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[title] **Intersexual Births**
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Abstract

This article aims to analyze a possible manner of approaching the birth of intersexual children. We start out by summing up what intersexuality is, and how it is faced in the dominant clinical practice (the "treatment paradigm"). We then argue against this paradigm, in favor of a postponement of genital surgery. In the second part of this paper, we take into consideration the general question of whether only two existing sexes are to be recognized, arguing in favor of an expansion of sex categories. In the third part, we illustrate the reason supporting the provisional sex attribution, which is their best interest and in the respect of developing child's moral autonomy. This position aims to increase child's well-being and self-determination, limiting parents' freedom to take decisions on behalf of others, in particular, those decisions concerning basic aspects of their children's personal identity.

Keywords
Intersexuality; Genital Surgery; Sex Assignment; Epistemology of Sex; Proxy Consent; Autonomy

Intersexual Births: **The Epistemology of Sex and Ethics of Sex Assignment**

1. Introduction

Although intersex issues have been long discussed, actually a justification for the common health practice is needed. Nowadays in some countries, there is legislation protecting intersexual subjects, in other, there is the option for a third gender/sex label, and in few others a prohibition of non-consensual medical intervention. Intersex activists have won several battles to a recognition of their rights, and even United Nations (2015) has recognized their efforts. Nevertheless, most of the practitioners in the field of intersexuality still embraces a traditional vision of the therapeutic treatment that includes sex and gender assignments, and early cosmetic, unnecessary, surgical and medical treatment, grounded on a paternalistic view of the best interest of these children. This medical management of the bodies of the people born intersex continues to be practiced (Human Rights Watch 2017: 47-52) and "have also been criticized as being unscientific, potentially harmful and contributing to stigma" (United Nations 2013).

The efforts of intersex activists have been toward the achievement of practical results (see Dreger and Herndon 2009). In the academic research, much of the work has been in sociology or the ethical discussion of early surgery, related to cultural, social and religious pressures. With this paper, we want to present an analysis of what intersexuality is and, in virtue of this, a justification for an enlargement of sex categories. By this analysis, we want to provide some considerations on the ethics of the management of intersexual infants and children.

Firstly, we shall present the terms of discussion: what intersexuality is and in which form it appears. Secondly, we will exhibit which is the traditional medical approach to these conditions, going on to summarize the criticism moved against it. Thirdly we will examine how intersexuality can be conceptualized arguing in favor of the enlargement of sex categories. Lastly, we will propose an approach to receiving this kind of births which promotes sex and gender self-determination of each human individual starting from an early age: the provisional assignment of sex and gender and the abolition of unnecessary surgeries until these individuals will be able to decide for themselves.

2. Overview of Intersexual Definitions and Conditions

"Intersexual" is the term employed in this paper to denote individuals born with "atypical" sexual characteristics. The expression used synonymously in scientific medical literature is "Disorders of sex development" (DSD), a formulation which was coined at the Chicago Consensus Conference and which "should be descriptive and reflect genetic aetiology when available" (Hughes et al. 2006: 554). By definition provided by the Consensus Conference, DSD consists in a heterogeneous group

of alterations of sexual characteristics, defined as congenital conditions with atypical development of chromosomal, gonadal or anatomic sex (Lee et al. 2006).

Coming into the world as intersex represents a peculiar condition because their "congenital conditions of atypical genital and gonadal development are in the intersection of sexual biology, social gender determination, and personal identity" (Rosario 2009: 267).

The nomenclature with which these individuals are defined, has a long and controversial history of changes; it is already itself problematic[1]. The term intersex, for example, "was never formally adopted by physicians as a diagnostic term" (Feder 2009: 241). The new terminology, DSD, according to some authors is better than other alternatives because more current, useful and "not pejorative" (Hughes 2008), but it has been considered stigmatizing by other points of view. Otherwise, the term "intersex", in the perspective of intersexed people and their parents, is considered a term that sexualizes them "by making the issue one of eroticism instead of biology; that it implies they have no clear sex or gender identity" (Dreger & Herndon 2009: 208). In addition to these two main expressions, others have been coined some alternatives to refer to intersex individuals, such as "variations of sex development" (Diamond and Beh 2006).

In this paper, the choice of using the term "intersex", instead of "DSD", stems from the acknowledgment of the performative and pathologizing connotations that the term "disorder" carries. We use the term "intersexual" because the intersexual subjects themselves use it (for example, by the extinct Intersexual Society of North America) and because it emphasizes their biological, value-free peculiarity as opposed to their failed homologation (e.g., Diamond and Beh 2006). We refer to "intersexual" individuals with regards to individuals whose sex is not so sharp and does not allow a categorization as exclusively male or female.

