed, documenting the age, height, and weight of the intersex body. Finally, the images have proliferated in number and perspectival variety. In many ways, these shifts are merely logical extensions of pre-existing tropes, the black bar doing the work of the blurred face; the metric sets further attesting to the flourishing microphysics of power operative in diagnoses of sex. What of the proliferation of shots, though? Later, in the mid to late 20th century, photographs of congenitally queer bodies will be presented in one of two ways – as shots documenting the patient over a succession of months and years during which they undergo hormonal regimens and surgical treatment to 'correct' sex (see figure 3), thus operating as documents of an enforced teleological journey towards the heteronormative promised land of proper dyadic, dimorphic sex; or as comparative images (see figure 4) that document similar cases with dissimilar outcomes, or dissimilar cases with similar outcomes.

In this image set from the Kinsey archives, however, in the absence of comparative or developmental documentation, the multiplication of photographic perspective alludes to another increasingly emphatic trope – what Linda Williams, in her book on hardcore porn, calls 'the principle of maximum visibility' (1989, p.49). This principle manifests in hardcore's privileging of close ups over other shots, the overlighting of too-often easily obscured genitalia, and the selection of positions that aim to display the intricacies of bodies and organs. She goes on to compare this principle with Edward Muybridge's motion studies, with their prominent grid of measurement attesting to his attempt to gauge the action of the body with increasing exactitude (1989, p.49). While this principle is certainly never estranged from medical

photodocumentation generally, with its aim to establish purely denotative and factic materials for study and professional use, it dovetails particularly well with the aims of documenting intersex bodies. This drive for the clearest possible rendering of a chimeric body merges with what Williams frames as the motivation behind the same principle in hardcore. Both are efforts to stabilize and render apparent (or, perhaps more accurately, to stabilize *through* rendering apparent) ever-elusive somatic aspects – for intersex bodies, the slippery and elusive evidentiary 'truth' of (dimorphic) sex; for hardcore, the documentation of what William's calls the 'thing' itself, thing being visible proof of female orgasm.

This motivational conjuncture of hardcore and biomedicine is the place at which the assumption of observational detachment veers, belies another possible motivation as well as a different way of viewing these congenitally queer bodies. It introduces questions of affect, the possibility of a passionate attachment to these images, to these bodies, an engaged and visceral response that is about something radically other than sex determination. These multiple images, meant to map the vicissitudes of what biomedicine terms sex deformity, speak also to the difficulty of drawing a line between the clinical and the pornographic. Not an anti-porn feminist, not sex-negative, and decidedly queer, this difficulty is of profound interest to me.

Williams positions hardcore as a genealogical derivative of Foucault's *scientia sexualis,* rather than belonging within a trajectory of erotic arts, and this derivation relies on a fascination with the unearthing of somatic mysteries and secrets pertinent to the composition of sex, gender, and sexuality – a drive to concretely render and stabilize the heretofore ineluctable, from the discovery of ovaries to etiologies of variegated genital structures. As such, the

sexological disciplines are close cousins of the stag film and the money shot. Moreover, their constitutive dialectic of concealment and revelation is not at all a stranger to queer discourses, to notions of outing, passing, and drag – albeit with one important and distinctive difference, in that beneath queer discourse there lies a less entrenched drive for the determination of sexed and sexual truth, a tendency to refuse to play what Foucault has called the 'truth game' of sex. Rather, queer performativity is constituted by a refusal of the original, the logic of the imitative or the bad copy (see Butler, 1990). Given the overlapping of the photographic practices of biomedicine and porn, how can we think the relation between the documentation of congenitally queer bodies and the representation of (other) queer bodies beyond the realm of the medical?

An important question, given the long institutional deployment of photographic technology as an apparatus of capture that attempts to clearly delineate and fix the meanings and practices of queer bodies – whether congenitally queer, in the case of intersex bodies, or otherwise queer, in the case of transfolk and gender non-normative (that is most, if not all, even 'straight-acting') gays and lesbians. Particularly when one discovers that each of these ostensibly separate species of queer were initially filtered through the figure of the hermaphrodite. Prior to the medical and social intelligibility of the homosexual, the modern gay or lesbian, and consisting still as parcel of homosexual intelligibility, is the notion of a 'hermaphroditism of the soul' (Foucault 1978, p.43) that which Foucault, referencing German psychiatrist and neurologist Carl Westphal's 1870 work on 'contrary sexual feeling,' understands as defined 'less by a type of sexual relations than by a certain quality of sexual sensibility, a certain way of inverting the masculine and feminine in oneself, in the form of an "interior androgyny" onto

which the practice of sodomy is transposed' (1990, p.43). Concomitant with the flourishing of medical discourse on the constitution of transsexuality in the 1950s and 60s we find that John Money, co-founder of the Johns Hopkins Gender Identity Disorder Clinic and specialist in both intersex and transsex/transgender disorders, writes on the diagnostic use of the term 'psychic hermaphroditism'. In a paper entitled simply 'Hermaphroditism' and appearing in the 1961 *Encyclopedia of Sexual Behavior*, Money submits both a synopsis of the differential deployment of this term as well as an intervention of sorts:

