

Therapy or Enhancement?

Sex reassignment therapy in the context of Plessner's Philosophical Anthropology

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"Being man is not tied to a certain shape and might thus also happen by various shapes which are not congruent with those we know."

Helmuth Plessner (1975, p. 293)

The practice of medicine is a practice of judgement. When a patient presents himself to a doctor, the patient will first be subjected to anamnesis and physical examination. The outcome of this inspection constitutes the first judgment of the doctor: is the patient healthy or ill? Subsequently, a second judgement is made: does the patient have to be treated or not? Therefore, two central divides will be applied to patients when they enter the domain of medical healthcare: health versus disease and treatment versus no treatment. However, some patients present themselves with other intentions than being treated for a disease. Let us consider two medical fields in which these patients are encountered.

The first field is sports medicine. Professional athletes strive to be the best in their discipline. Therefore, all of their efforts are focused on *enhancing* the capabilities which are involved in their performances. Commonly, when an athlete achieves these enhancements through physical training, adhering to a strict diet and taking adequate amounts of rest, such improvements are considered as being *natural*. However, some athletes use performance enhancing drugs or technologies – labelled as doping – which present an advantage over their competitors. The Spanish sports doctor Eufemiano Fuentes is a well-known example of a doctor aiding in these kinds of practices. In the past decade Fuentes was involved in the administration of blood transfusions to road racing cyclists with the aim to increase oxygen levels in the blood circulation of athletes (Verschuren, 2016). These kinds of enhancements are, however, considered *unnatural*,

and each athlete being involved in these practices is judged a cheater with reference to the presupposed 'normal' conditions of his sport.

The second field is plastic surgery. In general, plastic surgery consists of two subfields: reconstructive surgery and cosmetic surgery. According to the American Society of Plastic Surgeons: "reconstructive surgery is performed to treat structures of the body affected aesthetically or functionally by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally done to improve function and ability, but may also be performed to achieve a more typical appearance of the affected structure" (ASPS, n.d.-b). The procedures in reconstructive surgeries include, for example, skin grafting, skin cancer removal and cleft lip repair. Cosmetic surgery, however, includes "surgical and nonsurgical procedures that enhance and reshape structures of the body to improve appearance and confidence", in which "healthy individuals with a positive outlook and realistic expectations are appropriate candidates" (ASPS, n.d.-a). This includes procedures as breast enhancements, facelifts and lower eyelid surgeries. It is evident from the objectives and procedures of these subfields that in the field of reconstructive surgery the intent is to restore *health* in patients, while treatments in the domain of cosmetic surgery are focused on the improvement of aesthetic bodily features, i.e. *aesthetical enhancement*.

The intention to *enhance* characteristics seems to be present in both sports medicine as well as plastic surgery. While the practice of traditional medicine revolves around the dilemma of treating or not treating a patient with a disease, contemporary medicine also has the option of enhancing certain characteristics of a patient without further regard to the presence of a disease. Therefore, medical enhancement seems to emerge as a separate

category of medical treatment, apart from traditional notions. Present-day medicine makes developments possible through which human functioning can not only be restored or prevented from disease, but can also be *advanced*. In this way, the practice of medicine seems to change from a practice of prevention and therapy into a practice of enhancement – whose aims are defined here respectively as the distinction between using interventions to restore or sustain health, or “to improve human form or functioning beyond what is necessary to restore or sustain health” (Juengst & Moseley, 2016). As such, doing *good* becomes doing *better*.¹

A special case of the therapy-enhancement distinction becomes apparent in the debates surrounding sex reassignment therapy. Sex reassignment therapy involves all treatments that are needed for the physical conversion of male to female sex and vice versa. It has been discussed whether sex reassignment surgery, as part of sex reassignment therapy, is a form of therapy or has to be considered as a type of biomedical enhancement (Bracanović, 2016). This debate acquires significance when considering that sex reassignment surgery is performed only on patients that received approval from a psychiatric assessment. It has been argued that this process leads to the stigmatization and medicalization of transsexuals, whilst patients become part of the medical treadmill, and as such are being steered to receive a certain type of therapy, rather than being considered as taking part in some kind of medical enhancement (Bracanović, 2016, p. 89-92).