Nevertheless, a single, unique univocal condition called "intersexuality" does not exist; "intersexuality" is an umbrella term grasping different conditions, having in common e sexual peculiarity. In fact, upon further scrutiny of this expression or its medical formulation 'DSD', one can uncover a high number of different conditions. These biological variations are context-specific, depending on local standard about female and male sexual anatomy and its relation with genetic factors: "how many variation (and thus people) are included in the category intersex depends on time and place" (Dreger & Herndon 2009: 200). In certain kinds of intersexual conditions, there is a discordance between genetic sex and anatomical-gonadal sex, e.g., the case of Congenital Adrenal Hyperplasia (CAH), in which the subject presents an XX genotype while presenting a masculine

[1] In the past they were called "hermaphrodites" (see Dreger 1998), but for many reasons, this word is considered pejorative by intersex activists and scientific communities. Such word is referred to a mythological character who hold feminine and masculine anatomical feature.

phenotype (looks like a boy) and meanwhile possesses ovaries. In other types of intersexual conditions, there is a certain kind of genetic mosaicism, e.g., XX/XY individuals. Finally, there are individuals whose genotype does not coincide with the standard forms of either XX or XY (e.g., X0, XXY, XYY, and so on). It is considering the aforementioned cases that "intersexuality" is to be understood as an "umbrella term" which covers different conditions and etiologies, ranging from life-threating condition (as in the cases of CAH, in which the infant subject may die if not provided with the appropriate drugs) all the way to only aesthetic discordance with the sex/gender standard.

The global incidence of intersexuality is estimated to be 1/5,500 newborns, and it is classified as a "rare condition" by the medical community (Lee et al. 2006); nevertheless, it represents a consistent incidence concerning global population.

We analyze intersexuality mostly in term of sex, and less of gender. We adopt the standard distinction between sex and gender. The term "sex" refers to biological status, i.e., physical and genetic attributes such as chromosomes, hormones, and genital anatomy. The term "gender" refers to socially constructed roles and behaviors considered appropriate for one of those sex. (see American Psychological Association 2002; Mayer and McHugh 2016: 87-93; Fausto-Sterling 2000: 3-5). As pointed by Simone de Beauvoir: "one is not born but becomes a woman" (de Beauvoir 2011: 283). The main problems with intersexuality are if an enlargement of sex categories is possible and justified, and which sex attribute to an intersexual child (if it is possible to attribute one). We will focus on these points. Furthermore, there are issues concerning gender and intersex, as we should rear intersex children in one of the two genders, a third gender is possible to perform, but they are less discussed here, even they have great importance.

3. The Traditional Paradigm

Traditionally, medical management of intersex infant and young children consists in the so-called "treatment paradigm" (Karkazis 2014), which provides sex assignment, early sex assignment surgery, and hormonal therapies to homologate the subject's body on the basis of the female or male attributed sex. As a result, the subject is also assigned to a heterosexual coherent gender role which should be reinforced through education and environmental influences. The ambiguity of the sexual traits of the body is thus "normalized" through "corrective operations". The normalization of infants and children intersex is the standard of care until the 1950s (Dreger & Herndon 2009: 202; Money et al. 1957).

In accordance with this paradigm, the birth of intersexual children is perceived as a real "social emergency" (American Academy of Pediatrics 2000; Hester 2004; Chase 2003) since it is impossible to attribute one of the standard sexes to the individual, as the law of many states

requires[2]. Furthermore, there exists a social pressure pushing infants to belong to a specific sexual category and to ensure that their gender role is heterosexually coherent with the sexual category that they belong to (Feder 2006). According to health professionals, most parents of intersex infants interpret the physiological condition of their children as a "defect", a "malformation" that should be corrected as soon as possible. These births, classified in the medical field as "disorders", are accompanied by lack of social acceptance. The social non-acceptance of the unusual forms a body can take on does not just concern sexual characteristics but also applies to all parts of the human body. Nevertheless, there is a peculiar sense of shame, guilt, discomfort (Frader et al. 2004: 426; Parens 2006) secrecy and scandal related to atypical genitalia (Lee et al. 2016; Lee and Houk 2016, Committee on the Rights of Persons with Disabilities 2016). The social non-acceptance also concerns the ambiguity in the definition of the sexual and gender role of each individual, or the possible inconsistency of these two identities in the same individual.

