

# *People Born with Intersex Conditions*

## *Pastoral and Bioethical Considerations*

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*Abstract.* There exist a variety of biological variations known as intersex conditions (ICs) or disorders of sex development (DSDs), which cause a person's sex as male or female to be uncertain at birth. In the past several decades, cosmetic surgery aimed at "normalizing" the infant's body has become an increasingly controversial treatment for an infant with an IC or DSD. While ICs and DSDs are not addressed directly by Catholic moral teaching, the Catholic Tradition has a number of tools (prudence, dignity, and hospitality) that can undergird a Catholic response to the suffering of people with ICs and DSDs and support improved medical, pastoral, and spiritual care for them and their families. *National Catholic Bioethics Quarterly* 15.3 (Autumn 2015): 453–463.

### **Blessed Nicolaus Steno: A Model for Bioethicists**

The Spring 2015 issue of *The National Catholic Bioethics Quarterly* included a wonderful article by Frank Sobiech that presented Blessed Nicolaus Steno as a model bishop and bioethicist.<sup>1</sup> The talents and insights of the seventeenth-century "Royal

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<sup>1</sup> Frank Sobiech, "Science, Ethos, and Transcendence in the Anatomy of Nicolaus Steno," *National Catholic Bioethics Quarterly* 15.1 (Spring 2015): 107–126.

Anatomist” were tremendous. In addition to his anatomical discoveries, which helped to articulate biological differences between males and females, Steno was also a geologist who studied the existence of the saltwater seashells on mountaintops.<sup>2</sup> The placement of the seashells thousands of feet above sea level seemed impossible, and perplexed Steno. The main scientific theory of his day supposed that the Great Flood during the time of Noah washed some seashells to the tops of the mountains where they remained for centuries. Steno was dissatisfied with this explanation, because a forty-day rainwater flood would not be able to displace saltwater shells to mountaintops. Steno was eventually able to prove that the seashells were fossilized from when the earth was covered in water thousands of years ago.

Sobiech’s article shows that Steno’s faith and spirituality were not separate from his scientific research. Rather, his faith encouraged his pursuit of knowledge and understanding of the human person. Indeed, the grand victory of Steno’s writings was that he furthered both biblical interpretation and scientific understanding. Steno’s breakthroughs resulted from his ability to reconcile the truths of theology and science.<sup>3</sup> He is a model and an inspiration for the twenty-first-century Christian ethicist.

Steno proposes a conversation between science and religion, which was a robust and fruitful enterprise in medieval times.<sup>4</sup> The scholastics viewed Nature and Scripture as the two books authored by God that reveal who God is. In the twenty-first century, however, the relationship between science and religion has become tenuous because of misconceptions on both sides and a lack of meaningful dialogue at the highest level. Yet science and religion continue to be mutually enriching. As Pope St. John Paul II wrote to Rev. George Coyne, SJ, director of the Vatican Observatory, “Science can purify religion from error and superstition; religion can purify science from idolatry and false absolutes.”<sup>5</sup>

Steno took seriously the givenness of nature, which inspires us to search for knowledge and understanding of the human body. In the first section of this essay, we will examine the biology of the body. In the second, we will look back at how culture and society have shaped the body with their own preconceptions, which has made it difficult for people to choose and accept its givenness. Steno’s ability to use the two books of revelation, Nature and Scripture, is a great example of a bioethics that tries to educate, assist, and accompany people through difficult and sometimes unprecedented moral complexities.

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<sup>2</sup> *Ibid.*, 115–117. Sobiech describes succinctly Steno’s articulation of the ovary as something distinctively female rather than an atrophied testicle, which was the assertion at the time.

<sup>3</sup> Alan Cutler, *The Seashell on the Mountaintop: A Story of Science, Sainthood, and the Humble Genius Who Discovered a New History of the Earth* (New York: Dutton, 2003), 7.

<sup>4</sup> Sobiech, “Science, Ethos, and Transcendence,” 118.

<sup>5</sup> John Paul II, Letter to Reverend George V. Coyne, SJ, Director of the Vatican Observatory (June 1, 1988).

