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Review

Revisiting the Claims of Past Medical Innocence and Good Intentions

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Abstract: Medical professionals usually reject critiques of deferrable treatments that alter the sex characteristics of infants and children without personal informed consent on the grounds that intersex adults' experiences reflect 'obsolete' practice. However, past practice is also protected from criticism by claiming 'good intentions', a commitment to the child's best interest and context-dictated constraints on medical practice. I first examine foundational literature of the Optimal Gender Policy to verify the presence of statements of interests or motives, I then collect affect displays to identify motives, and I observe attitudes to clitoridectomy. Affect displays point to motives that are relevant in interpretive sociology, as they allow access to cultural or institutional dispositions when justification talk has not been provided. While a statement of interest is absent from the foundational literature, I identify the following affect displays: (1) unease and disgust; (2) attachment to heteronormativity, as well as three kinds of gratification or pleasure rewards; (3) power pleasure; (4) surgical pleasure; (5) and cosmetic pleasure. As surgical action appeases some of these affects and nourish others, previous medical professionals had interests that were their own and not centred on the children. Examination of attitudes to clitoridectomy reveals that clinicians were aware of the (phallo)clitoris' importance to sexual pleasure but dismissed it, further invalidating claims that past practice was based on children's best interest.

Keywords: intersex; medical culture; motive; clitoridectomy; interpretive sociology

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1. Introduction

Medical professionals involved in bodily norm conformity of infants and children with innate variations of sex characteristics commonly reject criticism. Their treatment notably comprises deferrable surgical and hormonal treatments without personal informed consent, examinations, and pathologizing language. When these children get older and some manage to impart their lived experiences, question treatment, and demand human rights protection through a collectivized position of intersex subjects (Preves 2006; Bastien Charlebois 2019), they are dismissed or misrepresented (Chase 1998; Carpenter 2024). North American and European pediatric urology and pediatric endocrinology medical associations as well as authorities in the field claim that these intersex human rights-based perspectives are inapplicable to current management of what they now frame as Disorders of Sex Development diagnoses. Experiences and demands are deemed anecdotal, unrepresentative, biased, uninformed, or even harmful to today's children (Lee and Houk 2010; Mouriquand et al. 2014; Societies for Pediatric Urology et al. 2017; Subramaniam et al. 2020; Wolffenbuttel et al. 2018). Trauma and suffering are euphemized, cast as self-created fantasies, misinterpretations, "counterfactual thinking" (Lee and Houk 2010; Meyer-Bahlburg 2005; Money and Lamacz 1987; Sandberg et al. 2017, p. 492), or associated with outdated practices conducted by non-specialists 'many years ago' (Frimberger and Gearhart 2005; Mouriquand et al. 2014)[1]. Human rights approaches are resisted and framed as simplistic, non-scientific, illogical, unreasonable, polarizing, and a threat to parental rights (Mouriquand et al. 2014; Societies for Pediatric Urology et al. 2017; Subramaniam et al. 2020; Gardner and Sandberg 2018; Pediatric Endocrine Society 2020)[2].

According to medical professionals, current management would not produce significant negative consequences since it would now be considerate and profoundly improved, requiring but minute adjustments. As a case in point, the joint 2020 Consensus Statement on Management of Differences of Sex Development of the European Society for Paediatric Urology (ESPU) and the Societies for Pediatric Endocrinology (SPU) responded to increased human rights-based challenges from intersex actors and organizations, UN treaty bodies, human rights-based NGOs, and legislative bodies by insisting[3]

> We, physicians, who daily take care of children with a variety of congenital conditions... are committed to the current, as well as the future, health and well-being of all children entrusted to our care. ... It is ironic that the current controversy occurs at a time when we have made great strides in medical and surgical advances. (Subramaniam et al. 2020)

Although this stressing of improved practice implies an awareness of the failings of previous practice, this does not translate into acceptance of it being critiqued either. Intersex adults' frustration over medical professionals' firm refusal to take stock of the damage endured and implement changes that would protect children from the harm of bodily violation does not find any more receptiveness even when the focus is shifted to historic management. Medical professionals attribute benevolent motivation or 'good intentions' to 'well-meaning' or 'well-intended' predecessors and stress or imply the impossibility of selecting alternatives to treatment standards (Blondin et al. 2017; Lee and Houk 2010; Thomas 2004; Lee et al. 2023): "Doctors, especially perhaps those in the paediatric disciplines, have always been motivated by the wish to do what they genuinely believe to be in the best interests of their young patients and their families" (Thomas 2004, p. 47). At a French Senate hearing, pediatric urologist Pierre Mouriquand lamented the criticism of past practice: "We very often receive criticism and come under attack for the decisions we made. I wish they would accept to understand the context of that time" (Blondin et al. 2017, p. 193, my translation). Additionally, past treatment approaches are elevated to the status of gold standard. They are presented as the best medical professionals could envision and apply at the time: "These [intersex] individuals may also fail to recognize that prior care was within the standard of care that existed at the time" (Lee and Houk 2010, p. 2). They refer to the approach established by famous pediatric endocrinologist Lawson Wilkins and his team at Johns Hopkins Medical University, who were instrumental in securing management of infants and children with innate variations of sex characteristics. This approach has since been designated as the Optimal Gender Policy (Meyer-Bahlburg 1998) and encompass gender assignment decisions, surgical and hormonal options, as well as parental, child information management.

Early medical figures who worked with or trained under Lawson Wilkins also bring up context-dictated constraints on treatment decisions when confronted with criticism at the end of their careers or after they retired. This is the case of gynecologist and surgeon Dr. Howard W. Jones (1910–2015), whose promotion of clitoridectomies was still accepted as late as 1974 (Jones 1974) and he is known to have reacted strongly to critique: "Dr. [Howard] Jones bridled at being criticized, long after the fact, for performing such surgery. 'You are doing what the conventional wisdom around that time said to do.'" (Hutter Epstein 2015, p. A1). Equally, Melvin M. Grumbach (1925–2016), a pediatric endocrinologist who trained under Lawson Wilkins, shared with the Johns Hopkins Bulletin:

> [C]linicians who have built careers on treating intersexuals advise against judging past events through "year 2000" glasses. "We look through the retrospectoscope and say, 'My God! How did we do that?'" says Mel Grumbach, a pediatric endocrinologist who was a fellow at Hopkins in the early 1950s... "It's not fair. A lot has changed since then. We must learn from the advances that have been made rather than point fingers." (Hendricks 2000, under "Because so much has changed")

Claims of constraints dictated by context suggest powerlessness over treatment protocol decisions. Under that perspective, past social norms and medical knowledge limitations made better treatment options impossible. This applies to clitoridectomies and clitoral amputations. Current practitioners claim predecessors ignored the importance of (phallo)clitoral sensitivity in sexuality (Hendren 1998) or imply it through the casual enunciation of medical progress in developing knowledge on the clitoris (Baskin et al. 1999; Lee and Houk 2014).