Parents of intersexuals intend to enable their children to integrate as best as they can in a social environment. Indeed, they believe, in most cases, that living with an intersexual condition exposes their children to civil limitation, social blame and potential psychological burden (see Schober et al. 2012; Houk et al. 2012). Other reasons supporting intervention is the attempt to avoid feelings of having abandoned children who need care and support, and the hypothesis that children would not be able to recall surgeries performed on their body at an early age (Karkazis 2014: 2910; Roen 2009: 29).

Some critical stances have been taken against this approach. Firstly, it could be argued that these surgical interventions do not take account of all the meanings – social, cultural, historical and political – taken on by the body, its organs, attributes and functions, meanings that go well beyond biological phenomena (Karkazis 2008: 287). It seems that human beings whose bodies are "atypical" when compared to the medical standard imposed by the dominant paradigm, must necessarily be conformed, stabilized, repaired to ensure a decent life. It seems as though these treatments really "have been contrived solely to conform people to our narrow ideas of 'normal'" (Reis 2013: 142; McCullough 2002: 155-6). A reason for this is that human adults are afraid of "atypicality". They possess specific ideas, culturally situated and socially built, about the kind of body human beings must have, and it is as though this kind of normativity which adults imagine is incised upon the body of intersexual children (Roen 2009: 22).

Secondly, another objection is that early surgery is "worthless mutilation", that causes damage to individuals who have not chosen to be subjected to those interventions. Indeed those interventions reduce sexual pleasure in many cases (Morland 2009: 286), impose a sex that might not coincide

[2] In some states this is no longer required, as in Germany, Australia, New Zealand.

with future gender identity, and in most cases are irreversible. Furthermore, outcome studies are scarce, and surgical outcomes are uncertain (Mieszczak et al. 2009). According to some, infant genital surgery is a real human rights issue, which should be remedied through "a complete moratorium on all surgical and hormonal treatments that are not medically necessary" (Dreger 2006: 87; Mason 2013; Smith 2013; United Nation 2015). Furthermore, such interventions are defined as "torture" by United Nation (United Nation 2013: 18-19).

Thirdly, in this field of pediatric treatments, the lack of the consent of individuals who undergo a definitive sex assignment raises difficult issues. On the one hand, they concern the exercise of the decision-making ownership of the parents or the guardian, that is those who have the power and the responsibility to decide on individuals who cannot do it for themselves. The goal of the proxy consent is to arrive at the choice that better than others favors the best interest of the child. The balance of costs and benefits should be, in this case, also take into account the possible side effects that the assignment of early surgical sex brings with it: pain, lifelong depression, incontinence, and scarring. On the other, there are the issues related to the children capacity and right to self-determination. We should protect the future autonomy of these children because their inability is temporary, and they will soon have a full decision-making capacity that distinguishes those who can sign an informed consent form. The ability of individuals to make decisions according to their values and beliefs should be able to be exercised before their bodies, and their developing sexual and gender identity is irreversibly compromised. We will come back later to explore this aspect.

Finally, this approach is charged with sexism to the extent that considers homosexuality and transgenderism as bad outcomes (Dreger & Herndon 2009: 202).

According to this perspective, all the clinical management of intersex newborns is judged controversial (Hester 2004; McCullough 2002: 150) and "maintains a morally and legally unacceptable paternalism" (Daaboul and Frader 2001: 1578). For these reasons it seems necessary to rethink the whole clinical management of intersex births, starting from the attribution of a new meaning to such births and the shapes of these newborns' bodies.

Moreover, these critics argue in favor of the provisional attribution of a sex and gender role without resorting to surgical intervention on the child's body, deferring final decisions to the time when intersex children can express their will and preferences. "Therefore, our society's concept of gender diversity needs to be reconstructed to include persons whose Gender Assignment is provisional" (Ozar 2006: 30). We shall come back on these issues in the last part of the paper.

Now, if we look at intersexuality *per se* and not only to its management the first issues to consider is how to "categorize" these people and what their birth represents. Rephrasing these articulated questions into only one: how many sexes are there?

4. Exploring the Concept of Sex

Whether we endorse an interventionist approach or whether we endorse a weaker approach based on a provisional assignment of gender without carrying out early surgery, the common grounding view is that there are two sexes. Unreflective thinking of western societies shares items and beings in two different categories: male and female. Religious visions often endorse this dichotomy. For example, the three monotheistic religions possess the myth of Noah who is required by God to pick up in the ark a couple (or more) of each living being, a male and a female, to repopulate the Earth (see. Genesis 7-9)[3]. However, this vision is grounded in a prescientific thought: not all living beings are male and female, some change their sex during their life, some have two sexes, some reproduce by parthenogenesis and other variations are present.