## Medical Treatment for Infants with Intersex Conditions

One such complexity has emerged in treatment of infants with intersex conditions. On April 1, 2015, the island nation of Malta became the first country to pass a law prohibiting unnecessary cosmetic surgery on infants. While parts of the Maltese law are problematic, it does earnestly seek to protect an infant's "right to bodily integrity and physical autonomy," especially in the event of congenital variations that can make determining the sex of a newborn difficult.<sup>6</sup>

At first blush, one might wonder why such a law would be necessary. Why would doctors or parents ever consent to unnecessary and potentially harmful surgery on infants? The answer lies in the confusion and anxiety caused by particular types of biological variations known as intersex conditions or disorders of sex development. ICs and DSDs encompass a variety of medical diagnoses that make it difficult for doctors to determine if the child is male or female.

The lack of accurate information adds to the confusion and controversy around these conditions. Describing these diagnoses with clarity and accuracy is the first step to better treatment for people who have these conditions. The anatomical maturation of a person with an IC or DSD is atypical in terms of chromosomes, gonads, and/or exterior body.<sup>7</sup> A person with an IC or DSD has genes, hormones, and/or bodily features typically found in both males and females. An IC or DSD can affect a person's

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<sup>6</sup> Section 14.1 of the Gender Identity and Gender Expression and Sex Characteristic Act (Malta, 2015) reads, "(1) It shall be unlawful for medical practitioners or other professionals to conduct any sex assignment treatment and/or surgical intervention on the sex characteristics of a minor which treatment and/or intervention can be deferred until the person to be treated can provide informed consent: Provided that such sex assignment treatment and, or surgical intervention on the sex characteristics of the minor shall be conducted if the minor gives informed consent through the person exercising parental authority or the tutor of the minor. (2) In exceptional circumstances treatment may be effected once agreement is reached between the interdisciplinary team and the persons exercising parental authority or tutor of the minor who is still unable to provide consent: Provided that medical intervention which is driven by social factors without the consent of the minor, will be in violation of this Act. (3) The interdisciplinary team shall be appointed by the Minister for a period of three years which period may be renewed for another period of three years. (4) The interdisciplinary team shall be composed of those professionals whom the Minister considers as appropriate. (5) When the decision for treatment is being expressed by a minor with the consent of the persons exercising parental authority or the tutor of the minor, the medical professionals shall: (a) ensure that the best interests of the child as expressed in the Convention on the Rights of the Child be the paramount consideration; and (b) give weight to the views of the minor having regard to the minor's age and maturity."

<sup>7</sup> Karen Marcadante and Robert M. Kliegman, *Nelson Essentials of Pediatrics*, 19th ed. (London: Elsevier Health Sciences, 2014), 1958. Additionally, medical literature and textbooks call intersex conditions "disorders of sex development." In the middle of the twentieth century, the term "hermaphrodite" was widely used. "Hermaphrodite" is still used as a referent, but currently IC or DSD is more commonly used.

external (genitalia) and/or internal (gonads) reproductive structures.<sup>8</sup> In 2006, an IC and DSD advocacy group, Accord Alliance, worked with health care professionals to create a handbook called *Clinical Guidelines for the Management of Disorders of Sexual Development in Childhood*. To educate caregivers, the Accord Alliance handbook lists several specific ICs and DSDs and describes how they manifest:

- Congenital development of ambiguous genitalia (e.g., 46,XX virilizing congenital adrenal hyperplasia; clitoromegaly; micropenis)
- Congenital disjunction of internal and external sex anatomy (e.g., complete androgen insensitivity syndrome; 5-alpha reductase deficiency)
- Incomplete development of sex anatomy (e.g., vaginal agenesis; gonadal agenesis)
- Sex chromosome anomalies (e.g., Turner syndrome; Klinefelter syndrome; sex chromosome mosaicism)
- Disorders of gonadal development (e.g., ovotestes).<sup>9</sup>

Of the above-listed conditions, congenital adrenal hyperplasia (CAH), androgen insensitivity syndrome (AIS), and Klinefelter syndrome (XXY) illustrate the complexity of determining biological sex for infants with ICs and DSDs. A child with CAH has XX chromosomes but receives an unusually high number of androgens (literally “man-makers”) in utero, causing an enlargement of the clitoris that medical professionals call “virilization.” While there is a type of CAH called “salt-wasting CAH,” which requires medical intervention for the health and safety of the child, often infants with CAH receive unnecessary clitoral reduction surgery. Adults with CAH who have had these surgeries report scarring, loss of sensitivity, and deep feelings of shame as a result of the surgery.<sup>10</sup> AIS is in some ways the opposite of CAH. People with AIS have XY chromosomes, but their bodies are unable to receive androgens in utero, so the fetus’s body develops exteriorly as a female. People with AIS have a female body that has internal undeveloped testes and lacks a uterus. In many cases, neither the child nor the parents have any knowledge of the condition until puberty, when the person with AIS, lacking a uterus, does not menstruate.