> Although its use is questionable, it is used from time to time as a synonym for homosexuality, transvestism, or contrasexism, the compulsion to have the body surgically and hormonally transformed to that of the other sex. The idea is that in these three allied conditions the patient is psychologically of one sex and morphologically of the other, and so is a hermaphrodite [...] the term psychic hermaphroditism implies a physical or constitutional basis for the discrepancy between sexual psychology and morphology. Theoretically and morally, the three disorders become more respectable, to some people, as a result of this implied physical etiology. (1961, p.483)

Money calls our attention to a few important aspects of the deployment of 'psychic hermaphroditism'. Firstly, that through the equation of homosex, transvestism, and 'contrasexism'(a diagnostic entity we now call transsexuality) with a disorder of sex that has a physical or constitutional – that is, visible, apparent, and thus irrevocably 'real' – basis, a certain legitimacy, at once biomedical and social, is granted. These attempts to legitimize queernesses that aren't immediately mappable as sex abnormality through recourse to medical facticity is heard repeatedly today in ongoing battles for queer legitimacy fought to secure legibility within conservative institutional and social realms. See the deployment of 'born that way'

explanations of queerness and the flourishing of genetic and neurological research on queerness and the constitution of 'brain sex'. Interestingly, Money refers to these conditions not as practically and theoretically separate, but as 'allied conditions', conditions that rely, for their own biomedical intelligibility as disorders constitutive of discrete modes of being, on linked discourses that work unilaterally to mark queer patients as *both subjectively distant from,* and *failures with reference to,* heteronormativity (understood as a total match of morphology, psychology, and desire along dimorphic, heterosexual lines).

Hermaphroditism, then, is the conceptual shibboleth of the queer, the figure that non-normative genders and desires are, and have been historically, understood through and in relation to. It is as if the spectrum of queer being is strung up between, at one pole, the dyad of the dimorphic heterosexual couple and, at the other, the hermaphroditic body. The conceptual centrality of hermaphroditism to both biomedical and popular queer intelligibilities is often overlooked within the arena of LGBT politics, shaped as it is by efforts to firmly distinguish shifting lines – of both amity and enmity – between these queer beings while attempting to maintain what is increasingly a solidarity of the homonormative. Gender studies pedagogy, too, devises heuristics to explain the dangers of conflating queer identities, of reading lesbianism into transgender practices, of confusing the concerns of intersex folk with those of genderqueers. There is a portion, subset, perhaps even subculture, however, that has formed against this endless entrenchment of queer seperability, of identitarian sects and boundary policing, and has instead aimed to blur these lines, to mediate against the enforcement of stagnant and categorial conceptions of queer being. This blurring is activated by a reclamation of queer corporeality that refuses the notion of a

transparent and mappable body as source and revelator of gendered truth. This refusal is the first step toward activating a process-oriented practice of relational queer becoming, without firm itinerary, without a final (male, female, or 'other') telos, that utilizes technologies of representation and reproducibility not to proffer homonormative 'positive representations', nor to transparently document the texture of queer lives, but as part-objects in assemblages that concatenate in processes of queer autopoiesis – that is, processes of becoming something other than taxonomic beings rooted in a long history of biomedical narratives of pathology, illness, and bodily impropriety.

Figure 1: The genitals of Eugenie Remy. Reproduced in Alice Dreger's *Hermaphrodites and the Medical Invention of Sex.*

Figure 2: Image set from the Kinsey Institute for Research in Sex, Gender, and Reproduction's file on Intersex Conditions