Taking the birth of intersexual children seriously imposes to rethink the concept of "sex". How can intersexuality be categorized? The first way to put these children into our scheme is staying in line with the *status quo* of sexual categorization and thinking that they are strange, monstrous or "against nature". It is the traditional way of thinking: Nature is considered to be stable and considered to move forth schematically and with regularity, while whoever does not conform to this modus is deemed to be an outcast and an exception to the rule (as if one day sun were blue). According to this way of conceiving intersexuality, we ought to reconduct these births to the standard, explain the exception leading it back to the rule. To come into the world without sharp sex is akin to having a sixth finger. It is starting from this condition that it is up to the physician to restore the standard condition: early surgery is thus considered to be the solution. It is anomalous to have a sixth finger just as it is to be of sex which is not well defined, and it is for this reason that one attempts to reinstate the rule of nature.

If we were to shift the focal point from Nature to the wellbeing of the person, then we would deal with intersexuality differently. Balancing pro and contra of surgery and its consequences, and infancy with a strange body, we can decide to not go through with surgery, to attribute intersexual children to one of two gender categories. If physicians were to recognize that intersexual children could grow up successfully even without surgery, they would not perform this action. They maintain the same categorization of the former thinkers: there exist only two sexes, male and female, but they shift the focus to the task of the physician, they do not operate to restore the law of nature, but they consider which is the wellbeing of the patient.

Starting from this point, some thinkers suggest going beyond this form of binarism. Indeed, if we believe that intersexed children can live an ordinary life with their genitalia, then it is feasible that

[3] For a discussion of intersexuality in a religious vision see for example Cornwall (2009).

intermediate genitalia are as normal as fully male and fully female genitalia. If we think that the pressure for surgery in infancy and childhood spreads the notion that bodies have to look a sure way to be acceptable (e.g., Holmes 2002), then we could think that a body that does not fully comply with the main sexual categories (male and female) belongs to another sex. Here the focus is again on the categorization of the world. Abandoning traditional procedure of classifying people, we may see some other sexual categories emerge.

Firstly, the world is not only male and female, in the manner in which we may conceive. In observing the world from a scientific point of view, one can discover various cases of sexual diversity. For example, there are some species of fish that change their sex during their lifetime, birds who can change it as well under certain conditions, some creatures (such as snails) are both male and female, and a certain degree of sexual variability can also be observed in mammals, e.g. spotted hyenas (Roughgarden 2004; Callahan 2009). These examples prove that the world of sex is too complex to be divided into only two categories which appeared late in the development of life on planet Earth, while for centuries and millennia life reproduced itself without sexual differentiation, which represents instead only a point of its evolution.

Secondly, some could agree with these claims yet nevertheless argue that for human beings the situation is sharper: one could accept that there is not a stable idea of masculinity and femininity in the world, that some species do not have a stable sex or can have no sex at all, yet approach the matter differently as far as human beings are concerned. The percentage of intersexuality in the spectrum of the human condition is tiny since in general sex is well defined as either male or female, while in other cases there are ambiguities that can be corrected with the right instruments.

Moreover, the power of sexual variance observation could be weakened questioning the relationship between humans and other species. Even though in other species sexes are not fixed, or present some variance inside, or are not two, in humans this binarism could be fixed and stable. For this reason, we should analyze the question independently.

The main first question we ought to ask ourselves is: how do we establish the sex of a newborn baby? In most cases, this is carried out by examining the genitalia, and this is sufficient to determine whether we are dealing with a boy or a girl. We have faith that the midwife will know the answer; however, she occasionally makes mistakes, as in the case of 5-alpha-reductase deficiency: the newborn baby appears to be a girl, but he has a crypto-penis, as described in the novel *Middlesex* (e.g., Eugenides 2002). Hence, it is clear that the appearance of the genitalia is not enough.

Human sex is multidimensional, meaning that multiple factors determine it. We have genetic (or genotypic) sex, gonadal sex, hormonal sex, phenotypic sex and psychological sex (Kemp 2006;

Fausto-Sterling 2012). For many of us, the various types of sexes coincide. For example, if one has an “average-sized" penis, two functional testes, a certain level of testosterone coupled with a low level of estrogen, the presence of only one XY genotype in body cells, one can be proud and happy to be a male (the opposite for woman). However, this is not always the case, and intersexuals prove that sex is a much more complicated issue. There are people for whom the various types of sex (genetic, gonadal, hormonal, phenotypic and psychological) do not blend in the "common manner". How can we classify these individuals? Collocating them within our standard binaristic classification is impossible, since they are in the middle of all or of certain sexual features, and unless we select a sexual characteristic which overrides the others, we cannot insert them into one of our categories. Intersexuals are not a male or a female, hiding under a shell: we cannot classify them as male and female according to current criteria.