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<sup>8</sup> Amy Wisniewski, Steven D. Chernausek, and Bradley Kropp, *Disorders of Sex Development: A Guide for Parents and Physicians* (Baltimore: Johns Hopkins University Press, 2012), 1.

<sup>9</sup> Consortium on the Management of Disorders of Sex Development, *Clinical Guidelines for the Management of Disorders of Sexual Development in Childhood* (Rohnert Park, CA: Intersex Society of North America, 2006), 2, <http://www.dsdguidelines.org/files/clinical.pdf>.

<sup>10</sup> See Sharon E. Preves, *Intersex and Identity: The Contested Self* (Piscataway, NJ: Rutgers University Press, 2003); and Katrina Karkazis, *Fixing Sex: Intersex, Medical Authority, and Lived Experience* (Durham, NC: Duke University Press, 2008). Both Karkazis and Preves include a number of interviews with adults with ICs and DSDs who have suffered as a result of the unnecessary and irreversible surgery they had as infants.

## Moral Reflections of Navarrete, Harvey, and Moraczewski

The Autumn 2014 issue of the *NCBQ* published an English translation of an article by Urbano Cardinal Navarrete, SJ, the late dean of the Gregorian Pontifical University in Rome. In the spirit of Steno, Navarrete addressed Klinefelter syndrome, a congenital condition in which a person's karyotype is XXY.<sup>11</sup> The article, "Transsexualism and the Canonical Order," addressed canonical issues around psychology and transgender, but Navarrete also devoted some attention to Klinefelter syndrome, where the Y and X chromosome "converged in the same ovum (with an X chromosome) at the same time in the initial genetic stage, and therefore there is an ambivalent (*bipollens*) chromosomal formula: XXY."<sup>12</sup> Klinefelter syndrome affects about fourteen million people worldwide, about one in five hundred people.<sup>13</sup> In a description of textbook quality and sophistication, Navarrete explains the three sex-indicators with their chronological manifestations in the progression of human maturation:

- *Genetic sex* determined from the moment of conception. A spermatozoid (containing twenty-two chromosomes and either an X or Y sex chromosome) fertilizes an ovum (containing twenty-two chromosomes and an X sex chromosome). Depending on the sex chromosome from the father's spermatozoid, the child will typically be either XX (genetic female) or XY (genetic male), or in the case of Klinefelter syndrome, XXY.
- *Gonadal sex* is manifested within five weeks after conception. Male gonads typically become testes; female gonads become ovaries.
- *Phenotypic sex* is determined by the visible genital organs, which is not always an easy determination. Often observable at birth, phenotypic sex is not fully developed until after the age of puberty, when secondary sex characteristics appear (i.e., voice, hair, physical structure/musculature, and sexual psychology).<sup>14</sup>

In typical human development, these three indications of sex (genetic, gonadal, and phenotypic) align in the course of the embryogenesis, and the secondary sex characteristics become strengthened in puberty. "In [the phenotypic] stage, especially after puberty, the perception of one's own sex develops at the same time in the psychological strata of the personality, together with a sense of identification with it."<sup>15</sup> Navarrete's description of an atypical embryogenesis illustrates the complexity of the development of human beings in regard to biological sex. In addition to Klinefelter

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<sup>11</sup> Urbano Navarrete, "Transsexualism and the Canonical Order," *National Catholic Bioethics Quarterly* 14.1 (Spring 2014): 105–118.

<sup>12</sup> *Ibid.*, 109.

<sup>13</sup> "Klinefelter Syndrome (KS): Overview," Eunice Kennedy Shriver National Institute of Child Health and Human Development, updated November 15, 2013, <http://www.nichd.nih.gov/>.

<sup>14</sup> Navarrete, "Transsexualism and the Canonical Order," 106–107.

