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Gender by *Dasein*? A Heideggerian critique of Suzanne Kessler and the medical management of infants born with disorders of sexual development

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Abstract This article explores the relationship between gender, technology, language, and how infants and children born with disorders of sexual development are shaped into intelligible members of the community. The contemporary medical model maintains that children ought to be both socially and surgically assigned and reared as one particular gender. Gender scholar Suzanne Kessler rejects this position and argues for the acceptance of greater genital variability through the use of language. Using a Heideggerian lens, the main question I seek to answer in this article is: does Kessler's approach succeed in its aim to better treat individuals born with disorders of sexual development? I argue that Kessler is successful in offering practical solutions for persons with intersexed conditions to exist and flourish as intelligible members of the community, but that her project ultimately relies on power to "challenge forth" greater acceptance of genital variance. Building on the work of Kessler and Heidegger, I argue that a better approach to making intelligible the existence of an infant born with a disorder of sexual development is not to rely on the manipulation of language, but to instead reinvigorate a sense of the sacred in response to having an intersex condition.

Keywords Disorders of sexual development · Intersex · Gender development · Martin Heidegger · Suzanne Kessler · Infants and children

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Introduction

In her seminal book, *Lessons from the Intersexed*, gender scholar and psychologist Suzanne Kessler argues that the practice of cosmetic surgery to normalize the genitalia of children born with disorders of sexual development emerged out of three historical conditions: first, the practice emerged due to technological advances in the fields of surgery and endocrinology; second, it emerged due to the influence of the feminist movement, which has called into question the practice of valuing a woman solely by her reproductive functionality, and which introduced the belief that functional gonads are no longer the only criteria for gender determination; and third, the practice emerged due to a new theory of gender plasticity developed by John Money and Anke Ehrhardt, which held that a child's gender identity is not fully formed until approximately eighteen to twenty-four months old [1]. Prior to eighteen months, children may be successfully "assigned" a gender regardless of their biologic makeup. Foundational to Money and Ehrhardt's theory is the belief that parents are not able to bond with an infant with ambiguous genitalia, thus causing psychological distress for both parent and child. As a result of these three phenomena, since the late 1950s, it has been common practice to surgically assign a sex to infants born with ambiguous genitalia.

In 2006, the American Academy of Pediatrics (AAP) published new guidelines pertaining to the medical care and management of infants and children born with disorders of sexual development (DSDs), previously known as intersex conditions. In the consensus statement, the AAP states that systematic evidence is lacking for the belief that surgery performed for cosmetic reasons in the first year of life relieves parental distress and improves bonding between the child and parents [2]. As such, surgical intervention "should only be considered in cases of severe virilization… and be performed in conjunction, when appropriate, with repair of the common urogenital sinus" [2]. But despite the AAP consensus and other recent scholarship suggesting that these surgeries may be harmful, it is still considered standard of care to perform cosmetic genital normalizing surgeries on infants born with DSDs. This is problematic because it fails to acknowledge and legitimate the actual lived, embodied experience of many individuals born with disorders of sexual development.

Kessler acknowledges this lived, embodied experience when she utilizes narrative accounts of persons born with intersexed conditions to argue for the acceptance of greater genital variability. *Lessons from the Intersexed* is widely held as one of the most influential texts on the ethics of sexual assignment surgery for infants born with DSDs. To date, the book has been cited over 665 times, and is referenced by prominent scholars such as Judith Butler [3], Rosemarie Garland-Thomson [4], and Anne Fausto-Sterling [5]. Published in 1998, Kessler maintains that greater acceptance of genital variation can be achieved by changing the way physicians talk about genitalia and intersexuality with their patients and their patients' families. Clear in Kessler's argument is the ultimate goal for the abandonment of the conception of *gender* as a whole.

Twentieth century philosopher Martin Heidegger famously critiques the contemporary understanding of technology in his 1950s essay, "The Question Concerning Technology." He argues that how we currently understand technology, as either instrumental (a means to an end) or anthropological (a product of human activity), is secondary to the true essence of technology. The essence of technology, he argues, is not equivalent to technology, but instead, is "ultimately a way of revealing the totality of beings … an ordering of, or setting-upon, both nature and man, a defiant challenge of beings that aims at total and exclusive mastery" [6, p. 309]. It is this condition of persons being ordered available at all times which is the defining characteristic of what Heidegger calls the technological enframing, or the *gestell*. In the *gestell*, persons are challenged forth as *standing-reserve*, to be always available, malleable resources on hand to be exploited.