These motivation- and context-based defences of previous management decisions have been made for around 25 years. However, they do not exceed a few sentences and have never been the object of medical articles. Older clinicians who drew from their professional experience to discuss past dispositions and context did so very succinctly, as illustrated by the previous quotes from Dr. Howard Jones and Dr. Mel Grumbach, and newer medical generations make these defences without referring to specific sources or documentation.

Past benevolent motivation and context as grounds for rejection of critiques have been employed in other social groups dynamics. A recent example is the reaction of educators working at residential schools and participating in assimilation endeavours of Canadian Indigenous peoples, as well as comments from theologians, legislators, columnists, or members of the public (Gulliver 2021; Justice and Carleton 2021; Turnbull 2021). 'Good intentions' are a tool of image restoration, used in diverse situations (Benoit and Drew 1997; Van Dijk 1992). They are not only availed of by social actors subjected to criticism, but also by sympathizers. When medical professionals invested in intersex management are concerned, the good intention defence has an added dimension. It is also brought up by social actors criticizing their practice. Intersex activists, social scientists, journalists, and human rights organizations alike mention that they understand that past medical professionals were 'well-meaning' or had 'good intentions' (Intersex Society of North America 2004; de María Arana 2005; Feder 2011; Guterman 2012; Reis 2020; Cabral 2019; Horton 2023). That social actors feel that such a statement is required when submitting critiques to medical professionals reveals the degree to which our 'Western' cultures readily assume benevolent motivations behind their actions[4]. Failing to utter it would be perceived as unfair criticism of medical professionals and compromise the social acceptance of grievances.

Nevertheless, good intention and context defences are getting challenged in some areas. Social actors criticizing colonialism and racism underscore the importance of examining past statements before assuming benevolent motivations (Heath Justice and Carleton 2021; Gulliver 2021; Turnbull 2021): "Arguments that Canada's Indian Policy was well-intentioned and humanitarian in nature must be evaluated against the harsh, condescending, and, at times, self-interested statements of the individuals who framed and implemented that policy" (Truth and Reconciliation Commission of Canada 2015, p. 112). In the field of intersex management, Juan E. Méndez (2014), the UN Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment stated that intrusive, irreversible, non-consensual, and non-therapeutical practices on "patients from marginalized groups" constitute forms of torture or ill-treatment despite medical claims of good intention (p. xvii). Feder (2015) argues that medical professionals insisting on good intentions while refraining from repairing the harm they caused does additional wrong. Peck and Feder (2017) argue that institutional pressures on intersex management did not morally dispense medical professionals with examining the effect of their actions.

Social science literature on intersex management has submitted important insights into medical professionals' motivation for securing control of bodies whose sex characteristics they consider as unfit to be classified as male or female. Redick (2004, 2006) and Reis (2009), investigating the inception of the Optimal Gender Policy by pediatric endocrinologist Lawson Wilkins's team at Johns Hopkins, both uncovered how medical professionals grew increasingly uncomfortable at waiting for intersex individuals' confirmation of their gender in the 1930s and 1940s. They suspected that some of them may be homosexual and attempt to evade law enforcement by posing as a sex (gender) they were not[5]. For medical professionals to solve that uncertainty required that they develop a treatment

approach that would allow them to intervene systematically on newborns. Examining management practice once it was institutionalized, Kessler (1990) has shed light on medical professionals' heteronormative lenses when reading of intersex(ed) bodies and treatment decisions. She later unveiled the intensity of disgust towards intersex genitalia but did not situate that discovery in a reflection on medical professionals' motivations (Kessler 1998). Feder (2011) did but focused exclusively on this affect "as a motivating force" for intersex management (p. 623). She came to question the assumption of good intentions after being confronted by expressions of disgust from medical professionals: "... [H]is disgust would disrupt my willingness to attribute good intentions not only to him, but to those physicians who continue to recommend and perform cosmetic genital surgeries" (p. 638). Her observations are mainly drawn from medical statements contemporary to her research. When interviewing medical professionals in the 2000s, Davis (2011) uncovered financial interest as one reason why some would resist intersex demands for self-determination. Although enlightening, these social science works did not have past motivations as the main objects of their research.

While researching an extensive amount of medical literature for a book project, I came across content complicating both claims of a practice guided by a commitment to a child's best interest, and the impossibility of considering other treatment options that would better serve them. This inspired me to bring this material together and add depth to motivation and context in the medical management of intersex children. Although both could be examined separately, they are closely related in medical discourse. Context defences are used to sustain the idea that past medical professionals centered their decisions on children's best interest as they had no better knowledge to base them on.

The main question I pursue is: whose interest did the previous management centre on? This entails illustrating the extent of motivations displayed and examining available knowledge for decision-making. Given that this last dimension could be broad, I will focus on knowledge and attitudes about clitoridectomy. This endeavour is heuristic or exploratory and does not aim at establishing quantified distribution of interests or motivations. It rather aims at documenting the range of motivations expressed at intersex management and examining whether these concurrent motivations are compatible or not with 'best interest.' This analysis of motivations will improve understanding of intersex management medical culture and the dispositions it allows or fosters.

2. Materials and Methods

Looking for intentions behind social subjects' actions has been the object of critique by researchers across various disciplines (Duranti 2006). Not only can "intention" be envisioned differently from one language to another (Duranti 2006, p. 34), but reflexivity, planning, or deliberateness cannot be presumed behind every action and discourse (Duranti 2006; Van Dijk 2006). While medical professionals' defence often draws on the "good intentions" figure of speech, we cannot presume that treatment decisions and protocol elaboration all stem from a reflexive stance. A common denominator would be motive, which can be open to grounds as much as to emotional force behind actions, to stated end goals as much as to initial impetus for action (Campbell 1996).

