

## **Institutional Evils, Culpable Complicity, and Duties to Engage in Moral Repair**

**Eliana Peck and Ellen K. Feder**

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*Apology is arguably the central act of the reparative work required after wrongdoing. Claudia Card's (1940-2015) analysis of complicity in collectively perpetrated evils moves one to ask whether apology ought to be requested of persons culpably complicit in institutional evils. To better appreciate the benefits of and barriers to apologies offered by culpably complicit wrongdoers, this article examines doctors' complicity in a practice that meets Card's definition of an evil, namely, the non-medically necessary, nonconsensual "normalizing" interventions performed on babies born with intersex anatomies. It argues that in this instance, the complicity of doctors is culpable on Card's terms, and that their culpable complicity grounds rightful demands for them to apologize.*

### **Introduction**

Among the most difficult moral challenges is reckoning with collectively perpetrated wrongs, a problem that Claudia Card confronts in her study of evils. Card's discussion of evils, delivered primarily in *The Atrocity Paradigm* (2002) and *Confronting Evils: Terrorism, Torture, Genocide* (2010), includes a rigorous account of evils perpetrated by groups and institutions, as opposed to evil acts committed by individuals in relative isolation. In her assessment of complex evils, Card takes up the challenge begun by Hannah Arendt's study of Adolph Eichmann (Arendt 2006) and provides an account of moral responsibility for the sort of intolerable harm that, we learned, is not committed only by "monsters," but can become ordinary. Card's analysis of evils departs from other contemporary conceptions that frame an evil act as an intentional, malevolent wrong; instead, Card emphasizes that evils may go unnoticed by many, expressed in local, everyday institutions and practices (2010, xii). She calls for a "demythologized" understanding of evil, one that directly acknowledges and confronts the fact that the effects of collectively perpetrated evils may not be specifically intended by anyone (Card 2010, 4–5, 8).

Assessing collectively perpetrated evils leads Card to investigate the nature of individuals' responsibilities for varying degrees of engagement in evils. She asks, "How well do we develop habits of reflection on what we are actually doing together, habits of inquiry into the history and consequences of institutions in which we participate or from which we benefit?" (Card 2010, 63–64). She insists upon the importance of expanding the categories of moral responsibility for evil to include not just obviously culpable perpetrators of harm, but also those

who participate in an evil practice or institution. Complicity, she emphasizes, captures the sort of moral responsibility many individuals bear in collectively perpetrated evils. Persons may be complicit in a collectively perpetrated evil if they benefit from, contribute to, or participate in its perpetration (Card 2010, 63–66, 78, 83). The fact that a person is complicit in an evil practice or institution does not necessarily mean that he or she is an evildoer, or even that he or she is morally blameworthy (Card 2010, 37, 63–64). Indeed, Card explains that in collectively perpetrated evils “responsibility is distributed among many agents, many of whose acts are not harmful enough to be evils, although they contribute to real evils” (2010, 69). Complicity, therefore, should not be demonized, but should be thoughtfully considered and addressed, particularly if individuals are to respond honorably to the evils that their complicity has supported (Card 2010, 4, 7, 24).

Though Card maintains that not all complicity is culpable, her study of collectively perpetrated evils does reveal the importance of assessing how complicity may be morally blameworthy (2010, 65, 78, 87). She rarely makes explicit her views regarding what is required of persons who are culpably complicit in institutional evils, but she does repeatedly convey the importance of such inquiries. A chapter of *The Atrocity Paradigm* is devoted to a study of the moral emotions that drive reparative efforts (Card 2002, 188–210), and in *Confronting Evils*, Card remarks that one of her motivations for studying evils is her hope that a greater appreciation for the ordinariness of some evils may move people to take responsibility for their contributions to evils, and respond honorably (2010, 3–4, 7–9). Her work reveals an interest in how persons that are culpably complicit in evils should make amends for the harms to which they have contributed.

Our goal is to consider the moral responsibilities of persons who are culpably complicit in collectively perpetrated evils, focusing on a central act of reparative work, namely, apology. A contemporary evil, the unnecessary medical “normalization” of babies born with atypical sex anatomies, provides an opportunity to examine an evil perpetrated by complicit agents.<sup>1</sup> After examining this evil on Card’s terms, we conclude that doctors who engage in the practice of the unnecessary, nonconsensual “normalization” of persons born with intersex anatomies are culpably complicit. Card’s analysis of culpable complicity directs us to identify an obligation to apologize in cases of culpable complicity in institutional evils. Her account is helpful for making a demand for apology intelligible even in the face of objections that apology is not needed from

those not obviously or singly blameworthy. We conclude that if, as Card demonstrates, complicity in an institutional evil may be culpable, then culpably complicit persons must apologize for the harm their complicity has supported.

### **Institutional Evils in Context: The Medical Management of Intersex Anatomies**

Card defines evils as reasonably foreseeable intolerable harms, produced by inexcusable wrongs (2010, 16). In light of her interest in collectively perpetrated evils that may appear “ordinary” (Card 2010, xii), we ask whether unnecessary medical interventions on babies and young children with intersex conditions satisfy her definition of an institutional evil or evil practice. For nearly the past century, infants and young children born with atypical sex anatomies, that is, genitalia, chromosomes, hormones, and/or gonads that do not fit typical, binary notions of male or female, have been subjected to non-medically necessary normalizing interventions, including cosmetic genital surgeries, removal of healthy gonads, and sex reassignment (generally involving the long-term administration of hormones). Doctors have often misrepresented the urgency of such procedures and overemphasized the importance of physical “normality” for a child’s development (Kessler 1990). Many also advised parents to conceal the nature of their children’s conditions from them, which has led to emotional trauma (e.g., Coventry 1999; Hughes et al. 2006, 555).

Beginning in the mid-1990s, individuals subjected to normalizing interventions in early childhood or adolescence began to speak out about the harms they had suffered (see, e.g., Chase and Coventry 1997). Many came to understand that they had grown up uninformed or lied to, by doctors and parents, about the anatomies with which they were born. The narratives of persons subjected to normalizing interventions include painful accounts of confusing hospitalizations, appointments with specialists, and multiple operations; many describe ongoing trauma following repeated genital examinations, which sometimes included being photographed by medical teams. Persons have described the physical and emotional scars left by these practices, including painful or absent sexual response, depression, sterility, and difficulty forming relationships. Individuals also express great shame surrounding the sense that their bodies are or were inadequate, and anger that they were coerced into a standard of normality not in their best interest (Liao, Wood, and Creighton 2015; see, e.g., Amanda 2015; Blair 2015; Inter 2015; Garcia 2015).