Each of these sexual factors (hormonal, gonadal and so on) can be represented as a segment between two extremes: male and female. The points in this segment are infinite, and each of us has a place in this continuum. The position that we occupy in each of these continua is our sex. If we were to look closer, we would find that we hardly occupy the extreme of the continua, as Callahan (2009, 161-162):

> No two of us is identical, even with regard to sex. And of course, the endpoints of this graph are hypotheticals, ideas, mental constructs, not real people. For some reason, we choose to call only the people who fall near the dead centre of this chart intersex. But the centre is just as essential as any part of the continuum –without the middle, neither end is possible. And the middle really has no obvious boundaries. In truth, we are all intersex, living somewhere in the infinite, but punctuated, stretch between man and woman.

In short, our sex is given by our position in a multi-dimensional graph (in which the axes represent genotypic sex, gonadal sex, phenotypic sex and hormonal sex). If we place these values in a graph in which the ordinates represent the number of people (from 0 to infinite) and the abscissas represent the variability between male and female (from 0, for male, to 1, for female), we will probably find that the values form a U-shaped curve: most people are in the upper part of the curve nearest to the values of zero and one, and represent our idea of male and female; others, however, albeit less than the first two groups, are in the central part of the curve, or in the lower part of the curve. In short, there are no doubt individuals who fall in the middle of the curve. Nowadays, with our categories, only one transversal cut is made, which divides the curve into two symmetrical parts: a male part and a female part.

However, why do we not operate more than one cut? If we do not think that the only-two-sex-division is written in Nature, or in God's designs, and if we think that intersexual individuals can lead satisfying lives, why shouldn't we recognize their sexual difference as an ulterior standard between male and female? We propose making two longitudinal cuts, which divide the curve into three parts; the first two (the highest) would represent a female and male component, and a third segment would hence represent what remains. It is not our intention to commit to a discussion on how many sexes exist therein this new label; regardless of whether there be one or many more, it must be recognized that there is something which is not reducible to male and female, (e.g., Fausto-Sterling1993; Ainsworth 2015).

Some could argue against this type of sex: the low incidence of intersex individuals indicates that it is they who have "problems", who are outside the path of nature, who are freakish, strange, who are errors of biology (see Reis 2009: 70-71). There are two sides to this objection: a naturalistic objection ("they are biological errors") and an epistemological objection ("there are too few: larger numbers bestow more importance").

Against the former statement, one way to answer is saying that "Nature does not make mistakes". The concept of "error" is human, not biological, and it is us human beings who make the mistake of being aware of what we ought to be doing this may be a form of the *is-ought guillotine* (e.g., Houdson 1969). Of course, we conceive some products of nature as intrinsically bad, as in the case of cancer. However, we could query if we should call them "errors". The concept of "error" seems connected to the concept of "goal": someone is in error if she has an aim to achieve, and gets wrong in doing it. For example, if someone wants to go to Sidney, but she catches the flight to New York, she is wrong, she is making an error. In this sense the concept of "error" attributed to nature is a personification, it is an attribution of will. The objection can be rephrased: intersexuality is not an error but something terrible for the individuals carrying this condition. However, we have argued that a child can live without any problem with its intersexual condition (except in some cases when the condition is live treating, but mostly it is not the case).

Regarding the second part of the objection: can the number make the difference? Firstly this point can be seen as a form of sorites paradox: when is the number significant enough to count? We cannot identify a precise point starting from which the number is sufficient. Suppose that in the world there are only sharp males and females, and suppose a virus begins to kill males up until the point where only one hundred of them remain alive. Are we justified to maintain that the "male sex category" still exists? So what if there is only one male? Our intuition would drive us to consider that that person is not a "strange female", but instead another different entity. The same could be said for intersexuals. As far as the definition of sexual categories is concerned, plain numbers seem

to be irrelevant: from a neutral point of view, if only one person does not fulfill the condition of being male or female, this person is another “entity” for these categories.

