The “Problem” (or Problems) of Atypical Bodies

Consideration of atypical bodies in medicine requires that we investigate commonsense views about bodily differences. We may understand assessments of normality in the context of medicine to be an objective measure of what is “typical,” but such measures may, as disability theorists have argued, carry unexamined judgments of value that reflect, or perhaps promote, social views of bodily difference that can, in turn, shape medical judgments concerning the meaning of these categories.

The first part of this chapter historicizes the division between normality and abnormality in medicine. The late 20th-century medical treatment of abnormal height in children illustrates gaps in the correspondence between medical views of normality and abnormality on the one hand, and health and disease on the other hand. Turning from the example of unusual height to unusual sex anatomies, the second part of the chapter looks more closely at the division between the medical and the social, and raises questions concerning the demands of conformity enforced by stigma and shaming. The complex work of what is now called “medicalization” of atypical bodies that these examples illuminate may, I conclude, spur further reflection on the ways that values and desires can make the lines between normal and abnormal, health and disease, less clear than we might have otherwise appreciated.

Normal and Abnormal

At the center of contemporary medical knowledge lies the distinction between “normal” and “abnormal.” Recognizing normal function of the complex processes of the human organism forms the bedrock for medicine’s role in maintaining health; indeed, it could be regarded as a standard that has been constant throughout the history of medicine. What has changed is the way that standard is figured.

Historians tell us that, for physicians in ancient Greece, health was figured as “harmony” (e.g., Plato 1989: 187a-e) or “correct proportion” of the elements (Lloyd 1983: 262). In medical terms, what we think of as “normal” (i.e., “healthy”) was assessed relative to the individual: what is healthy or normal was the harmonious functioning of a particular organism.

Ancient conceptions of health certainly differ in important respects from those that we hold today; if we experience pain, discomfort, or do not “feel like ourselves,” our medical providers might ask questions and order tests to assess whether individual substances fall within what is now regarded as a “normal range.” This range is defined not by what is optimal for an
individual but by what has been determined to be the norm or average for the species. Furthermore, examination of individual substances apart from others differs from the ancient medical view of achieving a “correct proportion” among substances.

We may nevertheless see areas of continuity between past and present views. For example, when a physician investigates whether pain or discomfort signals an infection, and tries to determine the number of white blood cells circulating in our blood, that physician’s assessment is based on a prevailing view of the “species-typical norm”; at the same time, that assessment could be described in the ancient medical terms of “excess” and “deficiency.” Perhaps some organ or system is not functioning as expected, and tests to measure levels of different hormones, for example, can indicate a problem that requires intervention to right that balance, to ensure that there is neither an excess nor a deficiency that signals an individual malady. These are cases in which the distinction between normal and abnormal aligns neatly with the distinction between health and illness, and they appear to be shared by ancient and contemporary physicians alike.

But observations about normality and abnormality do not always involve judgments about wellness and pathology. That a condition or capacity falls outside of the norm or average (the definition of “abnormal”) may have little bearing on the health of an individual (see Chapter 1, The concept of disease). Take double-jointedness or multicolored irises, what is sometimes expressed genetically as having two different-colored eyes (heterochromia): anomalies such as these are unremarkable, not only medically but also socially. Some abnormalities that have no bearing on an individual’s health can nevertheless carry significant social weight. Extraordinary height, for example, is a boon to athletes for whom it can confer an advantage, and indeed, being taller than average seems generally desirable for men, if not for women. Judgments such as these hardly seem to be matters of medicine, and yet, it was not so long ago that distressed parents of tall girls sought medical advice in order to protect them from the consequences of the stigma attached to a trait’s statistical abnormality, even though this abnormality has no effect on function.