In this article, I will argue that the current medical model of treatment for infants born with ambiguous genitalia is entrenched in our contemporary, technological enframing, i.e., the *gestell*. I will argue that Kessler attempts to break out of the *gestell* by arguing for the acceptance of greater genital variability through changing the way physicians talk about genitalia and intersexuality with their patients and their patients' families. I will argue that Kessler is successful in offering practical solutions for persons with intersexed conditions to break free of the *gestell* by creating the space for intersexed persons to experience being-in-the-world, and to exist, dwell, and flourish as intelligible members of the community. But, as I will argue, missing in Kessler's recommendations is a clear understanding of *poiēsis*. Simply stated, *poiēsis* or bringing-forth is the revealing of truth. Heidegger explains that it is through bringing-forth that "the growing of things of nature as well as whatever is completed through the crafts and the arts come at any given time to their appearance" [6, p. 317]. Kessler wants to use language to rid the world of constructs of intersex and gender completely, instead of allowing for gender to reveal itself to us (or to not reveal itself to us if it is in fact an ersatz way of being). In this sense, Kessler wants to control with the power of language what is recognized as a legitimate way of being. Building on the work of Kessler and Heidegger, I will suggest that a better approach to making intelligible the existence of the intersexed person is not to rid the world of gender completely, but to instead reinvigorate a sense of the sacred in response to being intersexed.

The medical management of intersex children

The practice of cosmetic surgery to normalize the genitalia of children born with intersex conditions emerged in the mid-1950s out of a theory of gender plasticity developed by Money and Ehrhardt, which held that a child's gender identity is not fully formed until approximately eighteen to twenty-four months old. Prior to eighteen to twenty four months, a child may successfully be "assigned" a gender regardless of their chromosomal makeup or biological realities. Money and Ehrhardt's theory provided essential groundwork for the practice of early genital surgery for children born with "abnormal" or "ambiguous" genitalia. Kessler points out that "supportive evidence for Money and Ehrhardt's theory is based on

only a handful of repeatedly cited cases, but it has been accepted because of the prestige of the theoreticians and its resonance with contemporary ideas about gender, children, psychology, and medicine" [1, p. 15]. The most famous of these oft cited cases is the story of David Reimer, otherwise known as the John/Joan Case.

Born a twin in the early 1960s, David Reimer (born Bruce Reimer) suffered penile ablation due to a botched electrocautery circumcision when he was approximately six months old. Distraught by their son's condition, David's parents reached out to John Money after seeing the doctor give a television interview in which he explicated his theory of gender plasticity. Money agreed to take on David's case. With the help of David's parents, Money sought to change Bruce into Brenda.

Over the course of his childhood, David would undergo several genital surgeries, yearly genital and psychological evaluations, and female hormone therapy as an early adolescent. Money famously used David's "successful" sex assignment to prove that his theory of gender plasticity was true. According to Money and Ehrhardt, in order for the successful gender assignment of a child to occur, four conditions must be met. If met, it was argued, the child would develop a gender identity in accordance with the assigned gender and would not question his or her assignment or request reassignment later [1].

The first condition is that experts must guarantee that the parents have no doubt as to their child's "true" sex [1]. It was believed that parents who were not completely sure of their child's sex would "ruin" the child's sex assignment. This was in part the reason why Money instructed David's parents never to tell their child the truth of his birth. David's parents needed to believe David was a girl just as much as David needed to believe it.

Second, genitals must be made to match the assigned gender as soon as possible [1]. Even though their own theory held that a child's gender identity is not solidified until the child is approximately 18 to 24 months old, Money and Ehrhardt worried that parents would not be able to bond with their infant if the child had ambiguous genitalia, and that a child who underwent surgery closer to this age would be traumatized by an early castration memory [1]. Under this theory, the age in which David presented to Money was ideal; David was just under a year old, still well within the time frame for successful sex assignment.

The third condition necessary for a successful sex assignment is that children must be given appropriate feminizing or masculinizing hormones at puberty [1]. Hormone therapy is necessary to ensure that the child being treated develops the appropriate secondary sex characteristics. Secondary sex characteristics are the bodily features which manifest at the age of sexual maturity. For females, this includes the enlargement of the breasts, increased distribution of fat around the buttocks, thighs, and hips, the growth of pubic and underarm hair, and the widening of the pelvis and hips. For males, secondary sex characteristics include the growth of facial hair, deepening of the voice, the broadening of the shoulders, and the enlargement of both the larynx and the penis. Prior to transitioning back to male as a young adolescent, David was given estrogen therapy (unbeknownst to him) in order to facilitate the development of female secondary sex characteristics.