If we were to accept that only number counts and recurrent events are important, we would be elevating “statistics” to a dignity of “natural law”; for example, in the case in which we observe certain recurring phenomena and events in nature and consider these happenings to be essential events only because of their frequent incidence in our world. What does not fall within the majority is “queer”, “strange” or “illness”. Statistics suggest which events are more or less frequent, and not which event is “normal”, or “good”, or “acceptable” nor which isn’t. If we were to admit that small numbers are an index of illness, then we would have to accept cold as a universally unpleasant condition and recognize that individuals with red hair have a terrible disease. We usually explicate our concept of "illness", "normality" and so on with the concept of "function" or "infection", not with the concept of "greater number". Intersexual individuals are a great starting point for a discussion on the epistemology of medicine since they are raising ethical as well as epistemological issues. The resolution of the problem is beyond the scope of this paper; nevertheless, it is important to underline that one of the issues that arises with intersexuality is the role of statistics in the process of constructing concepts. Statistics could be a good choice-criterion, but a bad criterion for concept-justification.

A stricter objection could be that the third sex group is impossible to “perform”, that it is an abstract invention, where nobody would live or where it is impossible to live. We take this objection seriously.

Someone could say that the new sex is superfluous. It could be redundant because it only points out the genital shape, but nobody knows what we have under our garments: gender attribution is performed without seeing the genitalia (Kessler 1998). For example, a transgender person is recognized as belonging to the new gender because he/she performs the new gender, even if he/she has not had genital surgery. This is due to the fact that there is not a specific way to perform the new sexual category. This objection is a mixture of two parts.

Firstly, someone could affirm that everybody falls within the gender category of “man” or “woman”, without the possibility of exception. If this is true, then the new category is superfluous since all human beings externally appear as man or woman, and for our aim the shape of genitalia is irrelevant. However, someone that would be recognized as different than male and female exists (the most famous cases were individuals in Australia and in France, see Dow 2010; Pascual 2015). Some individuals represent themselves as something different. These people want to be recognized as different, and their behavior is labeled as "(gender)queer” since they lie outside the boundaries set by the standard of cultures.

Secondly, someone could persist in this objection by stating that these behaviors are only “freakish", they are merely a modification of the standard (like a fashion). This scholar may hold that a radically different way to perform one’s sexual diversity, a new gender category, is just impossible. This objection is historically false. There is no logical impossibility for the third gender. Some cultures have experienced it, for example, *hijras* in India and *two-spirits* in some indigenous people of North America and also in other places (Herdt 1996). Nevertheless, we must ask ourselves if its institution is possible nowadays, in western society. Where can the third gender be established? It is difficult to answer this question.

There are movements in our society that show some interest in the issue. For example, genderqueer people try to destroy gender binarism while preferring to have a fluidal identity or identify themselves as genderless people. They probably envision a genderless future, but we can use their experience to construct a new way to perform gender. An alternative could be that intersexual people follow their example to perform their diversity. A problematic issue is the language. In fact, there are three pronouns for the third singular person: one for the man, one for the woman, and one for the items; meanwhile there is no pronoun for “intersexuals”. However, we could follow the example of a genderqueer community who invented the new pronoun “zhe” (Corwin 2009), or the case of Swedish convention of the gender-neutral pronoun "hen", which was introduced in the language to overtake the "hon"(she)/"han”(he) dichotomy. More, in general, we live in a time of cultural change which gives us the opportunity to radically modify gender-behavior and pave the way to the institution of a third way of being. In the future, the boundaries of gender will be hazier, and it will be easier to accept diversity.

The institution of new sexes could have legal importance (as it has had where it is permitted by law, as in Malta, Australia, New Zeeland, Germany, India, and France) because it could help physicians and families in cases where attribution is not possible. When an intersex baby is born, physicians and families may struggle to give it a name and may require some time to observe it to understand its sex; but at the same time bureaucracy requires an answer: it is essential to know if it is a he or a she. We would answer: neither a he nor a she, the baby belongs to another sexual category.

Moreover, the recognition of future possibilities could provide the appreciation of the particular situation of intersexual people. Many intersexuals affirm that they belong to neither male nor female groupings, that they do not acknowledge themselves as male or female, that they want a radical diversity that they have on a daily basis. Attributing non-traditional sex to a newborn baby could attract jokes and wariness, but this is every forerunner’s destiny.

5. What we ought to do?

We have argued that intersexuality as a unique condition does not exist, that it is instead a collection of different conditions that may have some phaenomenical similarities, making it more appropriate to refer to "intersexualities" or a specific condition. We then argued in favor of an extension of sexual categories beyond male and female, referring to "others" (we did not go on to consider exactly how many categories this "others" is comprised of). After analyzing the clinical management of intersexual births (the so-called "treatment paradigm") and the reasons that support the abolition of early sex assignment surgery, we go on to conclude by giving some indications on how to welcome these babies into the world.

Any choice one could make at birth represents an imposition upon the baby since the newborn cannot provide any form of consent nor participate in any choice; nevertheless, we make a decision. The question is: based on which principle do we make this choice?