Although sociology has mainly abandoned this wider understanding of motives after Charles Wright Mills (1940) influential proposal to reduce it to the production and tailoring of justifications to the situations where they are anticipated or requested, Campbell (1996) argues for its relevance. He agrees with Weber's ([1922] 1947) position that motives are key to explain actions, as actions that look identical at first glance will be different in nature depending on the subjective meaning they have for the actors. Campbell (1996) reframes motive as "a complex of meaning and affect which serves to energize action" (p. 106). I consider it important for sociology not to discard motives or affect displays as irrelevant to analysis. If they are not met with reprobation and corrective measures from the institution within which they emanate, it indicates that this institution allows it. If they are expressed by social actors as they establish practices that are quickly adopted and become greatly

influential within the institution, it indicates validation. Repetition of motives or affect displays from different social actors participating in this practice within the institution means a shared disposition, either as a subculture within a discipline or a discipline's culture itself. By ignoring them and solely focusing on rationales, though, we cut ourselves from a deeper understanding of social dynamics. This is especially the case when reasoned motivations, justification talk, or accounts from direct actors are absent or minimal, which applies to the dynamics at play in past medical management of intersex bodies.

Motives or affects are a delicate dimension to tease out of utterances. But, emotional investments being present even in dominant perspectives whose language is unmarked and incorrectly cast as neutral, I posit that it is possible to approach motives by extracting affect displays in speech acts. Emotions expressed towards a situation deemed undesirable and around actions undertaken to solve it can point to investments and motivations proper to the speaker—and others in his social or institutional group. Given the specific medical claim of serving the child's 'best interest', I will pay attention to who is the beneficiary of a medical professional's quelled or nurtured emotion in intersex management.

The emotional investments are those of clinicians active before public intersex critique. I carefully approach later declarations as they could be post hoc accounts, whereby past actions privately motivated by personal interest or prejudice or previous values are publicly justified by principles enjoying current social acceptability (Winchester and Green 2019). The first step of this analysis is to verify whether statements of intentions were part of the Optimal Gender Policy foundation or not. The sample material covers all documents published by Lawson Wilkins's team from Wilkins's (1950) seminal *The Diagnosis and Treatment of Endocrine Disorders in Childhood* through to the formal presentation and promotion of the driving principles and methodology of what will later be called the 'Optimal Gender Policy' in the *Bulletin of the Johns Hopkins Hospital* (Money et al. 1955) and *Pediatrics* (Wilkins et al. 1955), and ending with Money's Hermaphroditism chapter in the *Sexual Behaviour Encyclopedia* directed at social scientists (Money 1961)[6]. Since the rationale of an approach should be presented at its inception, this selection should suffice in locating the stated intention and its form. This should especially apply to invasive non-consensual treatments that do not aim at sustaining life yet produce fundamental and irreversible change.

The second step of this analysis is to look for affect displays from medical professionals involved in intersex management before intersex critique. This period spans from Wilkins' 1950 seminal book to 1994–1995, when the Intersex Society of North America (Intersex Society of North America 1994–1995) sent its first *Recommendations for Treatment pamphlet* after its foundation following Fausto-Sterling's (1993) essay in *Nature*. This examination does not encompass all material from that period, as the identification of alternative motivations suffices to provide a more adequate portrayal than the current one. Material includes medical literature, comments, editorials, speeches, medical reports and, since some affects are only expressed while discussing practice in general, interview excerpts or transcriptions of audiovisual recordings.

The third and last step addresses constraints on treatment options, most specifically the performance of clitoridectomies. It can be assessed through medical disagreements or hesitations towards the proposals of the Optimal Gender Policy. This can span again from Wilkins (1950) through to the presentation of the Reimer experimentation (Money and Ehrhardt 1972). This is based on Grumbach's statement, which claims the Optimal Gender Policy only found general acceptance after the presentation of the Reimer case (Colapinto [2000] 2006). For this three-step endeavour, I draw on extensive reading of the medical literature on intersex management since Wilkins's (1950) seminal book and close examination of the successive development and purchase of arguments supporting treatment aspects. The total intersex management medical literature read from the 1950 to 1993 period amounts to 126 publications.

Selection of quotes has obeyed the following principles. While I had to draw from the Lawson Wilkins team for stated interest, I took care of using quotes illustrating motivations or expressing views on clitoridectomy from clinicians who were well known or established

in the field before public intersex criticism. Given the delicate nature of the observations I make and the frequent indirectness of motivations, I provide up to three examples for each. This limits the risks of these motivations being discounted as isolated and supports the idea that they are worthy of in-depth investigations, to the extent that such an endeavour is feasible. I have increased quote selection to five on awareness of the importance of the clitoris to compensate for the shorter exploration of context.

Given that this article examines published and public medical discourse on intersex management, it is no interventionary study. Protective ethical measures are not required in this context.

3. Results

3.1. An Absence of Stated Interest

When initiating and sharing the Optimal Gender Policy (1950–1961), the Lawson Wilkins team does not mention whose interests it serves. Treatment recommendations are first introduced with statements on sex/gender determination. While intersex individuals are eventually mentioned as recipients, in what regard these sex characteristics constitute a problem in need of a surgical and hormonal solution is cursorily raised in two articles. Nowhere is data submitted to the effect that people with atypical sex characteristics are generally suffering from their difference. Even when broadening the scope to objectives, we are left with rare, indirect, and vague statements. In the 1950–1961 period, only three passages allude to interest or objective. Two come from Wilkins and his colleagues when they present their protocol in Pediatrics:

Uncertainty, protective secrecy or social ostracism make it difficult for the child to adjust properly. . .

> It is obvious that unless there is a fairly well-developed phallus the patient cannot function as a male and will be subjected to constant humiliation and embarrassment throughout life. (Wilkins et al. 1955, pp. 287, 296)

Or again, by Hampson et al. (1956), after the formal launch of the Hopkins approach:

> Few would dispute that the ultimate objective in the treatment of any hermaphroditic patient is to ensure the establishment and maintenance of a stable and pervasive gender role. (p. 548)

Wilkins et al. (1955) bring up adjustment difficulties due to social ostracism (p. 287), and express worry at the potential of "humiliation and embarrassment" for men with an 'underdeveloped phallus' (p. 296). While Hampson et al. (1956) do mention an "ultimate objective" (p. 548). In both cases, however, treatment recommendations are not answering an assessment of mental health risk among intersex people. We already know from his thesis that Money (1952) was surprised to observe so little mental afflictions as well as the capacity to develop a feminine or masculine 'gender role' despite strongly atypical sex characteristics (Colapinto [2000] 2006)[7]. This was also repeated in the early writings of the Psychohormonal Research Unit, after they conducted additional interviews (Hampson 1955, p. 266; Money et al. 1956, p. 53). While penis size mentioned by Wilkins et al. (1955) is indeed associated with great anxiety among many men in our societies, they leave the male function and the 'obviousness' of failing at it unexamined. 'Fairly well-developed' remains eminently subjective, as both individual medical professional impression and standard imply judgment. What the intersex individual would make of this function and evaluation of 'underdeveloped' is not explored. It does not substantiate that fabricating a body, approximating female medical norms, without that individual's express desire is 'obviously' in their best interest. Moreover, Wilkins et al. (1955)'s promotion of the protocol does not address all situations for which they deem invasive surgical and hormonal modifications imperative. For instance, nothing is mentioned of how amputation or clitoridectomy of (phallo)clitorises or performance of vaginoplasties on children they assign as girls would be in their interest.