Card's account of evil institutions and practices clarifies the nature of the wrong consisting of the unnecessary normalizing interventions performed on persons born with atypical sex anatomies, and the procedures' attendant harms. For Card, though evils may be perpetrated by individuals acting in relative isolation—she gives the example of domestic battery—evils often result, over time, from a collectively implemented policy or within an institution led by guiding norms (2010, 17–18, 27–28, 63–64). These evils may not be specifically intended; indeed, Card suspects that non-malevolent evils are commoner than malevolent ones (2010, 4, 24). Some evils take the form of what Iris Marion Young calls structural oppression, which is embedded within interconnected practices and norms rather than intentionally or tyrannically inflicted (Card 2010, 69). Such evils may have consequences that, although reasonably foreseeable, are neither anticipated nor intended by any specific individuals (Card 2010, 18, 65). Doctors engaged in the performance of unnecessary normalizing interventions for atypical sex anatomies act as members of medical institutions established to help and heal, and rely on a standard of care that they have been taught to trust. Evaluating the evil of unnecessary normalizing interventions therefore requires assessing, not just specific harms at the hands of individual doctors, but also the intolerable harm caused by the practice as a whole.

Card's understanding of evils centralizes the notion of intolerable harm, the severity and (often) irreversibility of which distinguishes evils from lesser wrongs (Card 2010, 5, 7). For Card, harm becomes intolerable when it “gravely, irreversibly, or irreparably jeopardizes access to basics that are ordinarily needed to make a life (or a death) tolerable or decent, from the point of view of the person whose life (or death) it is” (2010, 46). Card provides examples of such harm, including the elimination of “spheres in which one can exercise effective choice” and subjection to “severe and prolonged pain, humiliation, [and/or] debilitating fear” (2010, 46).

Narratives by patients powerfully attest to the intolerable harm that has resulted from the standard of care that was formalized in the 1950s (see, e.g., Chase and Coventry 1997; Jones et al. 2016). Konrad Blair recounts that soon after he was born, “the supervising physicians told my parents that plastic surgery was necessary to make me, an infant of questionable sex, ‘look like a female’” (2015, 91). Blair's doctors performed a phalloectomy, which left him with significant scarring and lasting sexual difficulties (Blair 2015, 90–91). Blair recalls the stress of the unanswered questions that plagued him; no one ever explained why he had had the surgery he vaguely remembered as a toddler, or why, throughout his childhood, “medical residents still

wanted to examine me, or why I had to be humiliated and ashamed, again and again” (2015, 90–91). It was not until Blair asked—repeatedly—for his complete medical records that he learned that he had been unnecessarily subjected to cosmetic surgery as a child, and the reason that he had needed to take medicine for most of his life. The records revealed what the doctors and hospital had tried to conceal; finally Blair understood why, despite being “female,” he had never felt at ease in his body or in the marriage to a man that, for his doctors, had marked his treatment a “success.” The records told him that his life could have been otherwise (Blair 2015, 90–91).

The intensity of the stress and anger Blair describes is echoed in most of the other narratives that have been published since the late 1990s. Unlike Blair, Amanda had participated in the decision to have a vaginoplasty, the surgical construction of a vaginal opening. Looking back, however, it didn’t seem like much of a choice:

I chose this fake hole when I was a teenager because I didn’t know there was another option. I was told from day one to be a female, to be heteronormative, to act like all the other girls, and the only way I could fully accomplish this is by looking the part. A fake hole would be necessary, I thought, to go along with the rest of the lies. Sometimes I think about how the doctors told me to lie about my surgeries and my scars. Sometimes I wonder what my parents would have told the world if I had died during [surgery]. Maybe they would have said “we were just trying to make her fuckable.” (Amanda 2015, 98)

The compliance Amanda describes, tied to a sense of trust in physicians’ and parents’ good intentions, or just a reliance on “how things are,” emerges in other narratives as well. Laura Inter did not have surgery as a child, though it was insistently recommended to her as a young adult. That she was able to refuse it may have been born of her unsettling experience of repeated exams throughout childhood:

From the time I turned one, I was subjected to genital examinations twice a year, during which the endocrinologist would touch my genitals and look to see how they were developing. These unnecessary and intrusive examinations had a profound effect on me. . . . I found it confusing, and terribly uncomfortable, and I just felt it wasn’t right. . . . I grew up with a feeling of being “inadequate,” of having a sense that something was wrong with me, though I didn’t know exactly what. These exams lasted until I was about 12 years old. Years later, as I began

my adult, sexual life, I realized how much those displays had affected me emotionally. (Inter 2015, 95)

These narratives—remarkably consistent with those published more than a decade earlier, and echoed by narratives continuing to emerge in a variety of national contexts—speak to the severity of the harms perpetrated at the hands of a medical institution, through a practice meant to heal. The harm persons born with intersex conditions have suffered meets the definition of intolerable that Card lays out (2010, 46).

For Card, intolerability is one of the major characteristics that sets evils apart from lesser wrongs. But to call unnecessary normalizing interventions an evil, we must also address the question of foreseeability. For the purpose of determining whether the harms entailed by unnecessary normalizing interventions satisfy the criterion of “reasonably foreseeable,” we need not establish that intolerable harm was foreseeable to all perpetrators, at all times (Card 2010, 29). Card explains that when evil practices and institutions are implemented collectively, not all agents occupy the same epistemic position; some people may have more access or less access to knowledge that the practice in which they are engaged is causing harm (2010, 27–28). Therefore, she argues, “It may suffice to say that a morally indefensible rule or practice or institution is evil if *anyone* can reasonably foresee its intolerably harmful consequences. . . . Extending that idea over time, we could also make sense of saying that a practice was an evil even at times when no one *then* could foresee or appreciate the harm that it does, if others at later times can appreciate that it does intolerable harm for which there is no moral excuse” (Card 2010, 29). Card indicates that one can make judgments about the evil quality of an institution or practice after the fact, even if people acting at the time of the evil’s inception cannot be held responsible for failing to recognize the evil in which they were participating. This is not to say that individuals acting in the early years of such a practice are evil (as we will discuss later, in our discussion of culpable complicity); Card argues that establishing the evil status of an institution or practice is not the same as determining that complicit persons have been culpable evildoers (2010, 37). Nor is it to say that we are never wrong, today, when we judge past practices to be evils. Rather, we do the best we can to evaluate evil practices that may have gone unnoticed or unseen in the past. For Card, therefore, showing that intolerable harm is foreseeable today in cases of unnecessary normalizing interventions is sufficient to say that the practice was always an evil (2010, 29).