In current debates, two theoretical perspectives have been used to counter the position that sex reassignment surgery should be labelled as a form of biomedical enhancement (Bracanović, 2016). The first perspective is the nontherapeutic view that states that a treatment should be considered a biomedical enhancement when it “improves, augments or increases, above average, any physical or mental trait” (Bracanović, 2016, p. 86). According to the nontherapeutic account, sex reassignment surgery does not belong to the category of biomedical enhancements, since no mental or physical traits are altered beyond average. Therefore, the nontherapeutic view draws a sharp distinction between therapy and enhancement, in which sexual reassignment surgery needs to be labelled as therapy. The second perspective, the welfarist view, posits that there is no divide between therapy and enhancement. Both therapy and enhancement are consid-

ered to be “subclasses of enhancements”, because they both “increase the chances of a person leading a good life” (Bracanović, 2016, p. 95). Considering the autonomous choice of patients for medical interventions, sex reassignment surgery is readily recognized as a biomedical enhancement. However, whether sex reassignment surgery induces positive changes in well-being of patients can only be considered *post-hoc*. Furthermore, every account of increase in well-being is highly subjective. Therefore, there is no need to assume that every instance of sex reassignment surgery functions as biomedical enhancement (Bracanović, 2016, p. 96).

It may be questioned whether sex reassignment therapy, or procedures that are part of sex reassignment therapy, should be considered as either therapy or enhancement, or as a subclass of enhancement. In this essay I will argue that although both therapy and enhancement can be distinguished as two different types of medical intervention, sex reassignment therapy has to be labelled both as therapy and enhancement. For this, I will rely on the philosophical anthropology of Helmuth Plessner as presented in his *The Levels of the Organic and Man* (1928), in which the constitution of organic beings, and the human lifeform in particular, are central themes. In this work, humans are presented as beings that struggle continuously between experiencing their existence both as *living organism* as well as *reflexive being*. This mode of existence is characterized by Plessner as the *eccentric positionality* of man. Humans are in continual need of mediation between these two experiences, which is achieved through the use of technological or cultural artefacts. As such, Plessner describes humans as “artificial by nature”. With the use of these Plessnerian concepts – the *natural artificiality* and *eccentric positionality* of humans – as a starting point, the impact of sex reassignment therapy on both the physical and mental state of a patient can be assessed and placed in the context of the therapy-enhancement distinction.

My argument in this article will be developed in the following manner. First, I will introduce Plessner’s philosophical anthropology, and expand on the notion of *eccentric positionality*, to form a fundament for the consideration of *health* and *disease*. Subsequently, I will consider Plessner’s anthropology in the context of medicine and medical practice, by placing the notion of *eccentric positionality* in relationship to notions as

health and disease. Further, I will argue that sexual reassignment therapy not only affects the eccentric positionality of a patient but also induces a *meta-eccentric* change. Finally, I will consider a central problem of the *meta-eccentric* account and will propose an alternative to popular views about sexual reassignment therapy.

Plessner's Philosophical Anthropology

Central to the philosophical anthropology of Plessner, as described in his *The Levels of the Organic and Man [Die Stufen des Organischen und der Mensch]* (Plessner, 1975) is his typology of various forms of existence that can be distinguished in organisms. Plessner discerns two types of bodies: *lifeless* and *living bodies*. To define these types of bodies Plessner refers to the physical boundary, or contour, of an organism. A living body has a boundary that separates itself into two spheres: an inner side (*Innenwelt*) and an outer side (*Aussenwelt*). Between these spheres, a transport is present over this boundary (*Grenzverkehr*). This *Grenzverkehr* can be assessed as having both a physical component and mental component, represented by respectively the intake and shedding of nutrients and fluids by organisms, as well as being both the source and receptor of experiences. Therefore, organisms have a certain relationship to both sides of this boundary, or in other words, a certain *positionality*. This distinction is denoted by Plessner as the *double aspectivity (Doppelaspektivität)* of an organism.