<sup>15</sup> *Ibid.*, 107.

syndrome, ICs and DSDs like AIS, CAH, and 5-alpha reductase deficiency all present some discord between an individual's genetic, phenotypic, and gonadal sexes. In responding to these extraordinary and unforeseen conditions, Navarrete ends his article with a surprising paragraph:

When it is a question of cases that are altogether extraordinary and not foreseen by the law, juridical norms that were legislated for common contingencies cannot be applied to these cases that depart so radically from the norm. Therefore, it must be determined what path should be taken in order to find a solution that salvages, as much as possible, everything that is to be salvaged: namely the good both of the patient and of the community in which he is incorporated and also of the Church.<sup>16</sup>

Navarrete's career as a professor of canon law at the Pontifical Gregorian University is evident in this final paragraph because it reflects the final canon of the Code of Canon Law, which contextualizes the whole code and sums up its ultimate goal: "the salvation of souls, which must always be the supreme law in the Church, is to be kept before one's eyes."<sup>17</sup> Paralleling the last canon, Navarrete's final paragraph acknowledges that there are extraordinary cases unanticipated by our norms, customs, and laws. In these cases, the good of both the community and the person should be prudently pursued as the priority. This stance provides a better foundation for practical theology and medical care to support the dignity and autonomy of a person born with an IC or DSD.

These conditions—CAH, AIS, and Klinefelter syndrome—illustrate that biological sex is not always as simple as being male or female in the initial stages of childhood. There exists an initial uncertainty for children born with ICs and DSDs, and lack of recognition of this ambiguity has led to poor medical treatment vis-à-vis cosmetic surgeries.

Navarrete's article was not the first ethical reflection on ICs and DSDs. In fact, Catholic bioethicists should be lauded for their foresight in exploring the theology and ethics of ICs and DSDs. The first time that Catholic bioethicists gathered to address the issues raised by ICs and DSDs was in 1981. Two years later, the Pope John XXIII Medical-Moral Research Center (now The National Catholic Bioethics Center) produced a book titled *Sex and Gender: A Theological and Scientific Inquiry*. This work, composed of the papers and discussions from a workshop of theologians, medical doctors, biologists, and psychologists to advise US Catholic bishops on human sexuality and personhood, is a forward-thinking collection of thirteen chapters, most of which are divided into two articles: an article from the field of science authored by a biologist or psychologist followed by a response by a theologian.

In one such chapter, Rev. John Harvey, OSFS (1918–2011), responds to the practice of surgery on the genital organs of infants with ICs and DSDs, stating, "The Catholic moralist has problems with this kind of solution to questions of identity

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<sup>16</sup> *Ibid.*, 118.

<sup>17</sup> Canon 1752, in *Code of Canon Law: Latin-English Edition*, new English translation (Washington, DC: Canon Law Society of America, 2012), 538.

confusion.”<sup>18</sup> Harvey’s criticism opposed early intervention surgeries to mitigate confusion about biological sex, the types of surgeries which Malta’s new law prohibits. In response to infant surgery, Harvey writes, “There is no way one can morally justify such operations.”<sup>19</sup> Harvey argues against infant surgery based on the inability of the family and doctors to determine the newborn’s biological sex: “The complementarity of male and female presupposes the completion of the developmental process. It is illogical to expect such complementarity where normal and valid developmental needs have not yet been fulfilled. It is a mistake to try and cure people of legitimate needs.”<sup>20</sup> Harvey’s statement asserts that infant surgery halts the developmental process before it is complete. By interrupting the human developmental process, although atypical in the case of ICs and DSDs, infant surgeries violate the dignity and integrity of these children, who are born into a tremendously vulnerable position.

In the comments and discussion section at the end of *Sex and Gender*, compiled by Rev. Albert Moraczewski, OP, the assertion against surgery is further developed into practical advice:

One should not act as if it were possible to say that a person arbitrarily can choose to be a boy or a girl. Rather, as professionals we can recommend to the parents when there is some doubt as to which direction to go, that the parents raise the child as a boy or as a girl. But that advice is made on the basis of many factors including the anatomy, behavioral limitations and future sexual activities. As much as possible, the recommendation to be made should be compatible with whatever biological reality is present.<sup>21</sup>

The articles from both scientists and theologians viewed infant cosmetic surgeries as built on a weak theory of the human body and psychology, for which there is virtually no empirical evidence that it provides satisfactory care for people with ICs and DSDs. In fact, there are a tremendous number of testimonies from adults with ICs and DSDs who were operated on as infants, who report intense and enduring physical and emotional burdens as a result of the surgery.<sup>22</sup> Rather than doctors assigning a biological sex to the child, Rev. James Sullivan (1934–2012), who was trained in theology, psychiatry, and neurology, called for a team of people to assist, educate, and counsel the family: “The team should include an obstetrician, urologist,

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<sup>18</sup> John Harvey, “A Reflection on Chapter Twelve,” in *Sex and Gender: A Theological and Scientific Inquiry*, ed. Mark F. Schwartz, Albert Moraczewski, and James Monteleone (St. Louis: Pope John XXIII Medical–Moral Research Center, 1983), 341.