Beginning in the 1950s, concern about the negative social judgment associated with tallness in women prompted physicians to prescribe the synthetic estrogen diethylstilbestrol (DES) to stunt the growth of tall girls. Cohen and Cosgrove report in their 2009 book, Normal at Any Cost, that DES had been in use for at least 20 years before it was prescribed to inhibit growth in girls. Though there was no evidence of its effectiveness as an antiabortifacient, millions of pregnant women took DES to prevent miscarriage starting in the late 1930s. In 1971, the U.S. government issued a safety warning following the revelation of a correlation between DES exposure in utero and vaginal and cervical clear-cell adenocarcinoma, an extremely rare form of cancer that had previously only been diagnosed in postmenopausal women. The government warning effectively ended the prescription of DES to prevent miscarriage. It curtailed, but did not end, the prescription of estrogen to stunt growth in taller-than-average girls (Cohen and Cosgrove 2009: 46–47).

Recommendations of growth-restricting treatment for girls appear to have continued for several more years, until the publication of successive articles in The New York Times in 1976. The reports provoked public awareness of the medical treatment of tall girls, and also led the Lawson Wilkins Pediatric Endocrine Society and the National Institute of Child Health and Human Development to hold a conference to consider the social and medical questions raised by the practice of treating preadolescent and adolescent girls with hormones to restrict their growth. In its recommendations, the conference committee acknowledged that there was as yet no evidence that the treatment of tall girls yielded any psychosocial advantage to the girls who had been prescribed DES, and urged that studies be undertaken to determine whether confidence in the benefits imagined by physicians and the parents they counseled could be
demonstrated (Cohen and Cosgrove 2009: 51). It furthermore acknowledged that the unstated risks of harm were in fact known: girls born with Turner syndrome (a condition in which the second X chromosome in females is completely or partially missing) had long been prescribed estrogen to compensate for the fact that their ovaries do not produce sufficient quantities of hormone to support typical pubertal development and to protect bone density through the lifespan. Although estrogen treatment had been effective in combating significant medical problems faced by individuals with Turner syndrome, doctors had seen an alarming incidence of uterine cancer in their patients, something that had also been noted in postmenopausal women taking estrogen replacement (Cohen and Cosgrove 2009: 51). The committee recommended that follow-up studies be undertaken to learn the outcomes of girls who had been prescribed estrogen for height. Although such studies were never undertaken, it is likely, given changes in society’s views toward tall women, that there is much less treatment occurring today. According to Cohen and Cosgrove, however, this treatment nevertheless continues to be prescribed, “especially when parents insist” upon it (Cohen and Cosgrove 2009: 454).

In 2003, the U.S. Food and Drug Administration approved the use of Human Growth Hormone (hGH) for “growth hormone deficiency,” an umbrella diagnosis that included different forms of dwarfism, but that also, controversially, included those with “idiopathic” short stature (i.e., shortness absent known pathology). A decade earlier, studies demonstrated the success of hGH in increasing height in otherwise healthy children (Cohen and Cosgrove 2009: 126). Leading up to and following approval, there was considerable discussion concerning the difficulty of distinguishing between interventions that were unquestionably warranted and those that were not, and whether, in the latter case, physicians should recommend them. One pediatric endocrinologist specializing in growth disorders put it this way: “The pathology you’re gonna do something about. The physiology you may do something about” (quoted in Cohen and Cosgrove 2009: 302 original emphasis). A disease or disorder impeding human function (“pathology”) unquestionably calls for medical intervention; while medical expertise may be effective in normalizing a variation in the body’s appearance that does not impede function (“physiology”), such intervention would, the endocrinologist suggests, be something one might characterize as “elective.”

With hindsight, the hazards involved in physicians’ efforts to prevent girls from being taller than average are too apparent; the panic that led physicians to prescribe powerful hormones to arrest growth in girls may now seem farcical. How could doctors have not anticipated the dangers and ignored relevant evidence of risk? Why was there so much anxiety about tallness in girls, and why is it the business of medicine to fix that anxiety? What story will be told about the current medical treatment of short stature in boys? The administration of DES and other hormones offers an exemplary case of making a social problem (like tall stature in women) into a “medical problem,” a phenomenon that sociologist Peter Conrad calls “medicalization” (Conrad 2007).