Plessner proceeds by making a further distinction in the types of positionality that exist in nature. The first type of positionality becomes manifest in a plant. A plant has a *Grenzverkehr* and therefore responds to internal and external influences as light, water and minerals. However, although a plant absorbs and secretes these components, it does not have a center that defines its relationship to its boundary over which these components are transported. Therefore, this type of positionality is defined as an *open positionality*.

This *open positionality* is followed by another type of positionality, denoted as *centric positionality*. This type of positionality is evident in animals. An animal stands in an active relationship with its own boundary. This particular form of existence can be described as *being* a body

(*Leib-sein*), as well as *having* a body (*Körper-haben*). An animal is aware of his body and actively engaged with his surroundings, using his body to achieve his aims. As such, an animal is an entity that is able to actively engage in and respond to his surroundings by means of being and having a body, e.g. an animal can direct his *Grenzverkehr* by searching for food.

The last type of positionality that Plessner distinguishes in *The Levels of the Organic and Man* is only present in humans. Humans have the most complex relationship to their own boundary. A human can be described as *being* a body, as *having* a body, and as *being outside of* his body. From this perspective, humans *are* not only living bodies, nor do they solely *have* living bodies; humans are aware of their experience as living bodies. In other words, humans are *reflexive* beings. This gives humans a special position: humans are inside as well as outside of their body. In the words of Plessner, humans have an *eccentric positionality*. This enabled humans to develop themselves in an unmatched manner and to subordinate lifeforms of the first two types of positionality. Being equipped with an eccentric positionality, humans are permanently trying to resolve the dichotomy they experience between being inside as well as outside of their bodies. In this process of self-realization, humans express themselves continually by means of culture and technology. This could for example take the form of wearing specific clothes, conforming to certain laws and using particular types of technologies. In this manner, humans try to mend the gap between their inner experiences (*Innenwelt*), the world of culture (*Mitwelt*) and the world of physical objects (*Aussenwelt*). This ongoing activity, however, is according to Plessner the practice of a dystopia: man will never “achieve his own oneness” (Tolone 2014, p. 164). Humans, as such, remain homeless (*Heimatlos*):

[Man is] between being in agreement with his own corporeality, like all the other animals, while at the same time never being completely in agreement with it, allowing a certain degree of external and internal distance. (Tolone 2014, p. 163)

Due to their *eccentric positionality*, which is apparent in the continual need to seek oneness, humans are condemned to *express* themselves. According to Plessner, in this process humans are subjected to three fundamental laws.

The first one is the law of natural artificiality. Humans are characterized by their use of supplements to express themselves as:

[an] [e]ccentric being, with no balance, no time or place, eternally exposed to nothing, constitutively out of his element, having to become something in order to find balance; he can only find it with the help of extra-natural things which derive from his creation. (Plessner, 1975, p. 334)

The use of *extra-natural things*, i.e. 'tools', is central to Plessner's philosophical anthropology. The range of that which can be regarded as a 'tool' is extensive. Tools may encompass technological instruments as watches, surgical knives and cars, but may also include cultural expressions as language and music. As such, Plessner characterizes humans as "artificial by nature".

All these tools give humans the ability to bridge the gap between the experiences of their *Innenwelt*, *Mitwelt* and *Aussenwelt*, and as such, to *mediate* their eccentricity. However, just as these tools are able to perform certain acts because of their *form*, humans are always mediated by their own corporeality. Plessner describes this aspect with his second law of *mediated immediacy*: although humans are immediately present in the world, they need the mediation of their body to be present, and act in the world. Therefore, the body is a prerequisite for humans to *exist* as well as to *act*. Or in other words, the body *mediates* human existence and handling. This is furthermore evident in the tools that humans produce and use. While tools are a form of mediation in their use, they are also immediate in their own existence.