Contemporary statements of recognition of the moral and medical violations entailed by unnecessary interventions support the assessment that this practice constitutes an evil. The United Nations and the Council of Europe have acknowledged that “children’s fundamental human rights to physical and psychological integrity and self-determination may be violated” by these nonconsensual interventions (Council of Europe Commissioner for Human Rights 2015; United Nations Human Rights Office of the High Commissioner 2015). A national ethics council in Switzerland has also formally recognized the risk of harm and has insisted that surgery should be deferred until a patient can provide informed consent or refuse treatment (Swiss National Advisory Commission on Biomedical Ethics 2012). In 2016, the U.N. Committee Against Torture responded to calls from advocacy groups by demanding that the United States provide a report on how many children born with intersex conditions have been subjected to “sex assignment surgery” (United Nations Human Rights Office of the High Commissioner 2016). Most recently, in February 2017, the European Parliament released a statement in which they referred to the physical, psychological, sexual, and reproductive harms suffered by “intersex persons subject to genital mutilation” and called on member states to develop specific policies to provide mental health support to such persons (European Parliament 2017). Notably, these acknowledgements of harm have mostly come from groups outside the medical community. While the 2006 Consensus Statement by the US and European pediatric endocrine societies provided some hope for change within medical practice (Hughes et al. 2006), anecdotal evidence from physicians (Feder 2014, 133-152) and the increasing numbers of critical statements by UN Committees suggest that little has changed. Nonetheless, these statements, together with the patient narratives now widely available, make the harms of unnecessary normalizing interventions foreseeable on Card’s account of evils. The remaining factor left to evaluate is that of inexcusability.

Card argues that evils, unlike lesser wrongs, are utterly without excuse. She details two types of possible excuses. The first is the metaphysical excuse, which alleviates culpability because an actor was in a state of justified (that is, not culpable) ignorance or was compelled by some external force (Card 2010, 16). While a metaphysical excuse could be claimed by an agent acting in genuine ignorance or unquestionably compelled to commit a wrong, it does not appear that Card’s notion of metaphysical excuses could mitigate the evil quality of a practice or an

institution that has caused intolerable harm. An evil institution or practice cannot be understood to act out of ignorance or compulsion; it can therefore claim no metaphysical excuse.

The second type of excuse that Card details, what Card calls a “moral excuse,” demands more careful consideration. A moral excuse, justifying wrongful action, mitigates blameworthiness without denying that a wrong has been committed, and without denying that someone or some group was responsible for it. Card gives the example of a midwife, stopped for speeding, who explains to an officer that she violated the law because she is on her way to deliver a baby (2010, 21). Moral excuses, then, mitigate culpability, but only if they are good excuses, ones that hold moral weight. “It is not sufficient,” Card writes, “that the agent thinks there is a good reason. There must be one (and it must be the agent’s reason), a reason defensible on reflection and in terms of moral values” (2010, 17). Inexcusable wrongs, by contrast, are those in which culpability is not diminished by any good reason (Card 2010, 17, 23). Though perpetrators may claim to have some good reason for their actions, we may determine upon reflection that this reason does not carry sufficient moral weight to justify the practice.

The evidence—and the striking absence of medical or ethical argument to the contrary—suggests that there is no moral excuse for the practice of unnecessary normalizing interventions (individual doctors’ claimed excuses will be addressed later, in our discussion of culpable complicity). Despite the fact that these procedures have been performed for several decades, the idea that normalizing interventions will allow children born with intersex conditions to lead “better” lives remains, as many have indicated, unsubstantiated (e.g., Liao, Wood, and Creighton 2015). Patients’ narratives support the idea that the risk of harm is too great to justify such interventions.

Normalizing surgeries and associated interventions have caused reasonably foreseeable intolerable harm, and the excuses given for it are insufficient; they do not justify the practice, morally, in light of the evidence. On Card’s account, the standard of care that promotes the use of unnecessary normalizing interventions counts as an evil, one that some have begun to call intersex genital mutilation (IGM) (see, e.g., Swiss National Advisory Commission on Biomedical Ethics 2012; European Parliament 2017). Card’s analysis of complicity provides essential tools for considering the responsibility of individuals engaged in evil practices that have been promoted within institutional contexts, such as unnecessary normalizing interventions.



### **Complicity in Evil Practices and Institutions**

To help make sense of the dispersed responsibility in collectively perpetrated evils, Card discusses complicity, the study of which is a critical component of her account of evils. Persons can be complicit in an evil by association with it, because they benefit from it, or because they are participants in or contributors to it (Card 2010, 63–66, 78, 83). When considering whether an individual is complicit in an institutional evil, we may ask whether the person’s choices causally contributed to harm, and whether the harm could have been prevented if some individuals within the institution had chosen differently (Card 2010, 65). We should investigate whether the individual *knew* that his or her choices were contributing to harm (Card 2010, 65). Finally, we can ask whether the person was or was not obligated to choose differently; this obligation would arise based on some special role within the institution, which could leave an individual with an additional responsibility to prevent harm (Card 2010, 65). Though not dispositive, these factors can help establish whether a person has been complicit in a collectively perpetrated evil.

Card explains that the nature of institutions is such that that they may foster conditions under which culpable complicity in evil is more likely. The commission of evils may become routinized within an institution, and made to seem unremarkable. Individuals may follow procedural rules without questioning the mission toward which they work; worse, taking “the status quo to be natural, normal,” such individuals may defend questionable practices “against attack” (Card 2010, 70). Following Arendt, Card observes that in a bureaucratic institution—which may compartmentalize tasks, diffuse responsibility, encourage anonymity, and elevate loyalty and efficiency—it is easier to ignore the evil in which one is engaged (2010, 70). Card writes, “We often act (or fail to act) from weakness or inertia. We may go along uncritically with practices we suspect are questionable, giving others the benefit of our doubts” (2010, 63). Though the individual actions of such persons may not, themselves, be evils, they may, taken cumulatively, amount to an evil (Card 2010, 7; 65). Complicit agents may therefore be blameworthy for the intolerable harms that they ignore or facilitate (Card 2010, 64).

When harm has resulted from the deeds of one person, that person’s culpability is often relatively clear. But when persons are complicit in an evil perpetrated by many agents, it can be much more difficult to determine whether an individual is culpable. Card explains: “A major difference between the evils done by individuals . . . and institutional evils is the role of culpability. An individual whose deed is metaphysically and morally inexcusable is culpable. But

the indefensibility of a norm does not settle the question of whether a responsible agent who applies or benefits from that norm is culpable. Individual culpability depends on such things as what options and what knowledge an individual has and the costs, including moral costs, attached to those options” (2010, 18). Card recognizes that a variety of roles may be played by agents involved in collectively perpetrated evils, each of which may allow for distinctive possibilities for knowledge and action (2010, 27–28 63–64). Such differences will affect assessments of individuals’ culpability. Many people involved in institutional evils contributed to harm, not because they made a conscious decision to do so, but because they failed to critically examine their reasons for acting, or how their actions made them participants in an evil (Card 2010, 22–23). Indeed, Card explains, there are likely to be institutional evils for which no one is culpable, or few people are (2010, 64-66). Trying to describe all individuals as “wrongdoers” fails to capture the different degrees of responsibility at work in a collectively perpetrated evil.