In sum, statements of intentions are absent from most 1950–1961 literature and vaguely broached in two articles. Given that suffering to the point of needing systematic interventions without personal consent is not demonstrated, the idea that it is in intersex individuals' 'best interest' to be subjected to them is groundless. Furthermore, "Establishment and maintenance of a stable gender role" (Hampson et al. 1956, p. 548) lends itself no more to having the interest of the intersex individual in mind as to caring about the preservation of a heteronormative gender order. Some may still argue that the absence of assessment does not preclude treatment decisions founded on a desire to serve intersex individuals' best interests, even if left unstated. After all, Hampson et al. (1956) present their objective as obvious or taken for granted with "Few would dispute" (p. 548).

If 'interest' has the intersex individuals as recipients, however, it is solely determined by the team members' presumptions. Wilson's team has solicited no input from intersex individuals on what treatment approaches they consider to be in their best interest. In fact, at the very moment of its inception, the Optimal Gender Policy was met with protest from some distressed children. This is illustrated by Money et al.'s (1955) reaction to a three-year-old's acute distress at being subjected to a non-urgent surgery he did not consent to: "[H]e had grossly misconstrued his surgical experiences to signify that his penis was being mutilated…" (p. 298). Not only is this child's fright over what was done to his penis dismissed, but this article contains many passages ridiculing his response. His wish to preserve his penis is not accepted, as the team simply decides to postpone the other operations.

In the absence of direct claims, determining whether medical professionals were motivated by children's best interest or other interests will better be answered by documenting and examining affect displays throughout the period preceding intersex critique (1950–1993). These affects emerge when describing intersex bodily difference and conjecturing on their future social, sexual, or love life, as well as when discussing treatment and surgery. As they only are expressed by medical professionals, it cannot be surmised that they are shared by intersex individuals. Moreover, many of these affects follow mentions of actions only medical professionals execute. As such, actions undertaken by medical professionals are susceptible to quell or feed these affects.

I have identified five affect display types that can be independent of caring for an intersex individual's well-being or serving their interest. I have observed (1) unease and disgust; (2) commitment to gender norms, as well as three kinds of gratification or pleasure rewards: (3) power pleasure, (4) surgical pleasure, (5) and cosmetic pleasure. I have selected some quotes as illustrations for each of these affect types.

3.2. A Motivation to Quell Unease and Disgust

Unease and disgust have already been exposed by Kessler (1998). While significant, the list she submitted is not exhaustive, thus illustrating the importance of this affect. Here is a selection:

> Diseased nature oftentimes breaks forth in strange eruptions. (King Henry IV, Act III, Scene I, line 27, quoted in the preface to Jones and Scott 1958)
>
> The excision of a hypertrophied clitoris is to be preferred over allowing a disfiguring and embarrassing phallic structure to remain. (Gross et al. 1966, p. 300)
>
> Failure to [proceed with surgery] will leave a button of unsightly tissue. (Kogan et al. 1983, p. 748)

The disgust and unease expressed at atypical sex characteristics belong to the medical professionals and not the intersex individuals. In Lawson Wilkins's famous surgeons Jones and Scott's (1958) case, the quote has particular significance. It precedes the introduction to a book designed to instruct fellow practitioners in the surgical standards and approaches they developed and applied, thus broadcasting what sentiment drives their practice. Their attribution of 'diseased nature' to sex characteristics is more than framing them as a pathology, that is an undesirable state that must be altered. It imbues them with

tragedy and presents them as a trouble for normalcy, 'erupting' as they do into expected naturalness. This quote is no objective, dispassionate description. The surgical approaches and techniques Jones and Scott presented are meant to deal with the tragic existence of atypical sex characteristics, to counter the trouble they cause.

The intensity of unease is manifest in other passages where disgust is openly expressed. Gross et al. (1966) and Kogan et al. (1983) present atypical sex characteristics as utterly undesirable to their eyes. The affects in these passages are not externalized and attributed to other social actors or intersex individuals but emanating from medical actors. The most generous interpretation would be to allow for an omission based on a purported obviously shared affect among all social actors. What reveals medical professionals' proper investment, however, is their perceived imperative of immediate surgical modifications trumping recipients' own consideration of what would be in their best interest. Abstaining from performing surgery would be a failure. Not intervening would be allowing undesirability, sexual freakiness, or unsightliness. The urgent performance of deferrable surgery without personal informed consent is considered by these medical professionals as a necessary response to the repulsion they experience when seeing atypical sex characteristics. In essence, surgery treats their disgust.

3.3. A Motivation to Preserve Gender Order or Heteronormativity

After the turn of the 1940–1950s, where Reis (2009) and Redick (2004, 2006) observed a wish for the systematization of intersex management stemming from doubt about self-declared gender identity, motivation to preserve gender order has been present in further texts. These are manifest from the inception of the Optimal Gender Policy up to the latest publications preceding intersex critique. In her groundbreaking work arising out of interviews with leading medical professionals in the field of intersex management, Kessler (1990) identified heteronormativity at play in treatment format and decisions. I also identified further examples.

> Dr. LAWSON WILKINS: Now, what should we do with those intersexes?
>
> (under "Discussion" section of Joan Hampson 1956, p. 130, proceedings from a symposium held on the 3–4 September 1954)

One of the few fundamental aspects of life is that of sex. Its normal functioning is vital to the survival of our race. . .