<sup>19</sup> *Ibid.*, 347.

<sup>20</sup> *Ibid.*, 348.

<sup>21</sup> Albert Moraczewski, “General Discussion Interchange of Speakers/Authors,” in *Sex and Gender*, 355.

<sup>22</sup> I know of three excellent books that detail the accounts of adults with ICs and DSDs who suffered tremendously not as a result of their condition but as a result of the surgery they had as infants. See Elizabeth Ries, *Bodies in Doubt: An American History of Intersex* (Baltimore: Johns Hopkins University Press, 2009); Ellen K. Feder, *Making Sense of Intersex: Changing Ethical Perspectives in Biomedicine* (Bloomington, IN: Indiana University Press, 2014); and Karkazis, *Fixing Sex*.

pediatric endocrinologist, geneticist, psychiatrist/psychologist, and social worker,”<sup>23</sup> which Accord Alliance’s 2006 handbook similarly suggests. Sullivan also stated that “a period of delay is far better than future reversal of the sex assignment.”<sup>24</sup> This might seem like common sense, but the influence of John Money and the practice of infant cosmetic and “corrective” surgeries have proved difficult to dislodge. Sullivan’s final page is titled “Implications for Theology.”<sup>25</sup> He writes,

Theologizing is the enterprise which incorporates empirical data into religion in order to manifest how the data relate to revelation and salvation – the two essential elements of theology. Theologians need to theologize concerning the biological data of sex and gender. Sex and gender have a powerful impact on religious faith and practices. Theologians must incorporate the results of their theological analyses in order to weigh the value of the decisions made by the health care sciences and parents/guardians. The purpose of decision-making is to select values and channel behavior.<sup>26</sup>

While Catholic bioethicists were early to join the conversation, there has been little development of the medical treatments, spirituality, theology, and pastoral care of those with ICs and DSDs. While the publication of *Sex and Gender* was Steno-esque in its forward-looking moral reflection on ICs and DSDs, there is still a need for practical and concrete policies in Catholic hospitals, much like Malta’s ban on cosmetic surgeries for infants. To develop policies, we can build upon what Sobiech calls the four elements of Steno’s ethos: intuition, reflection, empathy, and caution.<sup>27</sup> I would add the virtues of prudence, compassion, and hospitality. Within Catholic theological ethics, the virtue of prudence can help to refocus our efforts on caring for the patient rather than focusing on the sociocultural norms of biological sex.

When reflecting upon ICs and DSDs and considering treatments, the first element of the Catholic Tradition that should be lifted up is prudence or “caution,” as Steno might suggest. Prudence examines the goals of a situation and seeks to find the most appropriate way to achieve them. Reprioritizing the autonomy of the patient (in the case of ICs and DSDs, an infant who is unable to make future decisions about their identity) can guard against potential paternalism and create circumstances for better education and decisions.

Whenever we encounter something that is unanticipated or unaccounted for in our categories of thought and practice, the primary Christian response should be to apply Steno’s ethos alongside prudence, understanding, generous mercy, and the conditions for flourishing. As the history of people with ICs and DSDs has shown, it is not enough just to intend to do the right thing. In the case of a person with an IC or DSD, there must be a “keen assessment of circumstances, careful deliberation and reflection, and a moral imagination healthy enough to enable us to judge different

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<sup>23</sup> James Sullivan, “Reflection on Chapter 2,” in *Sex and Gender*, 82.

<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.*, 97.

<sup>26</sup> *Ibid.*

<sup>27</sup> Frank Sobiech, “Science, Ethos, and Transcendence,” 115.



possibilities for appropriate action. That is what prudence provides, and it explains why it ranks first among the cardinal virtues.”<sup>28</sup>

The *Catechism of the Catholic Church* defines prudence as “the virtue that disposes practical reason to discern our true good in every circumstance and to choose the right means of achieving it. One of the cardinal moral virtues that dispose the Christian to live according to the law of Christ, prudence provides the proximate guidance for the judgment of conscience.”<sup>29</sup> Citing St. Thomas Aquinas, the Catechism adds that that “prudence is right reason in action.”<sup>30</sup> It is also called the “charioteer of the virtues” because it guides the other virtues by applying moral wisdom to the particulars of real life. In regard to the treatment with people with ICs and DSDs, prudence guides us to listen to their voices, learn how they have been treated, and discern how to accomplish the good. Prudence acknowledges reality and then helps us to do what is right, just, and good within a given situation.<sup>31</sup> What is good accords with reality, and as we have seen above, there has been imprudence in the surgical interventions responding to the biological reality of ICs and DSDs.