Finally, the fourth condition of Money and Ehrhardt's theory of gender plasticity is that children must be kept informed with "age appropriate explanations" [1, p. 15]. Oftentimes, this final condition was used to justify lying to children about their sex assignment. In David's case, he did not learn of his male birth, traumatic circumcision, and female surgical sex assignment until he was an adolescent. An article published in the *Hastings Center Report* in 1998 argued "that a physician could justifiably withhold information from a sixteen-year-old AIS patient and/or her parents if he believed that the patient and/or family was likely to be incapable of handling the fact that she had testes and an XY chromosomal compliment" [7, p. 31].[1] Prior to the early 2000s, like in David's case, it was common practice for physicians and parents of individuals with DSDs to withhold the truth about the individual's anatomical histories and conditions. Narratives of adults who learned of a DSD diagnosis and/or sex assignments surgeries performed while they were a young child or adolescent without their knowledge or consent reveal feelings of "freakishness," isolation, degradation, and unease [7].[2]

Despite feminizing genitoplasty and hormone therapy, David never felt quite "right" as a female. As a young adolescent, David's father finally admitted to him that David had been born male. At this point, "Brenda" decided to change her name to David and live full time as a male. David began testosterone therapy, and would eventually go on to marry and adopt his wife's three children from a previous relationship. But unfortunately, the psychological scars of David's past were too much to bear. In 2004, he committed suicide at the age of 38.

Medical management

The medical management of intersex infants as it is today would not be possible without technical developments in surgery and endocrinology [1]. Kessler writes: "Diagnoses of specific intersex conditions can be made with greater precision. Female genitals can be constructed that look much like 'natural' ones, and some small penises can be enlarged with the exogenous application of hormones, although surgical skills are not sufficiently advanced to construct a 'normal' looking and functioning penis out of other tissue" [1, p. 14].

In their 2006 consensus, the AAP identified the following general concepts of care for infants and children born with a DSD: first, gender assignment must be avoided before expert evaluation in newborns; second, evaluation and long-term management must be performed at a center with an experienced multidisciplinary team; third, all patients should receive a gender assignment for the purposes of rearing; fourth, open communications with patients and families is essential, and

[1] AIS stands for androgen insensitivity syndrome; in complete androgen insensitivity syndrome (CAIS), persons are genotypically male with external female genitalia; these persons are unable to respond to testosterone and are generally reared, successfully, as females. Persons with CAIS almost always identify as female and are attracted to men.

[2] "As a young woman, Sherri Groveman, who has AIS, was told by her doctor that she had 'twisted ovaries' and that they had to be removed. At the age of twenty, 'alone and scared in the stacks of a medical library' she discovered the truth of her medical condition" [7, p. 31].

participation in shared decision making is encouraged; and finally, patient and family concerns should be addressed in strict confidence [2].

The AAP stresses that a highly qualified team of experts must be involved in the diagnosis and medical treatment of infants and children with DSDs. In ideal situations, this expert team should include "pediatric subspecialists in endocrinology, surgery, and/or urology, psychology/psychiatry, gynecology, genetics, neonatology, and, if available, social work, nursing, and medical ethics" [2, p. 490]. Prior to making recommendations to the family or other care providers, the team should "develop a plan for clinical management with respect to diagnosis, gender assignment, and treatment options" [2, p. 490].

In regards to diagnosis, the AAP points out that there has been ample advances in the genetics and human sexual development, but only less than twenty percent of DSD cases can be identified with a specific molecular diagnosis [2]. It is noted that "Diagnostic algorithms do exist, but with the spectrum of findings and diagnoses, no single evaluation protocol can be recommended in all circumstances" [2, p. 491]. Technological tools used for diagnosing a child with a DSD include: karyotyping, abdominopelvic ultrasound imaging, gonadal biopsy, urinalysis, and the measurement of anti-Müllerian Hormone, testosterone, gonadotropins, 17-hydroxyprogesterone, and serum electrolytes [2].

In regards to gender assignment, there is currently no absolute medical standard in determining which gender to assign a child born with a disorder of sexual development. Factors which influence a sex assignment include "diagnosis, genital appearance, surgical options, need for lifelong replacement therapy, potential for fertility, views of the family, and sometimes, circumstances related to cultural practices" [2, p. 490]. Regardless of which sex they are assigned, approximately twenty-five percent of persons born with incomplete gonadal dysgenesis experience dissatisfaction with their sex of rearing [2].

In regards to surgical assignment, systematic evidence is lacking for the belief that surgery performed for cosmetic reasons in the first year of life relieves parental distress and improves bonding between the child and parents [2]. Accordingly, surgical intervention

> should only be considered in cases of severe virilization (Prader III-V[3]) and be performed in conjunction, when appropriate, with repair of the common urogenital sinus. Because orgasmic function and erectile sensation may be disturbed by clitoral surgery, the surgical procedure should be anatomically based to preserve erectile function and the innervation of the clitoris. Emphasis is on functional outcome rather than a strictly cosmetic appearance. [2, p. 491]

Examples of surgical interventions for infants born with DSDs include reduction clitoroplasty, feminizing genitoplasty, restructuring of labioscrotal folds into a labia,

[3] The Prader scale is a diagnostic tool used to score the degree of virilization, otherwise known as genital masculinization. A score of 0 indicates a female child absent of virilization. Stage I indicates a child with an enlarged clitoris (cliteromegaly) who is absent of labial fusion. Stage V indicates a scrotum-like labia, penile phallus, and a urethral meatus at the tip of the phallus.

vaginoplasty, creation of neovagina, gonadectomy, hypospadias repair, removal of Müllerian structures, and phallic reconstruction. The AAP notes that "The rationale for early reconstruction is based on guidelines of timing of genital surgery from the American Academy of Pediatrics, the beneficial effects of estrogen on tissue in early infancy, and the avoidance of potential complications from the connection between the urinary tract and peritoneum via the Fallopian tubes" [2, p. 492]. It is also argued that there is risk of ongoing androgen exposure in infants who are assigned female if orchiectomy is not performed, therefore, the "removal of testes in female-assigned infants will ensure the best cosmetic appearance" [8, p. 184].