> [An intersex child] conjures up visions of a hopeless psychological misfit doomed to live always as a sexual freak in loneliness and frustration. (Dewhurst and Gordon 1969, pp. vii, 1)

> Perhaps the most traumatic failure to meet our expectations of normalcy is presented by sex errors of the body. Genital abnormalities, in particular, challenge the basic tenets of our identities as men or women. We regard the sex we are as an eternal verity. It lies at the core of our being and is therefore sacrosanct. One of the great mysteries of creation, it is not to be tampered with, explored, analyzed, explained, or questioned. To do so is to debase it. This mystification of sex leaves no room for doubt, no place for ambiguity. The first thing asked of every new human being is whether it is a boy or a girl. It must be one or the other. There are no additional categories. (Louis Gooren 1994, preface author in Money 1994, p. ix)

Motivation to preserve gender order is implicit. It appears when we observe medical professionals lamenting over being unable to agree on the proper "sex" of a child or—as is the case with Wilkins (Hampson 1956, under "Discussion" section, p. 129) and some peers—not being able to dictate the proper sex at birth (see note 7 above). That atypical sex characteristics cannot be left as they are denotes how medical professionals see them as unsuitable with strong notions they hold of sex, gender, and sexuality. Wilkins's "what should we do with those intersexes?" (Hampson 1956, under "Discussion" section,

p. 130), which he uttered during a talk with colleagues at a symposium before the formal announcement of the Optimal Gender Policy, follows not a presentation on why intersex individuals would need having their sex characteristics modified without their consent, but simply a mention that their bodies are not readily classifiable in a male/man or a female/woman sex/gender. This is said in a context where Wilkins does not ignore that previous clinicians would wait until puberty to confirm an individual's gender and where he prefers a protocol that would systematize management at infancy. Flexibility is undesirable to him and to some peers. Furthermore, the fact that he and his team would have assignment standards that follow strict heterosexual norms of penovaginal sex (i.e., Wilkins et al. (1955)'s "serviceable vagina" (p. 296) or '(non-)fairly well-developed phallus') is an indication of his and their investment in maintaining heteronormative sex/gender.

A few years later, Dewhurst and Gordon (1969) depict the risk of not managing intersex people by evoking boundless threats. Their stressing of how the "normal functioning of sex" is "vital" for the "survival" of humanity draws from heteronormative dread of queer sex whose marginal existence could topple the collective capacity for reproduction. Threat is also implied with the 'misfit' categorization. While worry about the intersex individuals' future is present, it is mingled with strong affect regarding the impact of their existence on society. The 'sexual freak' depiction conjures up danger and unease. In what sense that individual would be a sexual freak is left unsaid. In that context, it could be the haunting trouble of homosexuality with bodies too similar with one another for heteronormative comfort. It could be objects as recipients of desire with fetishism, so-called active–passive roles, sex work, sexual acts, or even invasive behaviour. It also is a mystery how purported loneliness would allow sexual activity. All this reflects unformed thoughts and further strong affect from these professional medicals. The imperative of sexual normalcy also serves to appease these medical professionals' fear of disorder.

Invited by Money to write the foreword to the second edition of his *Sex Errors of the Body* (1994), professor emeritus and endocrinologist Dr. Gooren offers a flowery statement over the preciousness of conventional sex convictions: "eternal verity", "core of our being", "sacrosanct", "one of the great mysteries of creation" whose questioning would "debase it" (p. ix). It is a further illustration of how medical professionals can hold sex, gender, and sexual norms dear. Sexual ambiguity should have no place and its existence is an affront to the sacrosanct nature of sex and the great mysteries of creation. While he does not call out for surgeries, his statement as well as the fact that it introduces Money's second edition of a book on intersex management implies their execution. Ambiguity is to be erased, as its presence risks the questioning of norms, which is not to be allowed or tolerated.

3.4. A Motivation to Experience the Pleasure of Power

The pleasure of power is hinted at occasionally. Overtly stating that we love to exercise power over other people's lives goes counter to shared cultural expectations. Still, one can find examples of older medical professionals who have expressed delight at having the possibility to impact intersex bodies so profoundly. Two of these examples are retrospective, but still relevant given that it lends itself to critique and thus does not indicate self-censorship:

> Nothing in medicine is more spectacular and gratifying than the prevention or control of virilization in female pseudohermaphrodites which resulted from the discovery in 1950 that virilizing adrenal hyperplasia can be suppressed by physiologic doses of cortisone (Wilkins 1957, pp. 214–15)

> Doctors were very influenced by the twin experience... That's powerful. That's really powerful... This case was used to reinforce the fact that you can really do anything. You can take a normal XY male and convert it into a female in the neonatal period, and it won't make any difference. (Grumbach, interviewed by Colapinto [2000] 2006, p. 76, emphasis in the original)

> REPORTER JACKIE POU: "The criticism is always, these doctors are playing God."
>
> Dr. TERY HENSLE: "No. I used to. And I really liked it. [laughs:] But it wasn't the right thing to do." (ABC News Nightline and Pou 2015, 5:28–5:38 min)

Wilkins's (1957) quote illustrates that he relished the spectacular changes the treatment he devised managed to produce in people's bodies, not as an answer to their wishes, but guided by his belief that the presence of a uterus dictates a female gender. Traditionally and for decades to come in some cultures, many individuals of this variation were assigned male and had developed a male identity. Having and exerting the power to produce this high degree of change is gratifying, that is, it gives pleasure and satisfaction. Grumbach, who trained under Wilkins, also illustrates the pleasure of being able to do "anything" (interviewed by Colapinto [2000] 2006, p. 76) to an intersex individual, implying the availability of a range of options that medical professionals get to pick. Although he veils his own affect behind a collective "you" (p. 76), he does not exclude himself from it. He implies a shared disposition with colleagues. In this context, his stressing and repeating of "powerful" (p. 76) involves more than strictly being convinced by the Reimer twins experiment of Money. It indicates enthusiasm at the actions medical professionals can undertake with that knowledge, that is, again, determining something as decisive and far-reaching as one's body and one's gender, with the expectations and treatment they will be subjected to in all areas of social and intimate life. Dr. Tery Hensle, pediatric urologist and professor emeritus at Columbia University, first reacts with a "no" to reporter Jackie Pou's mentioning of the 'doctors are playing God' critique. He quickly relents and says that it had been the case, locating it in the past. He adds that he liked it[8]. Since 'playing God' is a metaphor, it cannot be construed as an avowal of seeing oneself as God. It nonetheless indicates an enjoyment of the decisive power one can exert over another person's life and body.