If tall stature in girls and short stature in boys are good examples of what most would agree to characterize as social, and not medical, disorders, then there are any number of conditions in which unusual stature is a feature of pathology in the ordinary sense. Serious risks of heart failure come with Marfan syndrome, characterized by unusual tallness, for example; unexpected tallness may also signal the presence of a pituitary tumor. Those with achondroplasia, the most common form of dwarfism, have a heightened risk of being born with hydrocephalus and spinal stenosis. In the case of height, history has demonstrated the extent to which questions concerning “function” may be conflated with negative social views (what in hindsight we see as different kinds of prejudice). Things get more complicated still when we consider that medical interventions intended to address features of a disorder can be prescribed as (medicalized) enhancements, as we see today in the prescription of hGH for shorter boys.
Medical and Social

Though the distinction between “pathology” and “physiology,” as the pediatric endocrinologist put it, may seem obvious, we have already seen how the distinction between the two can become blurred in medical treatment of “abnormal conditions.” Why, we should ask, is pathological difference yoked to certain kinds of (nonpathological) physical variation? And why is (nonpathological) variation a “problem” for medicine to solve? In his investigation of the history of European medicine, Michel Foucault noted an important shift in the conception of “health” and “normality” between the 18th and 19th centuries that suggests that the identification of pathology and variation have not always been understood in the terms they are today. Understanding more about this history may help us better appreciate the challenges we encounter in thinking about atypical bodies in medical care.

According to Foucault, standards of health in the 18th century focused on what could be understood as specific to a particular individual—“vigour, suppleness, and fluidity, which were lost to illness and which it was the task of medicine to restore” (Foucault 1994 [1963]: 35). Early modern medical standards in this sense shared with ancient Greek medicine a view of health as specific to the individual. Although physicians identified general standards, it was still possible for individuals to be their “own physicians” who judged, and managed, their health. A subtle but important change comes in the 19th century when, Foucault observes, medicine “formed its concepts and prescribed its interventions in relation to a standard of functioning and organic structure” (35) that was imposed from without. The medicine that previously took as its object “the structure of the organized being” was transformed into “the medical bipolarity of the normal and the pathological” (35, original emphasis). It was no longer the judgment of the individual that mattered most, but that of “experts” authorized to evaluate and treat the individual as prevailing standards dictated. Moreover, medicine comes to see its role as identifying a “single” norm that would be applied to the population as a whole.

The recent history of the medical treatment of height highlights the powerful operation of medicalization with respect to the understanding of atypical bodies. However, there is more at stake in Foucault’s analysis. In the shift in focus from attending to health and disease occurring in the individual body, to assessing the individual against a standard cast in terms of the normal and abnormal, a transformation of the object of medicine occurs, as well. The health of the individual body remains a consistent object of concern, but, as Foucault’s analysis suggests, individual health is understood as a component also of social health. Where previously disease had been figured principally as a threat to an individual’s health and well-being, the changes in medicine marked a shift in understanding of disease, disorder, and “abnormality” as a threat to the social body, as well. Another example will better illustrate what we may understand as a deeper change in the conception of medicine that Foucault describes.

The treatment of atypical sex anatomies in the 19th century exemplifies the legacy of the change Foucault observes. As Alice Dreger recounts in her Hermaphrodites and the Medical Invention of Sex, physicians developed toward the end of the 19th century a taxonomic system to classify hermaphroditic “types,” a nomenclature that persisted for more than 100 years. It defined maleness and femaleness in terms of standard female and male anatomy; deviations from standard anatomies were described as “male and female pseudohermaphrodites” and “true” hermaphrodites, each of which presented different mixtures of male and female anatomy (Dreger 1998: 35–40). These categorizations were not simply medico-scientific descriptions of human anatomical differences and their variations; these categories also contained prescriptions for social life and organization.