The AAP consensus statement notes that surgical construction of the genitals will generally need to be refined at the time of puberty [2]. Specifically, "vaginal dilation should not be undertaken before puberty…. An absent or inadequate vagina (with rare exceptions) requires a vaginoplasty performed in adolescence when the patient is psychologically motivated and a full partner in the procedure" [2, p. 492]. Unclear in the AAP consensus is the rationale for the assertion that vaginoplasty is required for adolescents who lack or who have an inadequate vagina. Implicit in this assertion is that, even if infertile, in order to be female, one must have a vagina. For patients receiving a male gender assignment, "The magnitude and complexity of phalloplasty in adulthood should be taken into account during the initial counseling period if successful gender assignment depends on this procedure. At times, this may affect the balance of gender assignment. Patients must not be given unrealistic expectations about penile construction, including the use of tissue engineering" [2, p. 492]. Clearly articulated in this recommendation is that having a "normal" penis is foundational to a successful male gender assignment.

In addition to surgical intervention, many children with a DSD will require hormone therapy. For example, some children with a DSD will not begin puberty naturally on their own. For these adolescents, hormone therapy can be used to induce puberty and force the development of desired secondary sex characteristics.

Heideggerian critique

As stated above, Money believes that his model helps identify and tease out a child's "true" sex. In this sense, he believes technology and psychology can be used as a tool to bring forth and reveal that which is objectively true about the child. But Money's model is not gently bringing forth the child's "true" sex, but is instead challenging forth a gender in the child for a greater purpose: the social machine. Just as a technician programs a computer, the physician following the Money model programs a child via the use of deception, surgical intervention, and hormone therapy in order to accept or assume the identity of a particular assigned gender—an assigned gender that the child may not otherwise develop on their own. Just as challenging forth "puts to nature the unreasonable demand that it supply energy which can be extracted and stored as such" [6, p. 320], challenging forth a gender into the intersexed child sets unreasonable demands on the child's body and psyche. It forces a child to supply a particular gender narrative that can be stored in the mind

to be later used as a means for the flourishing of society. For Reimer,[4] the demands to his body included the loss of reproductive functioning and numerous painful surgical interventions. In regards to demands to the psyche, Reimer underwent trauma as a young adolescent when he learned about his birth, botched circumcision, and sex-reassignment. This psychological trauma stayed with Reimer until his death by suicide at the age of 38.

Under the *gestell*, the craftsman no longer responds to the grain of wood but instead to the needs of the community. Likewise, in the enframing, the Money-influenced physician no longer attends to the needs of the individual child, but the needs of the greater heteronormative community. The social machine implicit in Money's model is one in which heterosexual *acts* are fundamental to the flourishing of a person and, by extension, society. Kessler points to how Money "states 'The primary deficit [of not having a sufficient penis]—and destroyer of morale—lies in being unable to satisfy the partner' … [and] the most serious mistake in gender assignment is to create 'an individual unable to engage in genital [heterosexual] sex'" [1, p. 126]. When Money "mocks gender theorists who have gone to the extreme of proposing that there are five sexes" and states that intersex treatment enhances wellbeing and health to the furthest possible extent [1, p. 121], he does so out of an implicit heteronormative bias which holds that heterosexual coupling is necessary for the proper psychological health of the individual and for the proper ordering of society. For example, Money believed that Reimer would be so psychologically devastated as a castrate that he would never be able to function properly as a man.

The development of a child's gender narrative under the Money model is analogous to the acquisition of energy in Heidegger's windmill and hydroelectric plant. Heidegger writes:

> The hydroelectric plant is set into the current of the Rhine. It sets the Rhine to supplying its hydraulic pressure, which then sets the turbines turning. This turning sets the machine in motion whose thrusts sets going the electric current for which the long-distance power station and its network of cables are setup to dispatch electricity. In the context of the interlocking processes pertaining to the orderly disposition of electrical energy, even the Rhine itself seems to be something at our command [6, p. 321].