### **Culpable Complicity and Unnecessary Normalizing Interventions**

Doctors who recommend and perform unnecessary medical interventions are complicit in an evil practice; many of them have inflicted intolerable harm, and all have contributed to sustaining a standard of care we have shown is an evil. But as Card shows us, noting the complicity of doctors does not fully explain the nature of their moral responsibility for engaging in an institutional evil. It remains to be seen how we should view these doctors as moral actors, whom we would normally wish to hold accountable for evils to which they have contributed. To evaluate whether doctors’ complicity in this practice is culpable, we must consider whether the intolerable harms they inflicted were foreseeable, and whether doctors have a good moral excuse for their actions, which might mitigate their blameworthiness (Card 2010, 64).

While Card directs us to call a practice like unnecessary normalizing interventions an evil even if intolerable harm was not foreseeable at its inception (2010, 29), we should consider whether this lack of foreseeability mitigates individual doctors’ culpability during the early years in which practices for normalizing atypical sex conditions were developed. Historian Alice Dreger discusses the emergence of this standard of care. She explains that in the nineteenth and twentieth centuries, rising access to gynecological and medical care led to a surge in the medical identification and treatment of people with intersex conditions. Increased knowledge about persons with intersex conditions, Dreger writes, posed “powerful challenges to biomedical

claims about the natural, inviolable distinctions between men and women” (2000, 28). As a response to this challenge, physician William Blair Bell recommended in 1915 that surgery be used to make persons born with intersex conditions conform to their “true” sex, to be determined and constructed by doctors. Dreger comments, “Only two true sexes would still exist, with a limit of one to each body, and the medical man would still be the interpreter . . . [and] the amplifier [of] true sex. This—the assignment to and the surgical construction of a single, believable sex for each ambiguous body—was the way of the future. . . . Medicine had won out over the threat of the hermaphrodite” (2000, 166). In the mid-twentieth century, doctors and medical institutions began to promote the idea that surgical and hormonal normalization was necessary for patients’ well-being, a concept that integrates assumptions and concerns regarding parental love, sexual performance, social acceptance, and the subjugation of deviance (Dreger 2000, 181–84).

The history Dreger offers complicates the question of whether individual, complicit doctors could have foreseen intolerable harm in the early years during which physicians engaged in efforts to “correct” bodies displaying “confused sex” (2000, 185). When assessing foreseeability, we should ask: To what degree did doctors recognize the risk of harm to their patients? What evidence or information was available to help them understand that risk? To what extent did physicians distinguish the use of medical practice to relieve individual versus social ills? Certainly, doctors’ judgments would have been colored by social anxieties about persons with atypical bodies, and a suspicion of sexual deviance (Dreger 2000, 27–28). If such concerns led doctors to believe that their patients’ well-being depended on normalization, these doctors may not have been able to anticipate the intolerable harm likely to occur as a result of their attempts to prevent harms they arguably believed would result from atypical sex anatomies.<sup>ii</sup> Furthermore, in this period, no persons who had undergone normalizing interventions as babies would yet have come forward with complaints about their medical treatment. If they had, we can fairly judge the doctors they confronted as culpable for acting in a way they could have foreseen was harmful. But if doctors’ assumptions were not challenged by harmed patients or their advocates, it is not clear that intolerable harm was foreseeable by all, or even most, doctors engaged in early normalizing interventions. Their ignorance of the potential for harm might mitigate some of these doctors’ culpability.

There is reason to think, however, that many doctors might still be culpable for their engagement in normalizing interventions even in the mid-twentieth century, when treatment protocols were being formalized. Dreger explains the widespread failures to study the risks of unnecessary normalizing interventions, going back to their earliest use (2000, 192–94). On Card’s account, doctors and medical institutions at this time might very well be culpable for failing to inquire about the potential for intolerable harm (Card 2010, 23). Today, the abundance of evidence means that one may reasonably censure physicians’ failures to pursue robust follow-ups of their patients (see, e.g., Liao, Wood, and Creighton 2015). Medical professionals who continue to support the unnecessary normalization of people born with intersex conditions may be judged as we judge parents who smoke around their small children; in the 1940s, they would not have been expected to know the dangers of second-hand smoke. Today, there is no such excuse.

Tracing the history behind normalizing interventions on persons with atypical sex anatomies is helpful for assessing the question of foreseeability. It also allows for a better investigation into whether the doctors concerned have moral or metaphysical excuses, which would also mitigate their culpability on Card’s account. One might argue that powerful social norms regarding sex and gender count as metaphysical excuses for doctors’ treatment of persons with intersex conditions; doctors might claim ignorance of wrongdoing, resulting from their reliance on the soundness of prevailing standards. Resources for evaluating such claims might be found in the growing literature on structural oppression and epistemic injustice, which has addressed the ways in which social norms and practices may affect the implicit attitudes of individuals, and their moral responsibility for harm (see Young 1990, Fricker 2007, Medina 2013). The practice of unnecessary normalizing interventions is embedded in complex social norms that link notions of healthy human beings with two categories of sex: male and female. Such assumptions are not themselves evils, but may be more accurately described as “blind spots” in what José Medina has called “social scripts” (2013, 68). In the context of such norms, we might understand why doctors find it difficult to imagine allowing a child with an intersex condition to grow up without medical intervention.

Card shows us, however, that even people with “blind spots” may be judged as culpable for the infliction of intolerable harm (2010, 64). She also clarifies that in cases of institutional evil, there may come a time when a metaphysical excuse no longer applies (Card 2010, 19).

When engaging in procedures that are medically unnecessary or non-medically urgent, as are normalizing interventions, doctors and medical institutions have a responsibility to identify evidence of harm and to interrogate their reasons for acting in light of the risks. This is true even when a normalizing practice of this sort aligns with the (structurally oppressive) norm that to be a healthy human being one must have a body that conforms to specific social standards. Particularly today, but in the past as well, unhesitating reliance on assumptions and “social scripts” is not a metaphysically valid excuse for doctors’ culpable complicity in the evil practice of the unnecessary normalization of persons with intersex conditions. Doctors who perform these interventions demonstrate what Medina calls “intellectual laziness” and “epistemic arrogance,” leading them unquestioningly to abide by norms without critical inquiry (2013, 68–69, 146). Card clarifies the moral violation that such laziness and arrogance entails: “When it is clear that others may be threatened with serious harm, failing to think is no excuse if we are in good health, free from other pressing demands on our attention, and have the time and opportunity” (2010, 23).