Interest in hermaphroditic bodies was entirely in line with the modernization of medicine that took place in Western Europe in the late 19th and early 20th centuries, interested as
it was in carefully measuring, classifying, and mastering knowledge of the human body and its functions, normal and aberrant. However, the interest in hermaphroditic bodies was also distinct from general medical curiosity about the human body: hermaphroditism provided an inordinately rich object of scientific and medical interest that combined medical and scientific curiosity and concern with managing what was perceived as a social menace. The cases connected to the developments Dreger traces at the end of the 19th and beginning of the 20th centuries were not cases of mere physical variation, but of “mistaken sex” (i.e., cases where a person’s anatomy could not be easily categorized as male or female), or more importantly at this time, where the secondary sex characteristics (e.g., body hair, musculature) and corresponding behavior (especially including the object of sexual desire) of someone who had been raised as one sex assumed the characteristics of the other sex. One example may be found in the 19th-century memoir of Herculine Barbin, made famous when 20th-century French philosopher Michel Foucault discovered the manuscript in the 1970s (Foucault 1980). Cases such as Barbin’s, and others that Dreger describes, posed challenges to a social order that depended, as Dreger writes, “on there being (only) two sexes” (Dreger 1998: 8). Cases that did not present such challenges, one expects—because they were not written up and disseminated, or because people did not consult doctors or surgeons to the extent that they eventually would come to—were not extraordinary, and would not cause the sort of consternation that the birth of children with intersex anatomies did beginning in the mid-20th century.

Today, the prevailing standard of care for the medical management of intersex cases is based on work carried out by psychologist John Money and his colleagues starting in the early 1970s at Johns Hopkins University (see, e.g., Downing, Morland, & Sullivan 2015). Together with Joan and John Hampson, Money worked out what was called the “optimal gender theory,” which took “gender roles” as produced not simply by nature but in interaction with culture. This interaction, Money and his colleagues proposed, suggested a certain sort of malleability that could allow children born with atypical sex anatomies to be assigned as “boys or girls” without concern (Money et al. 1955).

Money’s work came to be famously discredited in the late 1990s, when it was revealed that the renowned experiment in child sex reassignment (the case of John/Joan) turned out to be a fraud (see Colapinto 1997). Despite this revelation, normalizing treatment of children with atypical sex anatomies has continued, to the distress and bewilderment of many who see the treatment of children with atypical sex anatomies as a straightforward matter of what Erik Parens, seeking to refine Conrad’s term, calls “bad medicalization.” Whereas medicalization takes nonmedical problem—“life or human” problems—and casts these in medical terms, bad medicalization, Parens proposes, should be understood as the commission of a category error (i.e., taking something to be a medical issue or problem that is genuinely a social problem for which medicine intervention is inappropriate or ineffective). Parens suggests that rather than see medicalization as “bad” per se, it is important to recognize that there are forms of medicalization—such as that resulting in birth control—that critics of medicalization would likely celebrate (Parens 2011: 6).

The history of the management of atypical sex is complicated, in the terms Parens introduces, by the combination of forms of medicalization it has entailed. Focused on removing sexual ambiguity, medical management of atypical sex anatomies has, since the 1950s, emphasized medical (and especially surgical) fixes for what might otherwise be understood in contemporary terms as social, political, or psychological matters of sexual identity. As critics have repeatedly demonstrated since the 1990s, these interventions have entailed significant harms (see, e.g., Chase and Coventry 1997); today, a number of national and international statements have acknowledged gross violations of humans associated with normalizing atypical sex anatomies (German Ethics Council 2012; Swiss National Advisory Commission on
One might reasonably ask why it wouldn’t be simpler to take intersex conditions out of medicine altogether, to “demedicalize” conditions that might instead count as ordinary human variations. The case for understanding differences in genital appearance as matters of variation is undeniably convincing, and yet there is an equally compelling case that some of the conditions with which genital variation are associated bring genuine health challenges that require not less, but substantially more, medical attention than has been afforded them. Perhaps the best example is the case of congenital adrenal hyperplasia (CAH), a condition that in some forms poses grave dangers to an individual's health.