In the case of the intersexed child, just as the hydroelectric plant is set into the current of the Rhine, the scalpel is wielded upon, hormones are injected into, and psychological fictions are thrust upon the child. This surgical, psychological, and hormonal intervention supplies the means to gradually modify both the body and the psyche. This gradual modification sets the formation of the gender identity in motion. Like the storage of energy in the case of the hydroelectric dam, in the case of an intersexed child, it is the acceptable gender narrative which is stored. The

[4] Even though Reimer was not born with a disorder of sexual development, his condition and treatment protocol mirrors that of male infants born with a micropenis. In this sense, Reimer acquired a disorder of sexual development and was medically treated as such. Some scholars, such as Sharon Anderson, classify penile ablation as a disorder of sexual development.

purpose of this storage is to hold the gender identity as a standing-reserve, ready for when the child is old enough to have [hetero]sexual relations and enter society as a "real" man or woman.

Of course, non-intersexed children reared under the framework of the same heteronormative lens will also (generally speaking) develop the narrative necessary to facilitate proper, i.e., heteronormative, social functioning. But allowing an intersexed child to develop unencumbered by medical intervention under our current gender binary system means that the child's gender narrative, however it may develop or manifest, is not purposefully constructed for the end of proper social functioning. Just as "the windmill does not unlock energy from the air currents in order to store it" [6, p. 320], the intersexed child's gender narrative is not orchestrated for the purpose of being stored in the child's psyche for the greater social ordering.

Genitals and gender and genitoplasty, oh my!

> *The medical management of intersexuality, instead of illustrating nature's failure to ordain gender in these isolated, "unfortunate" instances, illustrates physicians' and Western society's failure of imagination—failure to imagine that each of their management decisions is a moment when a specific instance of biological "sex" is transformed into a culturally constructed gender. [1, p. 32]*

Kessler's theory of gender

Prior to exploring Kessler's argument for the acceptance of greater genital variability, it is important to have a preliminary understanding of Kessler's theory of gender. Like Money and Ehrhardt, Kessler adheres to a social construction understanding of gender. Kessler has argued in previous essays that "gender is socially constructed in all cases" [1, p. 4]. This view is upheld and viewed as a foundation to most if not all scholars in the field of gender studies and queer theory. By social construction, Kessler means "beliefs about the world create the reality of that world, as opposed to the position that the world reveals what is really there" [1, p. 133]. Kessler defines gender as "the presentation of agreed upon social emblems" [1, p. 124].

For Kessler, gender is "real" in the sense that most individuals will categorize, identify themselves, and experience life as either male, female, or some sort of combination of male or femaleness. Yet, she explicitly rejects any notion that gender is somehow linked to an inner nature. Kessler conceives of gender as both a *practice* and an identity. Gender is both something we do and something we feel.

Kessler argues that the term "gender" should replace "sex" when describing anything related to *maleness* or *femaleness*, whether biologic or social, and that the term "sex" should be redefined and restricted to only conversations pertaining to

reproductive activities or "love-making." Under this view, there is no such thing as a "sexed" person. Persons are gendered, and sex is circumscribed to reproductive and love-making acts. Kessler's reasoning for this is that "this would emphasize the socially constructed, overlapping nature of all category distinctions, even the biologic ones" [1, p. 134].

Kessler's argument for greater genital variability

Kessler begins *Lessons from the Intersexed* by arguing that there are five "unexamined and deeply conservative assumptions" found in Money's argument in favor of the surgical assignment of children born with intersex conditions that have been adopted by gender researchers and medical professionals [1, p. 7]. These five assumptions are as follows:

1. Genitals are "naturally dimorphic" and male and female genitals are not socially constructed.
2. Genitals which fall outside of clearly demarcated boundaries of male or female should be surgically altered to appear "normal."
3. Even if socially constructed, gender is "necessarily dichotomous" given that genitals are naturally dimorphic.
4. Distinctively male or female genitalia are the "essential markers of a dichotomous gender."
5. And finally, psychologists and physicians have "legitimate authority to define the relationship between gender and genitals." [1, p. 7]

Kessler claims that gender researchers, such as herself, should have initially been more critical of Money's theory which puts too much emphasis on the genitals as evidence of gender. Kessler writes that her purpose in *Lessons from the Intersexed* is to introduce and interpret

> the medical literature on intersexuality for scholars and students in the area of gender studies, thereby contributing to feminist theory on the social construction of gender and providing a scholarly context for understanding the contemporary intersexual movement whose goals are to halt genital surgeries on intersexed infants and bring intersexuality "out of the closet" in families confronted with "gender crisis." [1, pp. 9–10]

The main goal of her book is to provide sufficient argument for the separation of gender and genitals. She writes that

> the medical community through its practices has constructed a particularly powerful view of intersexuality. Intersexuals, through their discourse and politicking, have constructed another view. Gender theorists are in the position of being able to demonstrate that intersex need not be constructed at all, and this is one pathway toward arguing that gender need not be. [1, p. 120]

By arguing that "gender need not be," Kessler desires to create a world in which individuals are free to exist without being forced to categorize themselves by false

conceptions of what it means to *be*. Kessler admits this is a lofty goal, but maintains that the ability for new understandings of social conditions have already manifested themselves. Ways in which gender has already changed can be seen in the number of women who now work outside of the home, and in the transgender movement[5] which seeks to dismantle traditional bounds of maleness and femaleness. Given that gender has already evolved, Kessler finds that it is possible for the way we treat intersexed infants to evolve [1].