Finally, in this mediated immediacy, humans seek to mediate their eccentricity by adherence to political or religious ideals. Plessner, however, believes that this will always result in a disappointment. No absolute goal, narrative or ideology will ever resolve the human burden of being an organism which neither completely 'has a body' nor 'is a body'. A situation in which man either completely 'is a body' or 'has a body', would signify respectively the *rootedness* and *eradication* of the human lifeform (Tolone, 2014, p. 165). Humans are therefore condemned to Plessner's third law of the *utopic position*.

Through technology humans are able to mediate themselves in many ways, e.g. using cars to transport themselves over long distances, brain-computer interfaces and using satellites to communicate. Because Plessner wrote his *The Levels of the Organic and Man* in 1928, it is reasonable to accept that the impact and developmental potential of many of these kinds of technologies could not easily be envisioned or recognized. While humans have always created tools to aid and enhance their functioning, innovations and developments in fields as neuro-engineering, nanotechnology, biotechnology, robotics and artificial intelligence are progressively able to change and enhance mental or physical human capacities. For example, deep brain stimulation or brain-computer interfaces are able to enhance cognitive capacity and motor modalities directly by affecting neural pathways. Consequently, technology is not only able to mediate the body, but it is also able to alter the mediation of the body itself. Through these contemporary technologies, which present unprecedented possibilities of mediation, the notion of human enhancement seems to gain another meaning.

These developments have also affected medical healthcare. Where a traditional divide of health and disease appointed the pursuit of 'doing good' as being the core principle of treatment, the arrival of a variety of technologies introduces a new category, namely 'to do better'. From a medical perspective, many questions exist about the status of the human condition in relation to the use of technological treatments in clinical practice. How do mediation and technology relate to notions as health and disease? In the next section, I will argue how the philosophical anthropology of Plessner presents a model to assess the relationship between the notions of health, eccentric positionality and technology.

A medical-anthropological model for the relationship between health, eccentric positionality, and human enhancement

Referring to medicine means referring to a field in which the notions of 'disease' and 'health' form the central dichotomy of clinical practice. Doctors may have an idea of what is meant by health and disease because of the medical knowledge and years of experience they possess. However, notions

of health and disease are difficult to define unambiguously. In this variety of definitions, the World Health Organization (WHO) has formulated a definition of 'health' in 1948 which is still widely used today in medical discourse:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (World Health Organization, 1948)

Two aspects are central to this definition of health. First, health is concerned with the condition of a human being as a whole. Not only the body determines whether a human is healthy. Therefore, in the examination of a patient, psychological, social, and physical factors all have to be assessed. Second, health is not defined in terms of *absence* of a disease. A person is unhealthy not only when a disease is present, but at times also in the absence of a disease.

This definition of 'health' corresponds to Plessner's phenomenological anthropology. From this perspective, health is not only confined to the *Innenwelt* (mental well-being), but also extends into the *Mitwelt* (social well-being) and the *Ausserwelt* (physical well-being). Moreover, the starting point of assessing health in the philosophical anthropology of Plessner is the examination of the eccentric positionality of man. In the double aspectivity of their existence, humans strive to oneness between 'being-a-body' and 'having-a-body'. For Plessner, 'disease' does not present itself when eccentric positionality bends more to 'having-a-body' than 'being-a-body', but becomes a reality in the total loss of eccentric positionality as such:

The two opposing poles immediately become dangerous and negative, should either of them be regarded as something absolute. To be wholly natural or wholly artificial, immediate or mediated, rooted or eradicated, any of these radical endpoints are bad for man's health. (Tolone, 2014, p. 165)

To remain healthy, man must therefore achieve a balance between 'being-a-body' and 'having-a-body'. At first glance, it may be especially surprising

that 'to be wholly natural' is being regarded as an unhealthy endpoint. However, in Plessner's *biological* view man is 'artificial by nature', as denoted by the first law of Plessner's philosophical anthropology. Consequently, this view has an implication for the practice of medicine as such:

The role of doctors and medicine is to guarantee harmony between being-a-body and having-a-body, to preserve the balance between each of the three spectrums: mediacy-immediacy, naturalness-artificiality, and rootedness-eradication. (Tolone, 2014, p. 168)

From this perspective, the role of doctors and medicine is to promote health and prevent disease by achieving a harmonic balance between the three spectrums, as outlined in Plessner's three anthropological laws. As such, this aim is supported by a view through which the physical, mental and social well-being of patients with regard to 'health' and 'disease' can be considered from an anthropological perspective.