CAH is a genetic disorder that involves malfunction of the adrenal glands. It affects males and females in equal numbers. What was early termed the “androgen push” associated with CAH, both in utero and after birth, prompts premature development of bone growth, which ultimately results in adult short stature—a particular social concern, we know, for affected boys—and virilization of sex anatomy, which can make a male look like an “infant Hercules” (Eder 2012: 71), and can make a genetic female appear more like a male. Both males and females with CAH may suffer from serious metabolic problems soon after birth (when it is usually detected) and throughout one’s life. In the “classic,” salt-losing form, it results in vomiting and dehydration and, if left untreated, can lead to death. Increased vulnerabilities—caused by ordinary illness and injury that can exacerbate various sorts of imbalances associated with CAH—are among the problems that require careful attention in early childhood and beyond.

Lawson Wilkins, “the father of pediatric endocrinology,” developed a detailed clinical understanding of the disease and its effects. This work led, in 1949, to the first attempt to determine whether CAH would be responsive to cortisone therapy. Wilkins refined the administration of cortisone over several years. It did not provide a hoped-for cure of the condition, but when administered in doses appropriate to the patient, cortisone could control the effects of CAH, which encompassed a range of what most would regard without controversy as ailments. Indeed, Sandra Eder’s history of Wilkins’s clinic (Eder 2012) suggests that we may find there an exemplary case of “good medicalization,” the identification of malady or disorder that had not been previously identified or had been misunderstood. In the wake of Wilkins’s work, physicians no longer theorized, as they had only some time earlier, about the “psychic influence on the part of the mother,” whose thoughts were believed capable of malforming the developing fetus in her womb (Dreger 1998: 70); the physicians in Wilkins’s clinic saw conditions that could alter the expected course of sex(ual) development as natural defects.

Though today it is clear that physicians and families see a continuity between the genuine medical problems caused by CAH and the social problem atypical sex is taken to present, this was not always the case. There is little evidence that “hermaphroditism” during the period that Dreger studies was associated with any condition we would regard as a disease or malady, as most forms of CAH are now recognized to be. (The important exception was the work of the French surgeon Jean Samuel Pozzi, who noted that undescended testes in those with the condition now termed “androgen insensitivity syndrome” could become cancerous [Dreger 1998: 64–65].) In other words, it was not the fact that atypical sex posed a medical danger that brought these bodies under special scrutiny (and display) in the Victorian period; instead, it is their deviation from “the norm” that is taken to be a threat to the social body (166). Rather than a concern with health, Dreger notes that the fascination with hermaphroditism was likely connected to challenges to sexual boundaries coming from new directions, particularly from first-wave feminists and homosexuals (26). Even as it appears that the continuing imperative to normalize intersex bodies is informed by the sorts of “social panic” that may be traced to its contemporary origins in the 1950s (Fausto-Sterling 2000: 72; Sandberg et al. 2004), the
recognition of the genuine threat to health and life posed by some forms of CAH has led to universal newborn testing in most developed countries.

It is crucial to see how, today, these histories of atypical sex anatomies as threats to the social order, on the one hand, and to individual health, on the other hand, are today intertwined, and why there remains so much controversy about the identification and treatment of atypical sex. Most cases of what are called Disorders of Sex Development (DSD; Hughes et al. 2006) do not pose challenges to individuals' health. Understanding something of the history of the treatment of intersex goes some distance to helping us to appreciate why normalizing interventions for atypical sex anatomies in children remain the standard of care, intended as they are to “correct” anomalies that become equated with “pathology.” But instead of a risk to healthy function, normalizing interventions are taken as a means to “protect” children who are regarded as—perhaps excessively or abnormally—“vulnerable” by virtue of their anatomical difference. There are today a number of robust ethical discussions of the problems entailed by the complex conceptions of health and illness, normality and abnormality, involved in the medical treatment of children and adults with atypical sex anatomies. But prior to questions of what is right or wrong, clinicians must ask themselves about the medicalization in which their practices are involved, and find ways to test the certainty with which medical decisions to normalize children’s bodies are made.