Through the course of the book, Kessler goes on to argue the following:

1. The medical profession suffers from a lack of imagination regarding the medical treatment of intersex children.
2. Genitals are not completely dimorphic.
3. Genital surgery to create dimorphism is problematic.
4. When given the opportunity, individuals can tolerate a greater amount of genital variation than is currently accepted in the contemporary medical model.
5. Therefore, the link between genitals and gender should be severed; genitals must not be used as a marker of gender; greater genital variation should be accepted.

Kessler's proposed solution

In order to facilitate greater genital variation, Kessler proposes that physicians do "less cutting and more talking" [1, p. 125]. She is critical of the normalization process[6] which occurs directly following the birth of an intersexed child, in which physicians frame the occurrence of intersexuality as a "normal" process in the development of a child's gender. In arguing that talking more and cutting less can better attend to the needs of the child and family affected with a DSD, Kessler compares the process surrounding the surgical sex assignment of an infant to the process of deciding to perform hand surgery on a child. For children in the UK who are candidates for hand surgery, Kessler notes how counseling programs are mandatory. In these mandatory counseling programs, "parents are encouraged to identify their feelings for and against surgery, and children are given the opportunity to communicate their feelings about surgery in individual sessions away from parents. The justification for this level of counseling reflects the physicians'

[5] "While some physicians practice gender on others, transgenderists, only sometimes with the help of physicians, practice it on themselves" [1, p. 121].

[6] See [1, pp. 22–23]. Kessler identifies four key components of the normalization process. First, "physicians teach parents usual fetal development and explain that all fetuses have the potential to be male or female." Second, "physicians stress the normalcy of other aspects of the infant." Third, "physicians (at least initially) imply that it is not the gender of the child that is ambiguous but the genitals." Finally, "physicians tell parents that social factors are more important in gender development than biological ones, even though they are searching for biological causes. In essence, the physicians teach the parents Money and Ehrhardt's theory of gender development. In doing so, they shift the emphasis from the discovery of biological factors that are a sign of the 'real' gender to providing the appropriate social conditions to produce the 'real' gender. What remains unsaid is the apparent contradiction that a 'real' or 'natural' gender can or needs to be produced artificially."

attitudes about how necessary the surgery is, the probability of success, and the psychological needs of families and children" [1, p. 125]. This is a drastically different management style compared to what is typical of children with an intersex condition [1]. Kessler argues that "the matter-of-fact way that counseling is handled in the case of missing digits suggests how intersex might be handled if gender meaning were stripped away" [1, p. 126].

Kessler continues the conversation by going through the similarities and differences between hand and genital surgeries. She compares hand surgery, such as using a toe to replace a missing finger, to genital surgery in order to speculate the differences in management which gender brings. Both conditions create anxiety in parents about how their child will fare in life [1]. In both, parents make decisions with their child's best interest at heart [1]. And in both, there are appearance and function considerations to be weighed, and in many cases, a tradeoff between the two [1].

In contrast, there is a sense of emergency which is absent from the child with the missing digits compared to the child with a missing penis [1]. In contrast to pediatric surgeons who operate on genitals, Kessler argues that surgeons who operate on hands are free to consider some dangers of early surgery since they are not constrained to gender ideology [1]. And in contrast to parents of children who undergo genital normalizing operations, parents of children who undergo finger replacement take responsibility for the decision, and often have the support of a group of peers [1]. Kessler writes "parents of intersexed children, who are cautioned to make decisions swiftly and without consulting support groups, rarely describe themselves as having made decisions. They may be in agony about their child, but they do not describe themselves as agonizing about what decision to make" [1, p. 128].

Kessler agrees that it is important that families feel comfortable with their children, but that surgery is just one way of achieving that end. Another end that Kessler argues can be used to achieve the same purpose is *language* [1]. Kessler calls for physicians to change the way they talk about genitalia and intersexuality. Specifically, she highlights two very different options for how physicians can talk about intersexuality. First, physicians can choose to confront intersexuality directly [1]. In this scenario, "physicians would not be so quick to normalize the conditions for parents but would help them acknowledge and deal with having an intersexed child and with prejudices about gender" [1, p. 128]. Second, physicians could choose to "not see" intersexuality [1]. In this option,

> physicians would refuse to give intersexuality credibility, even for themselves. By bracketing the existence of intersexuality, they would be left with only the genitals that might not even be noteworthy beyond their initial signal of an underlying medical condition. That it is possible to ignore or reinterpret conventional signs of intersexuality is evidenced by those men with diagnosable but "uncorrected" hypospadias and their sexual partners who are unaware of any penile "deformity." [1, p. 130]