The application of the conventional and presumptive criteria of legal age establishes by law that underage people, having not yet reached full maturity, are not regarded as autonomous individuals. They are judged, with some exceptions, incompetent to make decisions regarding their health. The law also establishes that, usually, their legal representatives – parents, or guardians, in their absence – provide proxy consent for clinical treatment and surgeries to be carried out on children's bodies.

In pediatrics ethics studies, the topic of who, why and within which boundaries should decide for those who are judged incapable of deciding for themselves, has been one of the main focuses of attention, along with the issue of the exercise of minor's self-determination regarding every personal aspects of their life, such as health and body.

In the case of intersex newborns, there is no doubt about their inability to make their own decisions. Some solid moral reasons justify the attribution of decision-making ownership to the parents of minors, compared to the other stakeholders involved in the lives of infants for purely professional reasons or related to them by less significant affective relationship.

Such parental decision-making ownership finds a limit in the obligation not to harm, and the harm could also regard the future exercise of the autonomy of newborns. Their interpretation of beneficence prevails on the other interpretations, but it cannot lead to the presumption of making personal and permanent decisions better than how could do the intersex person herself. Surgery sex assignment leads to irreversible body modifications, body perception, and functionality and clinical and pathological reasons do not justify this. Only individuals whose body undergoes such treatments should give the informed consent to these practices.

The ethical perspective here proposed is that the moral autonomy of individuals should be encouraged and safeguarded (e.g. see Faden and Beauchamp 1986; Grisso and Appelbaum 1998).

Autonomy, in the precise context of intersex births, is the means to reach the wellbeing of these children or at least it is the way that offers more guarantees on achieving such goal. It is assumed that the individuals' well-being is higher when their sexual and gender identity coincides with the shape of their body and with their desires about their self. Autonomy allows individuals to establish for themselves this aspect of personal life, that is, with which relationship to integrate body, personal and social identity.

The incompetence of these minors is constitutive, provisional and destined to be replaced by full decision making and self-determination capacities. Identity and bodily integrity of intersex infants must, therefore, be defended by surgical or other assaults until they can decide for themselves.

This is because even taking into consideration that parents are relatively in the best position in order to make right decisions for children who cannot choose for themselves (Wilfond et al. 2010), the children's interest, their parent's desires and the physician's "suggestions" may be in conflict (Hester 2004; Roen 2009: 24). Parents efforts to make the best choice for children may be misdirected by a distorted or incomplete understanding of the phenomenon of intersexuality and the benefits of early medical and surgical therapies.

> When physicians say that surgery is "what parents want", we should ask, specifically, what it is that parents ultimately want—that is, what they mean ultimately to achieve and whether surgery will satisfy these aims. If what "normal parents" want is the best chance for their children to flourish, we should not take for granted that normalized appearance guarantees flourishing (Feder 2014: 90).

Postponing the choice is the most common way of dealing with "very personal" or "life-altering" choices, involving all aspects that could have a profound effect on the identity of the individuals or lead to irreversible changes to their bodies. A procedure of this kind is used when it is believed that neither the parents nor the physicians nor anyone else can decide on behalf of the individual whether or not to undergo bodily changes since these decisions are a fundamental tenet of individual freedom (Diamond and Beh 2006: 107; Diamond and Garland 2014). Freedom to manage their own lives and bodies following their values and personal beliefs is safeguarded by postponing the decisions to the moment in which these individuals, that will gradually become more capable over time, will be able to decide for themselves.

The main reason that justifies the improvement of intersexual individuals' autonomy is that there are many uncertainties associated with these surgical practices, as already mentioned above. A list of these can be observed as follows.

There is no certainty that the gender identity of the individuals who undergo surgery will coincide with the sex that has been surgically assigned to them. For some intersex conditions, there is a

higher rate of "gender unpredictability", so individuals do not quite feel comfortable with the sex they were assigned.

Gender dysphoria, which sometimes presents in non-intersexual people, is more probable among intersex individuals: this is due to the fact that surgery is often brought forth on the basis of suggestions, wishes, of achieving cosmetically and functionally better outcomes, but not on the basis of future gender identity which is at the moment impossible to foresee, and the formation process of which is still unknown.

Postponing interventions on the bodies of intersex individuals "is the only scientifically sound and ethical way to ensure that the surgery coincides with each child's gender identity and interests in how his or her body might appear" (Diamond and Garland 2014: 3).