Knowledge and Doubt, Certainty and Denial

Research conducted by pediatrician and ethicist Jürg Streuli and his colleagues in 2011–2012 at the University of Zurich highlights problems concerning medical authority and patient (and proxy) choice in the context of care for children with atypical sex anatomies. This work should serve to promote the asking of questions concerning the medicalization of intersex bodies that the history of treatment of atypical sex anatomies has foreclosed. It may suggest, too, how reflection on the problem, not of atypical sex anatomies themselves, but of our understanding of the need to see the problem of atypical anatomies as medical problems, may be helpful in reflecting on the phenomenon of medicalization, good and bad.

In their study, medical students were shown a short video “asking them to imagine that they had just become parents of a child with ambiguous genitalia, whose (future) gender midwives and doctors were unable to identify by looking. They were told they would watch a second video, which would be “their first contact with a specialist able to counsel and inform them about their child’s condition.”

There were two versions of this second video, both about six minutes long. One featured an endocrinologist’s presentation of this first contact and the other a psychologist’s. The scripts for both were reviewed by specialists from each discipline, ensuring that the information and presentation accurately replicated their respective approaches. The difference between the two reflected the distinctive perspectives on care that are by now well recognized. The authors reported:

The medical professionals tended to medicalize, defining the child and its condition or behavior as a medical problem or illness that mandated or licensed the medical professional to offer a specific treatment. The parent, patient, activist, or psychologist, on the other hand, tended to demedicalize the issue by stressing the importance of the child’s social world, seeing the main task as offering the child professional support in its environment.

(Streuli et al. 2013: 1955)
Of the 89 students who participated in the study, 43% indicated in the questionnaire that they would choose normalizing surgery. There were considerable differences between the groups who saw the two counseling videos, with 66% of the group viewing the endocrinologist’s video favoring normalizing surgery, as compared with 23% of the group viewing the psychologist’s video. This point is perhaps not especially surprising; most of us would probably recognize that the position a medical specialist occupies would likely affect that individual’s recommendations and our view of these recommendations.

Perhaps more interesting than this basic difference in the proportion of respondents favoring surgery was what Streuli and his colleagues report regarding the difference in the “conviction in their decision”: “Those informed by the endocrinologist were more secure and convinced in deciding for than against surgery . . . whereas those informed by the psychologist were more secure in deciding against than for surgery.” (Gender and prior knowledge of intersex conditions did not have a significant impact on participants’ decisions, though the authors note that the majority of those who rated their prior knowledge as “detailed” tended—though not overwhelmingly—to favor a nonsurgical approach [Streuli et al. 2013: 1956].)

The most startling finding was that, “[a]ll participants believed their decision was based mainly on their own values, opinion, and attitude.” Participants saw their “personal attitude” as the main influence of their decision, and believed the content of the video had “little or no influence” (Streuli et al. 2013: 1956, emphasis added). No matter the group in which individuals participated, and regardless of the decisions they indicated they would make following their viewing of the videos, participants took their decisions to be independent of the information they had received. “Contrary to the majority participant perception,” however, the authors found in no uncertain terms that “it was not just their attitude that made them decide for or against surgery but primarily a 6-minute slot of information” (Strueli et al. 2013: 1956–1957).

What is novel about the study by Strueli and his colleagues is not so much the evidence demonstrating the influence of counseling that participants received, but the evidence of the lack of awareness of this influence. This study helps to clarify why, as authors of a study concluded a few years earlier, “parents might see surgery as obvious and necessary, without experiencing it as something that involved a decision-making process” (quoted in Streuli et al. 2013: 1954).