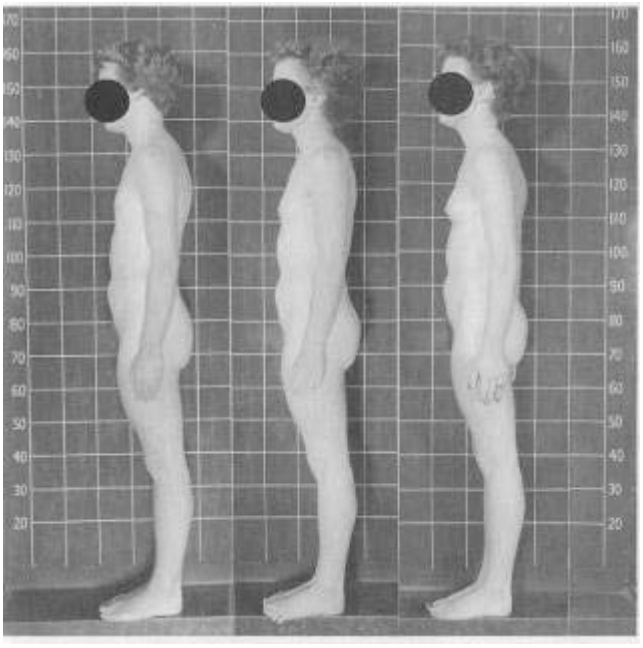

Figure 3. From the case files of John Money. Reproduced in John Money's *Sex Errors of the Body.* Baltimore, MD: The Johns Hopkins Press, 1968.

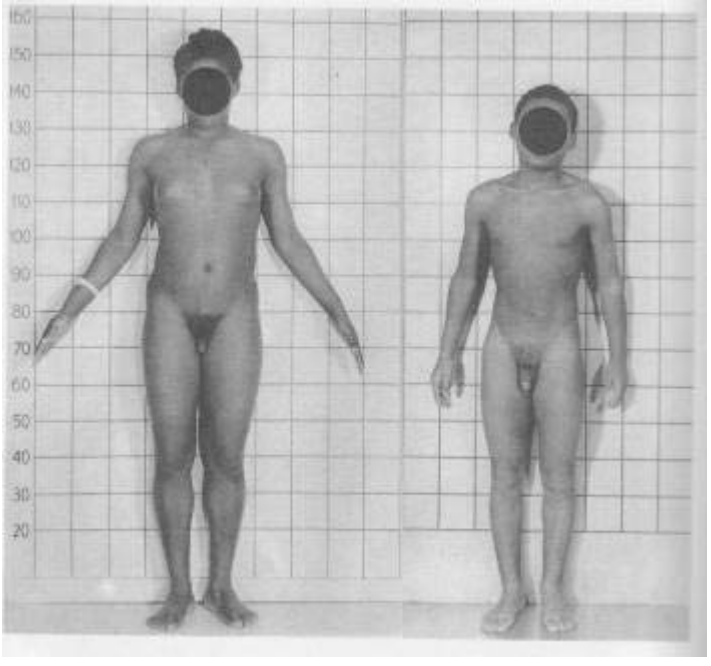

Figure 4. From the case files of the John Money. Reproduced in John Money's *Sex Errors of the Body.* Baltimore, MD: The Johns Hopkins Press, 1968.

Bibliography

Agamben, Giorgio. 2009. *'What is an apparatus' and other essays*. Stanford, CA: Stanford University Press.

Blacker, G.F. & T.W.P. Lawrence. 1896. A case of true Uunilateral hermaphroditism with ovotestis occuring in man, with a summary and criticism of the recorded cases of Tue Hermaphroditism. In *Transactions of the Obstetrical Society of London* (38).

Butler, Judith. 1990. *Gender trouble*. New York: Routledge.

Deleuze, Gilles & Felix Guattari. 1987. *A thousand plateaus*. Minneapolis, MN: University of Minnesota Press.

Dreger, Alice. 1998. *Hermaphrodites and the medical invention of sex*. Cambridge, MA: Harvard University Press.

Foucault, Michel. 1980. Introduction. In *Herculine Barbin: Being the recently discovered memoirs of a nineteenth century French hermaphrodite*. New York: Pantheon Books.

Foucault, Michel. 1978. *The history of sexuality: An introduction*. Vol. one. Trans. Robert Hurley. New York: Vintage Press.

Foucault, Michel. 1994. *The birth of the clinic: An archeaology of medical perception*. Trans. A.M. Sheridan Smith. New York: Vintage Press.

Haraway, Donna. 1997. *Modest_Witness@Second_Millenium: FemaleMan_Meets_OncoMouse: Feminism and technoscience*. New York: Routledge.

Karkazis, Katrina. 2008. *Fixing sex: Intersex, medical authority, and lived experience*. Durham, NC: Duke University Press.

Klebs, T.A.E. 1876. *Handbuch der pathologischen anatomie*. Berlin: A. Hirschwald.

Laqueur, Thomas. 1990. *Making sex: Body and gender from the Greeks to Freud*. Cambridge, MA: Harvard University Press.

Money, John. 1961. Hermaphroditism. In Albert Ellis and Albert Abarbanel (eds.), *Encyclopedia of Sexual Behavior,* 472-484. New York: Hawthorn Books.

Warner-Marien, Mary. 2002. *Photography: A cultural history*. London: Laurence King.

Williams, Linda. 1989. *Hard core: Power, pleasure, and the frenzy of the visible*. Berkeley and Los Angeles: University of California Press.