There is no certainty that surgery does not hinder the sexual satisfaction of the individuals, due to pain or compromise as a sexually functioning adult. There is no certainty regarding the long-term effectiveness of early medical and surgical intervention; there is no certainty that interventions of this kind will improve quality of life and satisfaction of operated individuals. Finally, empirical data suggests that sometimes intersex "persons who have had this surgery during infancy report being unhappy with their surgical results" (Howe 2006: 117).

These uncertainties have led to a much-requested review of the practices of intersex medical care. Rather than modifying infants' and children's bodies to adjust to a conventional threshold of social acceptability, we should modify this threshold and acceptance "of the various forms, considered as individual variations of the expression of sex / gender of a species (like the shapes of the ears or nose)" (Howe 2006: 117).

However, it is observed that the practices of sex assignment through surgical and medical treatments and the practice of cultural assignment of one of the two traditional gender roles to intersex people emphasizes the social unacceptability of intersex human conditions and perpetuates the mechanism of denial and concealment of this finding of fact.

Although postponing the choice regarding sex surgery confirms the inviolability of the bodily integrity of human beings without their consent - even when it concerns infants and children[4] - It also confirms the fact that intersexuality is not yet considered a mere possible anatomical deviation from the male and female types, that it is not yet socially acceptable, and thus it perpetuates the dichotomous view of human beings. In this perspective people who have nonconforming genitals

[4] This instance was also supported by the United Nations Human Rights Council (United Nation 2013: 23), by Europe Council Parliamentary Assembly, Resolution 1952 (Parliamentary Assembly of the Council of Europe 2013) and by The United Nation call against violations of the human rights of LGBTI people (United Nation 2015).

are considered to be socially acceptable, while people who are non-gender conforming cannot be left in an ambiguous and intermediate condition.

In this case, a provisional choice that allows the possibility of an individual's autonomous choice in the future should be achieved. However, which choice?

Let's start with a trivial consideration. Experiences with transsexualism suggest that every gender attribution (even the simplest) could be provisional. Indeed, each newborn could potentially develop a feeling of dissatisfaction with their imposed gender or a form of gender dysphoria at some time throughout their infancy, childhood or adolescence. In the "standard" case (when sharp sex is present), the decision of a gender attribution is made with the presupposition that the child in question will develop a coherent gender identity. Until we develop a method to foresee the future gender identity of the baby (if this will ever be possible), we provisionally make a choice on the basis of statistics: in the majority of cases, female newborns will develop a coherent gender identity. If this is the case, then we could decide upon the basis of statistics, although we have seen that statistics could be a good choice-method, not a good concept justification-method.

How about when sex is not clearly defined? Two alternatives remain: the first is not to assign any gender, leaving the "sex box" blank; the second is to attribute a provisional gender.

If we choose the first option, for coherence's sake we mustn't attribute a gender to newborns with a sharp sex either: in fact, if the reason for this missing attribution is the impossibility of foreseeing the gender identity of the intersexual child, the same impossibility must be admitted and recognized as far as standard male and female children are concerned.

The other possible strategy, probably more feasible, is that of attributing provisional sex and provisional gender to all newborns alike, a gender that a competent person can modify if she needs. In the case of intersexual children, we can use the same method of the sharp-sex children, that is to say, a statistical approach. There is a high probability that a genetic male-child with cloacal exstrophy will develop masculine gender identity (Maier-Bahlburg 2005), while there is a probability that a chimeric person develops an identity that it is not identifiable neither with man nor woman. Parents could attribute provisional sex and rear their child provisionally within a gender, hoping that they have made the correct choice.

Conclusion

We have presented the traditional approach to the birth of intersexual children (sex assignment, coupled with early surgery and hormone treatment) and the reasons for which this approach should be refuted. We then proceeded to focus on the epistemology of sex, displaying the traditional basis on which the western bisection into two separate sexes has been established and the inexistence of

pertinent reasons to bolster this structure, since in some non-human animals the distinction is not as sharp and since the low numerical incidence of sexual indetermination in human beings is not proof that intersexuality is an illness or is "against nature".

We proposed a new method to conceptualize sex and gender, carrying out two (or more) cuttings instead of only one in the continuum line of sex.

Anthropology illustrates how in some non-western cultures the diversity of sexes and genders is more readily accepted, how other gender categories (in addition to 'male' and 'female') can exist, and how in western societies there are certain movements (like "gender-queer") which oppose sexual binarism. We go on to conclude in favor of an enlargement of sex categories. We argued in favor of a provisional sex and gender attribution without resorting to any cosmetic surgery, in order to achieve individual self-determination, body integrity and reduction of unease in the case of gender dysphoria. Lastly, we proposed that provisional gender attribution into sexual categories should be made resorting to statistical data.

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