Interestingly, Kessler posits that this second method actually builds upon current medical practice, as it involves being even more mindful about language (something

that physicians are already very much concerned with, such as when they avoid trigger words such as "intersex" or "hermaphrodite") [1]. Kessler believes that practices such as this will be instrumental in the subversion of genital primacy. And by engaging in the subversion of genital primacy,

> gender will be removed from the biological body and placed in the social-interactional one. Even if there are still two genders, male and female, how you "do" male or female, including how you "do" genitals, would be open to interpretation. Physicians teach parents of intersexed infants that the fetus is bipotential, but they talk about gender as being "finished" at sixteen or twenty weeks, just because the genitals are. Gender need not be thought of as finished, not for people who identify as intersexed, nor for any of us. Once we dispense with "sex" and acknowledge gender as located in the social-interactional body, it will be easier to treat it as a work-in-progress. This is assuming, though, that gender is something worth working on. [1, p. 132]

Conceptually, Kessler wants to completely obliterate categorical constructs of sexual orientation, intersexuality, and gender. She desires people to experience life as unencumbered beings who are free to experience and express their attraction as it unfolds. She imagines a world where "just as a heterosexual woman today can legitimately claim not to be attracted to men with excessive body hair, in a newly configured system, she could claim not to be attracted to men with penises or to be attracted to men with breasts and a vagina" [1, p. 129].

Kessler ends her book by making the claim that "we rightfully complain about gender oppression in all its social and political manifestations, but we have not seriously grappled with the fact that we afflict ourselves with a need to locate a bodily basis for assertions about gender. We must use whatever means we have to give up on gender" [1]. For Kessler, *Lessons from the Intersexed* is much more about the medical management of persons with disorders of sexual development; it is a call to abandon the practice of gender completely.

Ultimately, by abandoning the medical, and thus *technical,* management of intersexuality [1] and by normalizing genitalia of all shapes and varieties, Kessler attempts to create a world in which the categorical constructs of intersex, sex, and gender are completely erased. In this world, persons would be free to experience *Being* without being forced into socially constructed and harmful notions of male or female. Persons are not challenged into factitious identities; they will no longer be a "man" or a "woman" sitting as a standing reserve for the good of the social machine. This is Kessler's attempt to break us out of the *gestell*.

Heideggerian analysis of Kessler

Language is in the house of Being.
In its home man dwells. [6, p. 217]

By subverting genital primacy and, by extension, eliminating gender as a whole, Kessler believes we can escape the *gestell*. But is she successful? I argue that, yes, Kessler is

successful in offering practical solutions for persons with intersexed conditions to break free of the *gestell* by creating the space for intersexed persons to experience being-in-the-world, and to exist, dwell, and flourish as intelligible members of the community.

One of Kessler's practical solutions is the introduction of new scripts for physicians to use when talking to parents about their child's disorder of sexual development [1]. For example, upon observing the birth of a girl with congenital adrenal hyperplasia, a physician might say,

> you have a beautiful baby girl. The size of her clitoris and her fused labia provided us with a clue to an underlying medical problem that we might need to treat. Although her clitoris is on the large size, it's definitely a clitoris. Who knows what it'll look like as she grows! Some parents don't have a realistic sense of what a baby's genitals look like. You probably haven't seen that many, but I have. I'll consult an endocrinologist, but we won't need a surgeon since there's nothing we need to do about the clitoris. The important thing about the clitoris is how it functions, not how it looks. She's lucky. Her sexual partners will find it easy to locate her clitoris. She doesn't have a complete vagina now and she can decide whether she wants one constructed when she's older. Surgical techniques will be more advanced then and her grown body will tolerate the surgery better, if she chooses to have it. [1, p. 129]

Kessler spends a great deal of time critiquing the Money model of medical treatment, and focuses her subversion of the gender binary on practices which can be incorporated into the existing medical model, like, for example, in the practice of rewriting doctor-patient communication scripts. This is consistent with Heidegger's claim that it is impossible to rid ourselves completely of technology, and that the way out of the *gestell* is not to abandon technology, but to dwell in it differently. By offering practical solutions to integrate genital variability into the practice of medicine already in place, Kessler successfully creates spaces in which individuals outside of typical categories of "male" and "female" can be regarded as legitimate and intelligible members of the social community. Her practical solutions make space for children to develop and grow without feeling forced, or challenged into a particular gender identity. In this sense, Kessler's practical solutions offer the space for children to undergo *physis*. Gone is the need to sexually assign a child to a particular gender so that the child can grow into a productive, heterosexual member of the social machine. Under this model, intersexed children are no longer standing reserve; they are blossoms encouraged (not challenged) to burst into bloom [6].