In addition to having no good metaphysical excuse for promoting and performing unnecessary interventions on persons with atypical sex anatomies today, doctors also have no good moral excuse. Though doctors who recommend unnecessary interventions may insist that the “normalcy” promised by these interventions will make a child’s life easier (Parens 2006, xiv; Preves, 62-3), Card’s view of evils reveals the flaw inherent in the claim that a person who “means well” is excused from moral responsibility. Card explains, “‘No moral excuse’ does not mean ‘no humanly understandable reasons’” (2010, 16). When great harm is at stake, doctors must question the urge to put social acceptance over the rights of patients to informed consent and to have their healthy bodies left intact. We can understand doctors’ actions without treating “good intent” as exculpatory. These doctors have been culpably complicit in an evil practice; we may therefore inquire about their responsibilities to recognize and repair the intolerable harms for which they are culpable.

### **Responding to Culpable Complicity**

Rarely does Card explicitly discuss responses to the culpable complicity of individuals in collectively perpetrated evils. She does, however, repeatedly indicate the importance of doing so. Card dedicates chapter 9 of *The Atrocity Paradigm* to a study of the moral emotions relevant to

responding to evils, asking, “How is it possible to repair the harms of such evils?” (2002, 200). She offers a limited discussion of a variety of emotional responses to the perpetration of harm—guilt, remorse, regret, and repentance—that may motivate “confessions, apologies, restitution, and reparations” and “constructive steps toward rebuilding relationships or correcting social injustices” (Card 2002, 207–8).

In *Confronting Evils* (2010), Card explains that she initially intended to follow *The Atrocity Paradigm* of 2002 with a book on responses to evils, including apology and reparative efforts (2010, 9). Though she never wrote that book, she maintained an interest in asking which responses to evils are honorable (Card 2010, 4, 8). Her interest in distinguishing evils from lesser wrongs was at least partly driven by her concern with the need to respond to contemporary evils with greater alacrity. Card writes: “Why distinguish evils from lesser wrongs? One reason is to help set priorities when resources are limited for preventing wrongs and repairing harms. . . . Lesser wrongs can be easier to repair. But evils are urgent. Life and basic quality of life are at stake. . . . The harm of evils is intolerable, often irreversible, frequently uncontainable. Progress in containing, terminating, preventing, and repairing what can be repaired is apt to be incremental. But even slow progress can save lives” (2010, 7). Card’s study of complicity therefore directs us to inquire about the moral responsibilities of persons culpably complicit for their contributions to an evil practice.<sup>iii</sup> In what follows we consider the act of apology, which appears to hold special promise for the repair of harms effected by unnecessary normalizing interventions.

### **The Reparative Work of Apology**

Apology and reconciliation after wrongdoing have recently become topics of psychological and philosophical interest (see Kort 1975; Gill 2000; Walker 2006; Smith 2008). In *On Apology* (2004) psychiatrist Aaron Lazare provides a detailed account of what good apology entails, that is, apology that holds the potential to effect repair, as opposed to obscure what has happened or excuse the perpetrator.<sup>iv</sup> Apology requires that wrongdoers admit that they did wrong and accept responsibility for the harms caused by their wrongdoing (Lazare 2004, 75). A good apology consists of a wrongdoer’s acknowledgment of the offense, a description of the wrong (displaying the wrongdoer’s understanding of its nature), identification of the wronged party or parties, recognition of the harm and its impact, and confirmation that “the grievance was

a violation of a . . . moral contract between the parties” (Lazare 2004, 75). Though circumstances may change the sequence and form of these steps, and not every step need always be explicit (though often, most should be), these are the building blocks of a good apology.

Apology, and, when appropriate, other reparative acts like long-term emotional or financial support, may provide restitution to victims, wrongdoers, and communities affected by harm. Margaret Urban Walker argues that victims are entitled to know that others grasp the fact of the wrong done to them, the perpetrator’s culpability, and the reality of the harm the victims suffered; an offender’s apology can provide all of this, and more (2006, 19). In its avowal of the wrongdoer’s culpability, apology clarifies that the harm was not the victim’s fault. The apology importantly assures victims that they are safe from further harm, and may restore their ability to trust others not to harm them (Lazare 2004, 59–61; Walker 2006, 93–94).

Good apology also acknowledges a victim’s worth, dignity, and personhood, which, Walker explains, were denied, even subtly, in the commission of harm (2006, 92). She insists that in the absence of efforts to repair harms to victims, “we may be outraged, or crushed by the sense that no one cares and we do not matter”; by apologizing, wrongdoers confirm that victims do matter (Walker 2006, 92–95). This is part of the wrongdoer’s duty to fulfill what she calls “burdens of accountability,” which arise due to shared expectations that others will comply with the moral standards to which we are also bound (Walker 2006, 67). Apology is an essential part of repairing our moral relationships when we fail to be accountable to others and engage in wrongdoing.

Ethicist Lee Taft argues that the ideal outcome of good apology is to provide healing for *both* victims and wrongdoers (2005, 71). Offering an apology often requires moral courage, because it requires that one identify oneself as a wrongdoer; therefore, engaging in apology is a virtuous act that, by aiming at repairing harms one has inflicted, has the capacity to restore wrongdoers’ conceptions of themselves as morally decent beings (Taft 2005, 71). Walker adds that apology may also allow individuals or groups who have participated in wrongdoing (like members of an evil institution), to be reconciled with the community that suffered or identified harm. She proposes that apology allows wrongdoers or offending groups to affirm the moral standards of the community, acknowledging that what was done violated those standards (Walker 2006, 89, 200–201). Ideally, acceptance by wrongdoers of responsibility for violating the community’s standards may allow them to be trusted, once more, by that community (Walker

2006, 96, 200–201). Good apology therefore holds promise for providing repair to all parties negatively affected by wrongdoing.

### **The Culpably Complicit Person's Apology**

Academic discussions of apology generally centralize a singly blameworthy wrongdoer, one whose relation to harm is obvious (e.g., Kort 1975; Lazare 2004; Walker 2006; Smith 2008). Where culpable complicity accurately describes an individual's involvement in an evil, there is less guidance on the ethical standards governing apology and participation in moral repair. Card, however, provides resources for thinking about the ways that complicity can be culpable and thus require apology. In the face of intolerable harm, the need to apologize is not diminished by an agent's "good intentions"; an individual's duty to engage in reparative work is not attenuated by the fact that others were also engaged in the evil (Card 2010, 78). Nor does the absence of legal liability obviate responsibility for repairing harms caused by one's complicit engagement in an evil practice. With respect to unnecessary normalizing interventions, apology from culpably complicit doctors would be a significant first step in the reparative work necessitated by decades of intolerable harm. By evaluating, through Card's lens, what apology can do when given by doctors culpably complicit in these practices, we hope to illuminate why apology is morally required of individuals culpably complicit in an institutional evil or evil practice.