Wilkins' "Now, what should we do with those intersexes?" (Hampson 1956, under "Discussion" section, p. 130) also involves power. From the outset, the sentence casually communicates medical authority. Medical professionals benefit from the leeway to secure management of intersex bodies/individuals and exclusively decide how it is devised, while taking that privilege for granted and obvious. The State has not requested the establishment of a protocol, nor did civil society, parents, or intersex individuals themselves. 'What should we do' convokes medical peers to joint deliberation, where they enjoy the authority of considering approaches without the pressure of accountability. In contrast, 'those intersexes' announces intersex individuals as distant, otherized, and passive figures. Their powerlessness is obvious, but that does not make medical professionals pause over this imbalance. Even if this is part of a medical paternalism deeply ingrained at the time, the cultural context cannot deny the pleasure derived from exerting so much power over intersex individuals' lives.

3.5. A Motivation to Experience the Pleasure of Surgery

Then comes the pleasure of surgery. Though not expressed in the original Optimal Gender Policy literature, I postulate that surgical practice in pediatrics is not isolated from general surgical culture. One would expect appreciation of surgical practice to get into surgical specializations. Here are quotes from two surgeons who achieved fame in intersex surgery before the emergence of intersex criticism and one from another who is head of a surgeon association:

> As reconstructive surgeons, often excited by what progressively appears in our hands, we are tempted to focus mainly on the immediate outcome of the surgical procedure rather than on the long-term results (Passerini-Glazel 1999, p. 1592)
>
> And after having, I would say, the pleasure—and let us not take it superficially–of the achievement, as one would say in English, of realizing with our hands the [surgical] project we have conceived. . .

(Nihoul-Fékété, interviewed by Dubosc 2009, 10:30–10:46 min)

> I love to cut. Many a resident has heard me say. . . "I can't believe somebody is paying me to do this.". . . At some time in your education, you were injected with the addicting drug called "surgery". You had and/or developed panache. You have become a very successful surgeon, which affords you job security, financial comfort, great respect in your community, and daily personal interactions that are profound and fulfilling. Best of all, when you go to work, you get to cut. (Thirlby 2007, p. 429)

Thirlby (2007), a president of a US medical association, portrays his relationship to surgery in such a way that he expects his eagerness and excitement to be a shared affect among surgeons. He does surgery because he loves it. Although pleasure at work activities is idealized and not problematic per se, it becomes complicated when the surgical practice one is trained in comprises or mainly consists of deferrable operations done on individuals without their informed consent. This enthusiasm seems to be general and applies to intersex management surgeons themselves. Surgeon Passerini-Glazel (1999), creator of a popular vaginoplasty technique, alludes to shared excitement among peers about their surgical practice to explain their tendency to negate the relevance of critique coming from people who testify it has harmed them. Eminent and retired French surgeon Nihoul-Fékété (Dubosc 2009) talks about her relationship to surgical practice and underscores the pleasure she draws from surgical practice. Considering that pediatric urology was developed in good part around intersex management, I surmise that these medical professionals would have an interest in having access to that important source of pleasure. In that regard, I agree with Iain Morland's (2005) assessment: "In the conventional medical approach to intersex, the subject is the surgeon, and the patient the tool of his professional desire" (p. 338). Older pediatric surgeons' interest in experiencing surgical pleasure enters into conflict with intersex individuals' best interest, as they also have a personal interest in promoting a surgical plan to parents.

3.6. A Motivation to Experience the Pleasure of Seeing Desirable Genitalia

Finally, there is the gratification felt when achieving 'pleasant-looking genitalia.' This one is the most controversial observation. I heard it being discussed in the community in informal contexts, but to my knowledge it has not been written publicly.

> The anterior wedge excision results in a more delicate feminine glans clitoris. (Newman et al. 1992, p. 647)

> Most pediatric urologists believe that the surgical procedures they currently use result in cosmetically pleasing external genitalia and a clitoris that has the potential to retain both sensory and erectile function. (Aaronson 2001, p. 190)

> When I turned 25 years old, I asked for my medical records.
> The medical report said that if my clitoris was removed, it would be more beautiful and feminine. It was even written: This intervention made a very pleasing cosmetic effect (Holmes, interviewed by Radio-Canada.ca Zone Société 2017, italics in original to highlight English quotation, translation mine)

Expression of medical satisfaction towards cosmetic results of surgery appears in pre-intersex critique literature or in later old-timer surgeons' assertions. Describing the result of clitoral reduction as a 'delicate' clitoris draws from a sexualized lexical repertoire, as do 'cosmetically pleasing genitalia' and 'very pleasing cosmetic effect'. These comments cannot be discounted as coming from untrained clinicians unrelated to the medical professionals who specialized in intersex management. The surgeon who performed the amputation of Professor Morgan Holmes in 1975 when she was seven is Robert Douglas Jeffs (Holmes 2015), hailed as a founding father of North American pediatric urology. Aaronson's (2001) comment also indicates that he considers his affect towards cosmetic results to be shared by colleagues. It remains that even when surgeons abstain from using words denoting sexual appreciation, what they consider to be 'cosmetically pleasing genitalia' cannot escape their

own sexual taste. External genitalia must be pleasing to the eye while females/women assigned must satisfy surgeons' sexual ideals of penetrability.

3.7. An Examination of the Constraints of Context

Despite claims of past practice being constrained by context, one can find through Wilkins's teams' literature different allusions or even direct answers to opposing views on intersex management. The Optimal Gender Policy first was a response to an 'idiosyncrasy' of approaches—from the wording of Money himself—preceding and existing at its inception. Although many medical professionals were swayed by Lawson Wilkins' authority and prestige after its formal launch, it still was met with doubt, specifically regarding the necessity of early and definitive gender assignment. It was expressed from Cappon et al. (1959), Armstrong (1966), Zuger (1970) or, to a lesser extent, Grumbach (interviewed by Colapinto [2000] 2006), but they did not gain ground because they were severely rebuked by Money and his followers, whom he had gained since his association with Lawson Wilkins.