Only a poet can save us

> *If I may answer briefly, and perhaps clumsily, but after long reflection: philosophy will be unable to effect any immediate change in the current state of the world. This is true not only of philosophy but of all purely human reflection and endeavor. Only a god can save us. [9]*

Kessler's quest for the abolition of the practice of gender is ambitious to say the least. Deeply entrenched in our contemporary understanding of persons and human flourishing is how we interact as gendered persons. So much of identity is tied up into gendered relational practices such as mothering or fathering. It seems highly unlikely that drastic change from Kessler's suggestions will happen overnight. She concedes this but argues that it is at least a step in the right direction for the abolition of gender.

But under a Heideggerian lens, it seems problematic that Kessler desires to rid the world of gender using the manipulation of language. For Heidegger, the highest form of bringing-forth is *physis*. Like "the bursting of a blossom into bloom" [6, p. 317], *physis* occurs when a person is allowed to arise from out of itself without the interference of being challenged forth. Related to *physis* is the concept of *technē*, which "is the name not only for the activities and skills of the craftsman but also for the arts of the mind and the fine arts. *Technē* belongs to bringing-forth, to *poiēsis*; it is something poetic" [6, p. 318]. More importantly, *technē* "is a mode of *alētheuein.* It reveals whatever does not bring itself forth and does not lie here before us…. Thus what is decisive in *technē* does not at all lie in manipulating, nor in the using of means, but rather in revealing" [6, p. 319].

Using power to create a new world order in which gender is no longer a construct is not allowing *physis* or even *poiēsis* to occur; in effect, Kessler argues for the challenging forth of a new world through linguistic force. A better approach to making intelligible the existence of the intersexed person is not to rid the world of gender completely, but to reinvigorate a sense of the sacred in response to being intersexed.

Heidegger recognizes the *gestell* as a "de-sacralized" space, which "reduces all to the quantifiable and the calculable" [11, p. 387]. Here, "Being becomes reduced to the objective presence of entities belonging to a 'standing reserve' or 'stock' (*Bestand*) for representation and manipulation" [11, p. 387]. But outside of the *gestell* and within the clearing (*Lichtung*), Heidegger purports that we are free to experience the sacred, which both overwhelms us and invokes awe [11]. Heidegger conceptualizes the sacred as an "ontological space" which "provides the space both for our dwelling as mortals and for what we look up to as the divine—an openness wherein humanity encounters god/s, a temporary configuration in the correspondence between ontological excess and the finite responsiveness of man" [11, p. 387]. It is "an openness to that which is *not* at one's disposal" [11, p. 389].

Inspired by the German poet Hölderlin, Heidegger suggests that "what the thinker thinks of as 'being' here, even as it withdraws from his conceptualizations, the poet calls 'the sacred.' The poet is the one who responds to the sacred with wonder as it *opens* the very question of being, hence the *truth* of be-ing" [11, p. 389]. Building on Heidegger, I would like to suggest that in regards to caring for children born with disorders of sexual development, what we need is not a scriptwriter but a *poet*.

Kessler's scriptwriting response to infants born with ambiguous genitalia, while altruistically rooted in an attempt to break free of the *gestell*, may inadvertently reinforce the challenging-forth foundational to the technological enframing. In contrast, a poets response to the intersexed child would not involve pre-determined

scripts aimed as manipulating how parents do or do not medically treat their children. Instead, the poet's response would be one which illuminates how these unique children, through their revealing, possess the ability to expand our knowledge of truth and Being.

This call to recognize a sense of sacredness surrounding the intersexed person is not unprecedented. Historically, intersexed persons have existed and flourished as intelligible members of society. Oftentimes, these members were understood to embody the sacred, acting as priestesses, shamans, and spiritual leaders [10]. For example, "the Roman historian Plutarch described the Great Mother as an intersexual (hermaphroditic) deity in whom the sexes had not been split" [10, p. 40]. Just as recently as the 1970s, transgender shamans were reported to be practicing in the Vietnamese countryside [10]. While I certainly do not want to suggest that physicians or scholars impose a sacred social status onto the intersexed or transgender community, what is encouraging about this sacred historical practice is that it recognizes a sense of the mystery surrounding our corporeal bodies in relation to gender identity, expression, and relationships. It allows non-normative bodies to be accepted and celebrated as legitimate members of society. It allows persons and bodies to just *be*.

It is not obvious what invigorating a sense of the sacred would look like in contemporary, medical practice. Perhaps infants born with a disorder of sexual development would not be "normalized" as in the current, medical model. Perhaps these children will not be regarded as a "medical emergency" in need of cosmetic, surgical intervention, but instead, their birth will be framed as a blessing—an expression of the mystery and uniqueness of the human condition. Regardless of how it would look exactly in practice, reinvigorating a sense of the sacred will better allow persons born with an intersex condition to exist and flourish as intelligible members of the community.

Compliance with ethical standards

Conflicts of interest Lauren Baker declares that she has no conflict of interest.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

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