The account by Konrad Blair of seeking, and ultimately receiving, an apology for his medical treatment reflects the importance of the repair that apology can provide to persons who have undergone unnecessary normalizing interventions. In his narrative, Blair explains that he reached out to his doctors, asking them to acknowledge that "what was done in the past was not the right thing to do, and [to] promise that things would be different for children like me in the future" (2015, 92). Blair subsequently received the first apology ever issued by a leading medical institution for the medical treatment of a child with an intersex condition. The doctors recognized that their methods were harmful; they acknowledged that there are other, better methods, and expressed a commitment to share this knowledge with other doctors (Blair 2015, 92). Blair explains just how much the letter from the doctors meant: "Their response represented hope, hope for me and for future patients, hope that one day the medical procedures to which I was subjected would become a thing of the past. I felt that finally, a child's voice mattered, that what I had experienced mattered. . . . The apology restored my dignity, and allowed me to accept



myself as the man I was supposed to become. It opened a door for me to speak out and be an activist so that others can be spared what was done to me” (2015, 92).<sup>v</sup> Blair expresses the healing he derived from the acknowledgment by his doctors of their wrong and the harm done to him. But in addition to showing the healing that apology can give to victims, the apology given to Blair showcases the particular power of an apology from a person culpably complicit in an institutional evil. By apologizing, these doctors chipped away at the authority of the standard of care that promotes unnecessary normalizing interventions, and they submitted the evil institution of which they were a part to the judgment of the community (Walker 2006, 200). The apology given to Blair was a way of taking responsibility, but it was also a way of requesting, as Walker insists is important in cases of institutional wrongs, that the truth about a particular wrong be established “for the record” (2006, 10). Whereas doctors might be expected to defend their application of the standard of care, their apology demonstrates the medical institution’s vulnerability to fault. It shows that complicit persons could become aware of the wrongfulness of these practices, despite the features of the institution that make such recognition less likely (Walker 2006, 200; Card 2010, 63; 70).

Apology can, therefore, promote broader ethical reformation. This was what Blair sought when he requested that his doctors express a shared commitment to ensuring that “things would be different” in the future (2015, 92). The type of apology given to Blair upsets the narrative that medical practices are unimpeachable or should be unquestioningly trusted; it marks the kind of thinking that could have prevented these harms in the first place. The understanding conveyed by such an apology could be translated into the production of improved practices, habits, and standards of ethics (Walker 2006, 10; Card 2002, 178). Such an apology can provide needed hope that what Walker calls “morally habitable conditions” can be restored (2006, 209). Ultimately, apology may stimulate changes to widely held attitudes, and even to the rules governing social and political institutions.

### **Confronting Resistance to Asking for Apology from Culpably Complicit Persons**

We suspect that there will be some resistance to the idea that persons who are complicit in an institutional evil have a responsibility to apologize. Much of this resistance may have its origin in a misunderstanding of the nature of culpable complicity; persons may claim that when an institution incurs blame for evil, individuals complicit in that institution should not be blamed

and do not need to apologize. Failure to understand the nature of culpable complicity can lead persons not to apologize, or to apologize badly.

In the case of the institutional, sanctioned practices associated with unnecessary normalizing interventions, the medical providers who enact these practices are individuals whose intimate relationship with their patients can make them look singly culpable. It may be most intuitive for victims in this case to look at a particular doctor or particular doctors who performed a harmful procedure and identify them as “sole perpetrators.” Failing to recognize a collectively perpetrated evil may lead to a failed process of repair because victims, wrongdoers, and scholars will not fully identify what the apology needs to do. Doctors who are culpably complicit in these practices may resist any interaction that requires them to admit fault on their part. Such doctors may decline to apologize on the grounds that they did not deliberately or maliciously cause harm.

This was the case in an interaction between intersex activist Sean Saifa Wall and his former doctor Terry Hensle, who had overseen Wall’s gonadectomy as a young adolescent. When Wall approached Hensle to seek acknowledgment of the harm done to him, Hensle recoiled at the suggestion that he ought to feel remorse (see Pou 2015). Even as Hensle recognized that Wall experienced harm, and that Hensle “absolutely” would proceed with Wall’s care differently now that he has a better understanding of the physical and emotional risks of unnecessary gonadectomy, Hensle insisted that he had no reason to regret his actions because he had not acted out of malice (see Pou 2015). Hensle seemed to think that Wall’s treatment would be wrong now but could not be judged wrong in the past, because it had been undertaken in good faith.

The resistance by Hensle to provide an apology is born of an idea that his good intentions excuse him from making amends for past harms. His claim that he intended to heal but now understands that he caused harm indicates his awareness of the factors that make him culpably complicit on Card’s account. Hensle resists, not the idea that the practices in which he engaged caused harm, but the idea that this makes him blameworthy. He appears to identify Wall’s confrontation as an indication that he is being called singly culpable, and seeing correctly that he is not solely responsible, he expresses neither remorse nor repentance. This resistance to identify a need to engage in reparative efforts consists of a failure on the part of the doctor to understand that he was culpably complicit in a larger institutional evil.

We suspect that in cases such as this such misunderstandings are common. Because the community of specialists who treat intersex infants and children is relatively small, and the harms so great, culpable complicity in the treatment of intersex may be particularly difficult to recognize. If doctors do not understand that they may be culpably complicit in an evil practice, they are more likely to think that a call for apology is a call for them to admit intentional evil-doing on their part, something they are very likely to resist. Card's analysis provides resources for working through the resistance to apology based on conceptions of collectively perpetrated evils that exempt individuals from apology because they are not singly culpable. Understanding complicity as Card does may open possibilities for doctors to identify their culpability for participation in an evil, and to apologize for their roles in that evil, without shattering their conceptions of themselves as healers.

One might argue that apology is not required of *individual* doctors, because these harms were “really” caused by a whole institution, of which individual doctors were only a small part. This claim is similar to the view that “following the rules” is an excuse for unethical conduct. But Card helps us appreciate the dangerous misconception that culpably complicit doctors are excused from responsibility because their actions aligned with the standard of care in which they were trained. Evil practices and institutions do not act on their own, but are implemented and sustained by those complicit in them (Card 2010, 63). To be complicit is not to be coincidentally tied to an evil institution, which perpetrates harm as a response to orders by an evil leader. Rather, institutional evils often occur *because* of the special dynamics of the institution, which may be structured in such a way that unquestioning adherence to the rules of the institution is encouraged.