In the context of Plessner's anthropology, these remarks about health and eccentricity can be extended to the context of technology and human enhancement. Technology is related to the body in two manners (Spreen, 2014, p. 427-428). First, technologies can be placed on the surface of the body. This placement is evident in the use of technologies such as the mobile phone, Google glass or smartwatches. Second, technologies can be integrated within the body. The scope of technological mediation is wide in this context, ranging from low-tech mediation as contact lenses to high-tech mediation as brain-body interfaces. The concept of the 'cyborg' – the physical synthesis of technology and man – appears in the consideration of technologies that mesh with the body in this manner. The public image of the cyborg, promoted by science fiction literature and movies, envisions radical forms of human enhancement and regularly appeals to ideas about the emergence of a posthuman species and the termination of human civilizations. However, technological interventions or human enhancements do not necessarily lead to the disappearance of man. As Plessner states, although man is able to appear in various and even unknown shapes, retaining his eccentric positionality makes him human:

Being man is not tied to a certain shape and might thus also happen by various shapes which are not congruent with those we know. Man is tied to the centralist way of organization which is the basis of his eccentricity. (Plessner, 1975, p. 293)

From the perspective of Plessner, health is defined as the harmonic interaction between 'being-a-body' and 'having-a-body', which is constituted by the continuous balance of mediacy-immediacy, naturality-artificiality, and rootedness-eradication. This means that man must balance the treatment of his body as something he can *use*, with the view that his body is an entity which he *is*. Furthermore, humans must treat their existence both equally as naturally given and as inherently artificial. Finally, humans must not live unmoved in current conventions as well as not believe too much in some ideology that promises to mend their double aspectivity. If this balance is preserved, humans do not lose their eccentric positionality as such. This also includes human enhancement and technological interventions which, despite their potential to change the human lifeform considerably, fall under the scope of 'health' when used according to these balances.

Because of the possibilities that the above mentioned medical technologies offer, situations have risen in clinical practice in which it is unclear whether patients receive treatment for the promotion of their health or as a matter of human enhancement. Sex reassignment therapy, for example, rigorously changes the anatomy and physiology of the human body, whilst no disease seems to be present. At the same time, sex reassignment therapy does not seem to offer innately enhanced humans. In the next section, I will contribute to the debate and use sex reassignment therapy as a model for the therapy-enhancement distinction. First, I will introduce the current praxis of sex reassignment therapy in the medical domain. Using the philosophical anthropology of Plessner and the medical-anthropological model, as mentioned above, I will subsequently assess the effects of sex reassignment therapy on the eccentric positionality of patients. I will argue that sex reassignment therapy both preserves and fundamentally alters the eccentric positionality of patients. Next, I will claim that this fundamental alteration of eccentric positionality should be considered as a form of *meta-eccentricity*. Finally, considering the previous arguments, I will argue that sex reassignment therapy falls both in the domains of therapy as well as enhancement.

Sex reassignment therapy and meta-eccentricity

According to the tenth edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10), transsexuality is a subset of Gender Identity Disorders and defined as "a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex" (ICD-10, 2016, F64.0). Diagnostic instruments have been designed to measure transsexuality on a spectrum. An example of such an instrument is the Benjamin scale, or Sex Orientation Scale (SOS), which categorizes transsexuality as having a non-surgical urgency (level IV), moderate intensity (level V) or high intensity (Level VI) (Benjamin, 1999, pp. 15-16). The SOS, however, is not in use anymore. In current medical practice, when a person expresses the desire to convert to his identified gender sexuality, a medical diagnosis of transsexuality can be made by an assessment from a medical health professional.