Prudence is also the art of “controlled readiness for the unexpected.”<sup>32</sup> Prudence can offer a two-pronged starting point, asking “What pastoral support can a community offer individuals with ICs and DSDs?” and “What theological underpinning can guide our pastoral practice in regards to vocation and intimate relationships to promote human flourishing?” When we encounter the unexpected or recently discovered, prudence, as practical reason, advises us to examine reality and action.<sup>33</sup> We should first seek to learn what we can about this unanticipated reality and then allow our actions to be informed by that knowledge. In both knowledge and action, we ought to direct ourselves to learning the truth and seeking the good. If prudence is the virtue that guides the ethical response, hospitality is the attitude guiding pastoral care for people with ICs and DSDs and their families. As Thomas Ogletree explains,

To offer hospitality to a stranger is to welcome something new, unfamiliar, and unknown into our life-world. On the one hand, hospitality requires recognition of the stranger’s vulnerability in an alien social world. Strangers need shelter and sustenance in their travels, especially when they are moving through a hostile environment. On the other hand, hospitality designates occasions of potential discovery which can open up our narrow provincial worlds. Strangers have stories to tell which we have never heard before, stories which can redirect our seeing and stimulate our imaginations. The stories invite us to view

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<sup>28</sup> Patricia Lamoureux and Paul Wadell, *The Christian Moral Life: Faithful Discipleship for a Global Society* (Maryknoll, NY: Orbis Books, 2010), 124.

<sup>29</sup> See *Catechism*, glossary, s.v. “prudence.”

<sup>30</sup> *Ibid.*

<sup>31</sup> Josef Pieper, *The Christian Idea of Man*, trans. Dan Farrelly (South Bend, IN: St. Augustine’s Press, 2011), 16.

<sup>32</sup> Josef Pieper, *The Four Cardinal Virtues* (Notre Dame, IN: University of Notre Dame Press, 1966), 22.

<sup>33</sup> *Ibid.*, 11.

the world from a novel perspective. Hospitality offers welcoming words and caring presence to those in our midst, who might have come as a surprise.<sup>34</sup>

Neither Scripture nor Tradition provides any direct answers for understanding people with ICs and DSDs or for promoting their flourishing.<sup>35</sup> Scripture, however, does provide us with principles and attitudes for treating those who have been marginalized, abused, shamed, and ignored. The Gospels and the Catholic Tradition both continually offer us Jesus's example of interacting with those who have been excluded (lepers, prostitutes, Gentiles, and Samaritans). In his life, Jesus responded to an inhospitable world by acting with hospitality and instructing his followers to do likewise. In his feeding of thousands, his welcoming of children, his healing of diseases, and in his parables, especially the Good Samaritan and Prodigal Son, Jesus always gave human attentiveness and companionship to the stranger and to those who were labeled as strange. In the case of ICs and DSDs, social views of the human person have become inhospitable to these biological variances, and the surgeries function to make them "more presentable" to an unwelcoming ideology, which does not accept otherness or ambiguity in biological sex. Hospitality for ambiguity can be a principle of care for people with ICs and DSDs.

### The Most Prudent Course of Action

Pope Francis has modeled and written about a posture that seeks first to learn what we can about this unanticipated reality, and then to allow our actions to be informed by that knowledge. Francis has named this idea the "culture of encounter." In a culture of encounter, there is an a priori posture of listening. As Francis writes, "Listening helps us to find the right gesture and word which shows that we are more

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<sup>34</sup> Thomas Ogletree, *Hospitality to the Stranger: Dimensions of Moral Understanding* (Louisville, KY: Westminster John Knox Press, 2003), 2.