Thus, to say that we ought only to request apology from the “monsters” of the institution, or to blame the “rules,” is to miss the point entirely. Implicit or explicit support by doctors of the standard of care constitutes their connection to the institutional evil of unnecessary normalizing interventions. Though we should not condemn every doctor who applied the harmful standard of care, we can assign varying degrees of responsibility to those doctors who failed to question it; indeed, the increasing evidence of harms suggests that the failure to attend to the evidence constitutes culpable complicity. Integrating Card's analysis of complicity into a discussion of apology highlights the problems with the idea that complicit individuals are innocent and a “whole institution” is *actually* to blame. Card shows that to be culpably complicit is to be

blameworthy for one's role in a collectively perpetrated evil; thus, to be culpably complicit is to have a duty to apologize.

Why is assessing the resistance to a call for apology so important? Failures to understand the nature of individuals' culpable complicity can lead to no apology at all, or the offering of bad apologies, which neglect the features of apology we've learned are needed (Lazare 2004, 75).<sup>vi</sup> Stories of bad apologies in the case of unnecessary normalizing interventions often involve a doctor's statement that he or she is "sorry" for the pain felt by the sufferer, which may indicate the doctor's sympathy or empathy, rather than an acceptance of responsibility (Lazare 2004, 25). A doctor might also apologize to the wrong person, ignoring the victim of harm, or perhaps apologize in a way that seeks to minimize the degree of his or her responsibility. We find this in the case of Kimberly Zieselman, who, after sending a written request for an apology from her doctors, received an e-mail message stating that too much time had passed to take action, acknowledging only what was referred to as her "unsatisfactory experience." When she responded with an offer to sign a waiver of legal liability in exchange for more dialogue, the hospital—where she had been treated not only as an adolescent, but where she was provided care as an adult at the time of her request—told Zieselman to seek medical help elsewhere (Zieselman 2015, 125).

Bad apologies exacerbate and increase victims' pain, rather than heal it (Walker 2006, 205). Victims may experience lasting anger, hurt, and mistrust against those doctors who continue to deny or justify the wrong (Walker 2006, 205). Furthermore, the failure to engage in reparative efforts that genuinely recognize the harms effected implicitly validates the standard of care that promoted harm in the first place. This failure is a type of what Walker calls "normative abandonment": it tells the victim that "no one cares" and that he or she "does not matter" (Walker 2006, 95). On Walker's account of failed apology, the unsympathetic e-mail that Zieselman received was not only a morally unacceptable extension of the first wrong against her; it constitutes a new wrong (Walker 2006, 205). The great risk of harm resulting from bad apology (or no apology) leads Walker to argue that even if there is no guarantee that an apology will succeed, a wrongdoer must try (2006, 209). Good apology, as a means of providing moral repair, is required of persons culpably complicit in the practice of the unnecessary normalization of people born with intersex conditions.

## Conclusion

The harms caused by the evil of unnecessary normalizing interventions have resulted from the culpable complicity of many medical providers over many years. Doctors have ignored the evidence of risk, failed to question the standard of care, and neglected to address the wrongs and harms of which they should have become aware. The actions and inactions of these doctors do not make them blameworthy in the classic sense; they did not maliciously cause harm, nor did they act alone. Physicians working today have engaged in these practices in accordance with a standard of care upon which they were taught to rely. But as Card's discussion of complicity powerfully demonstrates, doctors' complicity in the evil of normalizing interventions is culpable.

Card helps us see that to be culpably complicit is not to be a monster, it is not to be fully culpable, and it is not to be solely blameworthy for evil-doing. She moves us to recognize, however, that to be culpably complicit is, unequivocally, to be morally blameworthy. Neither good intentions nor past ignorance excuse culpable persons from duties to engage in repair. Card's work clarifies why demands for apology that fail to elucidate the nature of the culpably complicit person's blameworthiness are likely to be met with opposition; doctors will not react well to accusations of "guilt." To demand and engage in reparative work for complicity in collectively perpetrated evils requires understanding the nuances of complicity, and culpable complicity, that Card helps us assess.

By inquiring about culpably complicit persons' duty to apologize, we respond to Card's insistence that we have a responsibility "to be alert to the evils of our own time and appreciate the dangers of complicity in them" (Card 2010, 24), and her call for "habits of reflection" on those things we do together (Card 2010, 64). Though acting together does mean that harm will often occur, offering apology for one's complicity in complex cases of institutional evil—those very cases to which Card devoted herself—is a powerful means of repairing intolerable harms that might otherwise go unaddressed. In apologies for the normalizing interventions to which persons born with intersex conditions have been subjected, we find a promise of restoration for individuals and groups harmed by an institutional wrong. Such apologies provide a basis for building moral communities in which persons may come together to repair the damage wrought by harms perpetrated by many, a task that makes use of the best tools with which Card left us.

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## References

- Amanda. 2015. “The Truth in Writing.” *Narrative Inquiry in Bioethics* 5, no. 2:98–100.
- Arendt, Hannah. 2006 [1963]. *Eichmann in Jerusalem: A Report on the Banality of Evil*. New York: Penguin Books.
- Blair, Konrad. 2015. “When Doctors Get It Wrong.” *Narrative Inquiry in Bioethics* 5, no. 2:89–92.
- Card, Claudia. 2002. *The Atrocity Paradigm: A Theory of Evil*. New York: Oxford University Press.
- . 2010. *Confronting Evils: Terrorism, Torture, Genocide*. New York: Cambridge University Press.
- Chase, Cheryl, and Martha Coventry (eds.). 1997. “Intersex Awakening.” Special issue of *Chrysalis: The Journal of Transgressive Identities* 2, no. 5.
- Council of Europe Commissioner for Human Rights. 2015. “Human Rights and Intersex People.” Last accessed December 18, 2016, at [https://wcd.coe.int/ViewDoc.jsp?p=&Ref=CommDH/IssuePaper\(2015\)1&Language=lanEnglish&Ver=original&Site=COE&BackColorInternet=DBDCF2&BackColorIntranet=FDC864&BackColorLogged=FDC864&direct=true](https://wcd.coe.int/ViewDoc.jsp?p=&Ref=CommDH/IssuePaper(2015)1&Language=lanEnglish&Ver=original&Site=COE&BackColorInternet=DBDCF2&BackColorIntranet=FDC864&BackColorLogged=FDC864&direct=true).
- Coventry, Martha. 1999. “Finding the Words.” In *Intersex in the Age of Ethics*, edited by Alice Dreger, 71–78. Frederick, Md.: University Publishing Group.
- Creighton, Sarah M., Lina Michala, Imran Mushtaq, and Michal Yaron. 2014. “Childhood Surgery for Ambiguous Genitalia: Glimpses of Practice Changes or More of the Same?” *Psychology and Sexuality* 5, no. 1:34-43.
- Dreger, Alice. 2000 [1998]. *Hermaphrodites and the Medical Invention of Sex*. Cambridge, Mass.: Harvard University Press.