Streuli and his colleagues do not explicitly address the role of culture in decision making; however, their study provides evidence of the ways that our decisions cannot be understood outside of a cultural context ordered by rules. Only some of the rules by which we think and understand, that organize our knowledge and guide our actions, are of the sort that we can name (in the realm of ethics or law, for example). So many others of these rules are captured by what social theorist Pierre Bourdieu terms the “habitus” (Bourdieu 1990), a kind of implicit normative order that tells us “how things are,” how, at the same time, they are supposed to be. It is very difficult to describe habitus; for Bourdieu, the difficulty of making it an object of analysis is essential to its functioning as a background for knowledge. Threats to our understanding of sexual difference, and perhaps especially challenges to “the fact” of sexual difference taken as a natural division between male and female, may threaten the habitus. If, following Foucault, we see the importance of medicine and medical authority to our cultural understandings of the normal and the abnormal, we may better appreciate how the medical students, acting as parents in the Swiss study, commit themselves to act in ways that confirm and reinforce what seems “common sense,” and furthermore see decisions they project as their own.

The tensions evident in the very different responses of the two groups do not contradict Bourdieu’s analysis of habitus, but demonstrate how changes are adapted, and themselves made possible within its terms. Of special importance for thinking about the medical treatment of atypical bodies, we should note, with the authors, the possibility that parents charged with
making decisions see their choices as “obvious and necessary,” and may not therefore understand themselves to be engaged in the process of reflection and questioning that we may otherwise associate with the work of making decisions (Streuli et al. 2013: 1954). At the same time, the stark difference in the responses of the two groups suggests something of the tension the operation of habitus must involve. Respondents favoring surgical normalization, the authors report, judged autonomy less important than normality (Streuli et al. 2013: 1956). Presumably, both groups would see value in each, but the emphasis of one value over another indicates just the sort of flexibility that permits stability in systems of belief and value that habitus works to guarantee, and provides the means of working with changes it must tolerate or perhaps even promote. Taking seriously the results of the study conducted by Streuli and his colleagues, we may conclude that the sorts of certainty associated with normalizing interventions may not simply merit scrutiny but skepticism.

Conclusion

Both in medical practice and social life, atypical bodies demonstrate the sorts of changes—whether expressed as accommodation, assimilation, suppression, concealment, or celebration—required by challenges these bodies may be understood to pose. These examples illustrate significant changes in the ways that medicine and health are figured, together with the ongoing transformations of the categories of health and disease, normality and health. Examination of the medical treatment of abnormal bodies requires that we consider how exactly we understand “the problem”—or perhaps the problems—they pose. In some cases, such as simple tallness in girls, social conventions particular to a time and place may function to make of an atypical anatomy a risk to an individual’s flourishing. Medicalization of tallness could be understood with respect to the individual body of the tall girl; physicians who prescribed DES to tall girls saw the problem as the body of the girl. And yet, following Conrad, we could see the problem of tallness in girls as a social problem concerning gender norms rather than a medical problem as our common sense—itself shaped by social forces—would see it. Here the problem is not her body, but rather a political and ethical problem of intolerance and the heightened vulnerability that intolerance promotes. Investigating the medical treatment of these bodies could also raise questions about the relationship between medical authority and social norms, expertise and common sense. Where we locate “the problem” of tallness is no easy matter. Investigation of the medical treatment of atypical bodies is arguably more complicated in cases where medical risks posed by differences may coincide with social risks of unusual appearance. These are more confounding when the focus of medical attention appears to be concerned more with normalizing interventions to address social consequences rather than threats to health these conditions may pose.

References


### Further Reading


Parens, E. ed. (2006). *Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality*, Baltimore: Johns Hopkins University Press. (This collection, which looks at the cases of limb-lengthening for achondroplasia, surgical repair for craniofacial anomalies, and normalizing surgeries for atypical sex anatomies includes essays by philosophers, physicians, and individuals affected by these conditions.)