<sup>35</sup> People have suggested "eunuchs for the kingdom" (Matthew 19:12) as a possible analog, and while I do think that this may have some merit, the historical categories and the warrant for eunuchs (slavery, intentional castration, harems, concubinage) make it difficult to apply. I am not sure how accurately "eunuch" really describes people with ICs or DSDs. Also, Galatians 3:28—"There is no longer Jew or Greek, there is no longer slave or free, there is no longer male and female; for all of you are one in Christ Jesus"—has been cited as a scriptural text that potentially speaks to intersexuality. Paul, however, was writing about equality in Christ and calling for an end to social structures that create hierarchy and oppression, not biological conditions. While Scripture does not specifically address ICs or DSDs, the Talmud (200–500 A.D.) does. The rabbinic texts refer to both the *tumtum*, those of unknown or "hidden" sex, and the *andrognynos*, a person of ambiguous sex. In fact, "*Tumtum* appears 17 times in the Mishna; 23 times in the Tosefta; 119 times in the Babylonian Talmud; 22 times in the Jerusalem Talmud and hundreds of times in midrash, commentaries, and halacha. *Andrognynos* appears 21 times in the Mishna; 19 times in the Tosefta, 109 times in the Babylonian Talmud and countless times in midrash and halacha." Elliot Kukla, "A Created Being of Its Own: Toward a Jewish Liberation Theology for Men, Women and Everyone Else," *TransTorah*, 2006, [http://www.transtorah.org/PDFs/How\\_I\\_Met\\_the\\_Tumtum.pdf](http://www.transtorah.org/PDFs/How_I_Met_the_Tumtum.pdf). Kukla opens his article with this epigraph: "Rabbi Yose says: 'An *andrognynos* is a created being of its own.' The Sages could not decide if the *andrognynos* is a man or a woman. But this is not true of a *tumtum*, who is sometimes a man and sometimes a woman" (Mishna Bikkurim 4:5).

than simply bystanders. Only through such respectful and compassionate listening can we enter on the paths of true growth and awaken a yearning for the Christian ideal: the desire to respond fully to God's love and to bring to fruition what he has sown in our lives."<sup>36</sup> A culture of encounter leads to a culture of compassion and dignity. When we seek first to listen with hospitality, our capacity for prudence and empathy expands our ability to promote human flourishing and deepens our compassionate response. In both knowledge and action, we ought to direct ourselves to learning the truth and seeking the good.

People who care for those with ICs and DSDs should always exercise prudence, compassion, and hospitality, while keeping in mind the person's dignity as the top priority. Incorrect sex assignment in the presence of ambiguous external genitalia is a serious medical mistake that can be prevented. The most common and most drastic errors originate from hasty decisions made on the basis of appearance of the external genitalia alone. Despite data confirming the lack of satisfaction with cosmetic surgery for infants, the surgeries continue because of the anxiety of parents and doctors. Education and noncoercive counseling within a team approach represent current best practices. Prohibiting unnecessary surgery (or at the minimum delaying surgery until after puberty) is a desired outcome that respects the dignity, autonomy, and vulnerability of the child.

The only prudent and hospitable response to the birth of a child with an IC or DSD is for parents and caregivers to do their level best to discern the sex of the child and to raise the child as a boy or girl without surgery. Because it is difficult to predict how a child with an IC or DSD will develop before or after puberty, conditional assignments that prove incorrect are inevitable. As the child grows and secondary sex characteristics develop, the parents' original choice may prove incorrect. If the sex that was assigned is opposite to the one that prevails, the assignment can be changed as the child matures. In cases of ICs and DSDs, however, surgery compounds the trauma and suffering caused by incorrect conditional sex assignments at birth.

Variations in the body can make flourishing difficult because of the dual burden of physical atypicality and emotional anxiety. This is heightened by a culture that has misunderstood and mistreated certain bodies by surgically reshaping them. While these conditions are relatively rare, the way that we approach differences and biological variations illustrates how we view humanity as a whole.

Sobiech concludes that Steno promoted the body as the "interpreter" of divine love.<sup>37</sup> Indeed, Catholic medical care interprets Christian love for all people through empathy, prudence, compassion, and hospitality. The Body of Christ as a community is a body with endless variance and every possible physical difference. In all of our variance and difference, we are meant to flourish and thrive, and this flourishing continues in a bodily way even after death, in the Resurrection we profess as Christians. Our belief in the Resurrection is the belief that God never discards our bodies, but rather continually brings our bodies into closer union with God.

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<sup>36</sup> Francis, *Evangelii gaudium* (November 24, 2013), n. 171.

<sup>37</sup> Frank Sobiech, "Science, Ethos, and Transcendence in Nicolaus Steno," 125.