- European Parliament. 2017. “European Parliament Resolution of 14 February 2017 on Promoting Gender Equality in Mental Health and Clinical Research.” P8\_TA-PROV(2017)0028.
- Feder, Ellen K. 2014. *Making Sense of Intersex: Changing Ethical Perspectives in Biomedicine*. Bloomington: Indiana University Press.
- Fricker, Miranda. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. New York: Oxford University Press.
- Garcia, Diana. 2015. “The Secret Inside Me.” *Narrative Inquiry in Bioethics* 5, no. 2:92–95.
- Gill, Kathleen. 2000. “The Moral Functions of an Apology.” *Philosophical Forum* 31, no. 1: 11–27.
- Hughes, I. A., C. Houk, S. F. Ahmed, and P. A. Lee. 2006. “Consensus Statement on Management of Intersex Conditions.” *Archives of Disease in Childhood* 91, no. 7:554–63.
- Inter, Laura. 2015. “Finding My Compass.” *Narrative Inquiry in Bioethics* 5, no. 2:95–98.
- Jones, Tiffany, Bonnie Hart, Morgan Carpenter, Gavi Ansara, William Leonard, and Jayne Lucke. 2016. *Intersex: Stories and Statistics from Australia*. Cambridge: Open Book.
- Kessler, Suzanne J. 1990. “The Medical Construction of Gender: Case Management of Intersexed Infants.” *Signs* 16, no. 1:3-26.
- Kort, Louis F. 1975. “What Is an Apology?” *Philosophy Research Archives* 1:80–87.
- Lazare, Aaron. 2004. *On Apology*. New York: Oxford University Press.
- Liao, Lih-Mei, Dan Wood, and Sarah M. Creighton. 2015. “Parental Choice on Normalising Cosmetic Genital Surgery.” *British Medical Journal* 351.
- Medina, José. 2013. *The Epistemology of Resistance: Gender and Racial Oppression, Epistemic Injustice, and Resistant Imaginations*. New York: Oxford University Press.
- Smith, Nick. 2008. *I Was Wrong: The Meaning of Apologies*. New York: Cambridge University Press.
- Parens, Erik. 2006. “Introduction: Thinking About Surgically Shaping Children.” In *Surgically Shaping Children: Technology, Ethics, and the Pursuit of Normality*, edited by Erik Parens. Baltimore: Johns Hopkins University Press, xiii-xxx.
- Preves, Sharon E. 2003. *Intersex and Identity: The Contested Self*. New Brunswick, NJ: Rutgers University Press.
- Swiss National Advisory Commission on Biomedical Ethics. 2012. “On the Management of Differences of Sex Development: Ethical Issues Relating to ‘Intersexuality.’” Opinion No.

Please Cite Final Version – Peck and Feder 2017. *Metaphilosophy* 49 (3): 203-226

20/2012. Last accessed December 20, 2016, at [http://www.nek-cne.ch/fileadmin/nek-cne-dateien/Themen/Stellungnahmen/en/NEK\\_Intersexualitaet\\_En.pdf](http://www.nek-cne.ch/fileadmin/nek-cne-dateien/Themen/Stellungnahmen/en/NEK_Intersexualitaet_En.pdf).

Pou, Jackie. 2015. “The World of Intersex Children and One Person's Journey Between Two Sexes.” *ABC News*. Last accessed December 20, 2016, at <http://abcnews.go.com/Health/world-intersex-children-persons-journey-sexes/story?id=28667285>.

Taft, Lee. 2005. “Apology and Medical Mistake: Opportunity or Foil?” *Annals of Health Law* 14:55–94.

United Nations Human Rights Office of the High Commissioner. 2015. “Fact Sheet: Intersex.” Last accessed December 18, 2016, at [https://unfe.org/system/unfe-65-Intersex\\_Factsheet\\_ENGLISH.pdf](https://unfe.org/system/unfe-65-Intersex_Factsheet_ENGLISH.pdf).

———. 2016. “List of Issues Prior to Submission of the Sixth Periodic Report of the United States Of America.” Last accessed December 24, 2016, at [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CAT%2fC%2fUSA%2fQPR%2f6&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT%2fC%2fUSA%2fQPR%2f6&Lang=en).

Walker, Margaret Urban. 2006. *Moral Repair: Reconstructing Moral Relations After Wrongdoing*. New York: Cambridge University Press.

Young, Iris Marion. 1990. *Justice and the Politics of Difference*. Princeton: Princeton University Press.

Zieselman, Kimberly. 2015. “Invisible Harm.” *Narrative Inquiry in Bioethics* 5, no. 2:122–25.

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<sup>i</sup> These unnecessary and nonconsensual “normalizing” interventions are not to be confused with interventions that adults with intersex conditions and people who are transgender may choose later in life, when they are able to provide fully informed consent.

<sup>ii</sup> We do not address here the question of whether the treatment is in fact for the benefit of the individual patient (as medical treatment is typically understood) or is motivated by other factors, such as relief of parental anxiety or even as a response to disgust, experienced by or projected onto parents or society as a whole (see Feder 2014, 75). The application of the tools Card offers would serve to enhance an exploration of this dimension of the moral problem in question.

<sup>iii</sup> Card also indicates a need to assess appropriate responses from the non-culpably complicit. Following Young, she writes, “Even non-culpable complicity can give rise to an appropriate sense of responsibility to participate in efforts at repair” (Card 2010, 78). Such efforts would not necessarily centralize apology, but would involve forward-looking efforts to change harmful habits and attitudes (Young 1990, 151).



<sup>iv</sup> For an apology to be good, it need not succeed in providing repair to victims, nor must the apologizer be forgiven. “Good” refers to the formulation of the apology, which must include certain elements (though not always explicitly), as detailed by Lazare (2004) and Walker (2006). These elements, Lazare and Walker attest, are most likely to provide repair to those affected by wrongdoing.

<sup>v</sup> Blair recently shared with one of the editors of the journal issue in which his essay appeared that he no longer felt positively about the apology he received. The apology changed his life, but it did not guarantee that others would be spared the treatment he had experienced. Blair argued that if the apology had been heartfelt, his physicians would no longer allow what had happened to him to happen to other children under their care (Blair, personal communication 2016).

<sup>vi</sup> There is a risk that this very article (and other applications of Card’s theory of collectively perpetrated evils) may result in opposition to calls for apology because readers reject, misunderstand, or take offense to Card’s conceptions of evil and complicity in evil practices. We are concerned with these risks, but have tried to show the value of Card’s approach despite them.