Specific reservations about clitoridectomy can also be found in the literature since the very early days of the protocol. Even though the structure of the (phallo)clitoris has been little investigated for several decades, there already was knowledge of its importance for erotic sensation. Freudian prejudice relegating it to a secondary role in sexual development did circulate but would not erase that knowledge. Here is a selection of discussions on the advisability or not of clitoridectomies—emphases are mine:

> There should be a complete extirpation of both corpora cavernosa and not merely amputation which will leave a hard stump. Although some workers object to this procedure on the grounds that it may deprive the patient of future sexual gratification, the writer believes that it is justified because it removes some of the tensions and problems which cause serious difficulties. (Wilkins 1950, p. 224, emphasis mine)

> Dr. ROBERT J. McKAY Jr.: Anatomic studies have shown that the nerve endings responsible for erotic sensation in the genital area of the female are located in the labia minora and the foreskin of the clitoris. Therefore, if clitoridectomy is to be done, the cavernous portion of the clitoris should be removed, leaving the skin intact. (under "Discussion" section of Joan Hampson 1956, p. 134, emphasis mine)

> Although the importance of the clitoris to the female for satisfactory erotic stimulation during active sexual life is not settled, there is some evidence that it may be necessary (Bongiovanni 1963, p. 68, emphasis mine),

> . . .certainly not advisable unless there is a definite indication. However, it is questionable whether the clitoris is essential to normal adult sexual life. Kroger and Freed state, "In the child the clitoris gives sexual satisfaction, while in the emotionally mature woman the vagina is supposed to be the principal sexual organ." (Platt 1963, p. 152, emphasis mine)

> Whilst in theory preservation of the glans has some thing to commend it, the results of amputation appear satisfactory (Dewhurst and Gordon 1969, p. 41, emphasis mine)

As early as 1950, in his first edition of his seminal book, Wilkins evokes objections to clitoral amputation from colleagues—'workers'—on the grounds that it is crucial for sexual pleasure. Removal of an individual's (phallo)clitoris would go so far as to deprive them of that experience. Wilkins's (1950) answer to their objection means they are significant enough for him to feel the need to justify his approach. His justification for such a surgical approach and its concomitant gender assignment, however, was of acute vagueness: "removes some of the tensions and problems which cause serious difficulties" (p. 224). Nowhere in his book does he expand upon it. That such triple vagueness (tension–problem–serious difficulties) failing at coalescing into reasoned thought sufficed to caution infringement on children's

bodily integrity is additional illustration of the immense authority enjoyed by medical professionals. This authority would transmute individual and amorphous subjective conviction into scientific truth. In 1955, in a discussion between peers involving Wilkins, who promotes the approach he and his team developed, Dr. McKay Jr. (under "Discussion" section of Joan Hampson 1956, p. 134) voices his concerns over amputation. Although he is mistaken in reducing sensitivity to labia or foreskin, he nonetheless brings up the risk of compromising erotic sensation with this type of surgery. Wilkins' team member Joan Hampson's (1955) work on the supposed non-prejudicial effect of clitoridectomy on sexual pleasure is then brought up in that conversation as an attempt to assuage his fears. While Wilkins' team concludes thus, they did initiate that research as a response to apprehension from peers.

Hesitation remains even after the establishment of the Optimal Gender Policy. The importance of the clitoris for sexual pleasure is first mentioned or hinted at, but then cast aside through an 'it's-important-but-not' rhetorical dance, as we observe in statements from Bongiovanni (1963), Platt (1963), and Dewhurst and Gordon (1969). All hints at possessing arguments without producing any, or are content with superficial answers, like evoking the capacity for sexual pleasure of African women who were subjected to clitoridectomy (Gross et al. 1966). Contrary to the claim of past ignorance, older medical professionals did have an idea of the clitoris's importance for sexual pleasure but decided against it.

While we cannot claim with certainty that every critique of the Optimal Gender Policy would reject treatments without personal consent, the hesitation of some was in line with the previous practice of waiting until puberty to confirm sex assignment and perform any modifications. There was room for treatment decisions that would have better protected intersex individuals' integrity and sexual pleasure.

4. Discussion

4.1. Self-Centred Motivations as Negations of the Child's Best Interest

Although one would rarely if ever read statements to the effect that a given medical or health-related protocol is initiated with 'good intentions', one could deduce intentions, interest, or motivations and their benevolent character through the presentation of the problem or suffering the protocol is meant to solve. While some problems or sufferings may seem obvious enough not to need a presentation, problematization that is *centred around care about a subject's suffering* would be committed to understanding its specific dimensions and submit them as the starting point of treatment development. In the case of the institutionalization of intersex management, problematization has been scarce, vague, ambiguous, and brief. No data were brought up to demonstrate a state of suffering among intersex adults that needed a systematic solution involving invasive bodily modifications in infancy. We do have previous studies (Redick 2004, 2006; Reis 2009), however, of mid-20th century medical professionals' attitudes towards intersex adults that shed a light on whose interest they focused on. The suspicion about intersex individuals' own gender affirmation has been a major motivation behind securing and systematizing control over intersex children's bodies and gender as early as possible in their lives. Fear of intersex individuals getting away with homosexuality is not centred on the intersex individual's (best) interest, but on medical professionals' own investments in heterosexuality and its concomitant requisite of separate and 'complementary' gender roles. Though motivations and interests could theoretically shift with time, the period spanning manifestations of this attitude and the inception of the Optimal Gender Policy is too short for it to apply.

In addition to this context, affects expressed through what clinicians said of intersex bodies and their clinical practice included motivations unrelated with benevolent dispositions towards intersex individuals. These affects emanate from key actors of the Optimal Gender Policy and are repeated in the community of medical professionals invested in intersex management. None of these have been subjected to critique by peers. This indicates that they are not unrelated to, but are a part of this community's culture. The affects that are part of this culture reflect a desire to preserve heteronormative gender order, which is

consistent with the initial suspicion of homosexuality. This investment is deeply anchored in the clinicians' stance, as they express affects of great intensity with their revulsion and disgust towards bodies that are incompatible with their heteronormative sexual standards. Conforming these bodies to heteronormativity through surgery and hormonal therapy is a way for clinicians to appease their revulsion and disgust. Experiencing pleasure from the power to radically change an individual's bodily, gender, and sexual destiny is also compatible with the investment in heteronormativity and dominant gender norms. A clinician can draw satisfaction from being able to work as a bulwark against the disorder intersex misfits could cause in these norms with their intact bodies. This satisfaction is further fed from pediatric and urologist surgeons' enjoyment in producing conforming bodies despite the absence of the individual's consent. Surgeon investment in heteronormativity can go so far as being centred on their own relationship to sexually desirable female bodies, producing genitalia that is pleasurable to them. In all these cases, these affects are centred on the medical professionals and the actions they motivate serve their interest. The fundamental question is whether these interests are compatible or not with an intersex individual's best interest.

While some would argue that a clinician could be invested in heteronormativity but still draw pleasure from knowing he has the potential to drastically improve individuals' lives, this perspective overlooks the prerequisites of 'best interest.' Serving an individual's best interests implies that all actions directed at that individual be undertaken with their interests as a priority. Given that intersex individuals were not granted a say in what would be in their best interest, there is no way for them to set limits on differing interests. Postulating that intersex children's best interest would happen to be compatible with these other interests is denying their humanity. Their distinct personhood is dissolved into other social actors who enjoy more acknowledgement than they do. This is obvious when Thomas (2004) claims that management was undertaken with children's and parents' best interest in mind. Taking parents' interests into account means that a child's interest must yield when they conflict.

4.2. Past Medical Innocence and Good Intentions Claims as Revealers of Current Medical Culture

How medical professionals envision predecessors' affects and motivations is informative. Current defence of past clinicians indicates identification with them and their practice. This identification is even more obvious considering that the constant and heavy emphasis on distinguishing current practices from previous ones never turns into a disavowal of the latter. Acknowledgement that non-consensual treatments can be damaging is restricted to the past but still euphemized. Past practice will be inserted in previous '(gold) standards of practice' and removed from the field of objects that can be targeted by criticism, frustration, and anger—including from individuals who have had their humanity negated and have deeply suffered from them. For all the insistence on distinction of current practice from the past, it still rests on the foundations laid by the Optimal Gender Policy. Examining medical professionals' protection of predecessors and previous practice is as relevant to understanding current practice as are the motivations behind securing control over intersex management.

When one mobilizes 'standard of the times' to allow for damage caused by actions claimed to be undertaken in the name of vulnerable individuals' or social groups' 'best interest,' they expect that mere wish and presumption to know what is best will be considered as satisfactory substitutes for inquiry into what recipients wish for themselves. They also veil decision-making processes behind unavoidability and powerlessness. At the heart of acting "in the name of" lies the dehumanization of an individual or group whose perspectives are not considered relevant enough or credible enough to be consulted. It may have been difficult for actors of past contexts to behave otherwise. But, refraining from acknowledging how their actions were damaging because they were purportedly driven by 'good intentions' when in fact they were built on a dehumanizing relationship to vulnerable subjects means that medical professionals holding on to the 'good intentions' rationale fail

to see how this relationship is dehumanizing as much as they fail to see how it still applies in today's context. In the end, insisting on 'good intentions' cannot expurgate conflict, as these assertions originate from a power dynamic whereby a dominant group has imposed treatment on a marginalized group.

Current medical professionals' reduction of past motivation to 'good intentions' and 'best interest' could indicate that they are unaware of the earlier complexity of affects, which would reflect limited exposure in training to the history and early literature of intersex management. That they would nonetheless project good intentions despite this limitation indicates an investment in preserving predecessors' images. Combined with the defence of the successive standards of practice for being what past medical professionals considered the best approaches and protocols, this reveals the continued importance of protecting medical authority and self-regulation privileges. Acknowledging past practice as severely harmful and not centred on recipients' best interest undermines current authority. Acknowledging that "best interest" must be founded on social actors and individuals' own understanding of what it consists of—especially when treatment offered for children is non-life threatening—also does.

If current medical professionals are aware of the existence of potential alternative treatment but still consider them improbable, it indicates a normalization of credibility excess granted because of medical team prestige instead of examination and replication of claims. It would also be a normalization of dominant teams' scornful rebukes of dissenting views. The same applies to clitoridectomy. Former medical professionals' ignorance cannot be claimed given that they felt it necessary to defend it against the awareness that the (phallo)clitoris could be important in sexual pleasure. It is prejudice and not ignorance that made medical professionals willing to discard it with shallow arguments.

4.3. Concluding Remarks

This narrative has a functional purpose for current practice. We would gain from probing what motivates medical practitioners to resist intersex critiques and frustration and how they conclude that predecessors were being motivated by "good intentions" and could not envision treatment alternatives. We would also gain from exploring what it means to them to defend these predecessors. In their adaptation to medical intersex management of Card's philosophical reflections on institutional evils, Peck and Feder (2017) hypothesize that medical resistance to apology over past practice could stem from misunderstanding the different degrees of responsibility. While my observations indicate more motivations, this dimension is worth investigating. The 'good intentions' defence should be examined as part of a conversation on power, accountability, and reflexivity in medicine and other institutions. It should also spur a reflection on how we proceed to identify our intentions, motivations, and interests as citizens or professionals.

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Notes

[1] Incidentally, Peter A. Lee and Christopher P. Houk are the first authors of the Consensus Statement on Management of Intersex Disorders, which was broadcast as a more sensible and respectful approach to children with intersex variations (Lee et al. 2006). It has been criticized by intersex activists for its vagueness, its absence of commitment to stop normative surgeries, and its adoption of pathologizing Disorders of Sex Development nomenclature (Christian-Ghattas 2019; Holmes 2011; Carpenter 2016).

The exclusionary practices of medical professionals towards intersex activists in the drafting of the Consensus have also been subjected to critique (Karkazis 2008).

[2] Some of these references have medical professionals as authors but represent medical association statements.

[3] Carpenter (2024) points out that medical "claims about change" have been a useful political tool in hindering legislative regulation of medical management of people with innate variations of sex characteristics (p. 7).

[4] My putting 'Western' between parentheses stems from the fact that the word has its failings, as it does not adequately reflect geographical positions. I nonetheless use it to avoid universalizing observations made in European, North American, and Oceanic contexts. I do not presume they are absent from other contexts; my knowledge is simply insufficient to draw conclusions about them.

[5] In France, fear of "sex errors" in assigning gender to children drove famous medical professionals to push for legislation that would grant them the authority of assignment at birth. They stressed how laypeople's mistakes could introduce danger in segregated spaces and institutions, as well as create same-sex marriages (Houbre 2014).

[6] Ulrike Klöppel's thorough historical research has allowed finding informal discussions preceding presentations of the Optimal Gender Policy, which I included in my sample (Klöppel 2010).

[7] I have read Money's thesis, but it is forbidden to quote it directly (see Money 1952). Since Colapinto mentioned it before the introduction of this interdiction, I use his account.

[8] This exchange is discussed in Feder (2015). Dr Tery Hensle started his pediatric urology practice at the end of the 1970s.

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