This diagnosis of transsexuality is required for the patient to attain the permission to receive hormonal replacement therapy (HRT) and sex reassignment surgery (SRS), which both constitute sex reassignment therapy. A common first step in this process is HRT, which consists of taking testosterone and estrogen supplements to aid the conversion from an assigned to an identified gender identity by gaining respectively male or female traits. The second step in this transition is SRS, in which the secondary sexual characteristics of patients are altered to match the sexual characteristics of their identified sex. These sex reassignment surgeries include procedures as penectomy, orchiectomy, vaginoplasty, and phalloplasty.² Both HRT and SRS have considerable effects on human physiology and anatomy. Considerable effects of HRT are for example changes in body hair growth, cardiovascular status, bone-density and brain structures (Giltay & Gooren, 2000; Wierckx et al., 2012; Pol et al., 2002).

Now, to assess the effects of sex reassignment therapy on the eccentric positionality of humans, and in consideration of the notion of 'health', let us use the balance of the three spectrums as defined by Plessner: naturality-artificiality, mediacy-immediacy, and rootedness-eradication.

The natural artificiality of sex reassignment therapy is apparent: hormones and surgery are needed to transform the body of the assigned sexual gender into the identified sexual gender of the patient. With regard to the body as its own boundary, the use of treatments – Plessner’s ‘extra-natural means’ or ‘tools’ – have effects both in the domains of the inner world (*Innenwelt*) and outer world (*Aussenwelt*). Both hormone replacement therapy and sex reassignment surgery change the body from the *outside* (*Aussenwelt*), through the physiological effects of hormones inside the body as well as through the direct adjustment of secondary sexual characteristics, such as genital reassignment, at the surface of the body. Additionally, through adjustment of the hormonal balance, the inner world (*Innenwelt*) made up of experiences, emotionality and mood may also be affected.

Considering these changes, we can conclude that, although artificial means introduce rigorous changes in the body, the balance between artificiality and naturalness is preserved. First, although the body is altered in a rigorous manner, and the identified sexual gender is constituted through artificial means, the natural position of being a human with either a male or female genome is not changed. In other words, one becomes a male or female through identification and bodily transformations taking place through medical intervention, but one remains a male or female in a fundamental biological manner. Second, while using artificial means to transform the physical characteristics of patients, which are part of their assigned sexual identity, patients come closer to that position that they recognize as natural. Therefore, in both situations the balance does not tip to either side of the naturalness-artificiality balance and, as such, none of these aspects become absolute.

However, physiological and anatomical changes cause significant effects on patients’ relationship with themselves, as well as with the world. For instance, a transition from female sex to male sex through reassignment therapy, affects the potential to give birth without external interventions and, as such, to be present in the world as fertile. Therefore, the mediation of the body itself is mediated. Sex reassignment therapy does not affect the presence of the mediated immediacy of the body, but it does alter *how* the immediacy of the body is mediated.

Nonetheless, for transsexual patients this is in line with their wishes.

The patient wants to uproot his assigned sexual identity and transform to the physical makeup of his identified sexual identity. As such, the patient hopes to find a ‘home’. The *utopic position* of men presents itself here in a subtle way. First, the assigned sexual identity can never be eradicated as a whole. The stability of the genomic profile of the patient, for example, stays identical in sex reassignment therapy. Furthermore, patients will never be able to sexually reproduce in a way that is natural to their identified sex. Therefore, although the well-being and life satisfaction of the patient increases, the balance between rootedness – maintaining the genomic profile of one’s assigned sex – and eradication – losing one’s capability to procreate without external interventions – remains central to the life of the patient, which only emphasizes his utopic position.

Hence, as the assessment of the three anthropological laws with regard to sex reassignment therapy shows, the patient is not ‘wholly natural or wholly artificial, immediate or mediated, rooted or eradicated’. Therefore, the patient does not lose his eccentric positionality as such during sex reassignment therapy, and the medical professional treats the patient with regard to the principle of health. However, as the impact of sex reassignment therapy on the mediated immediacy of the patient indicates, sex reassignment therapy does alter how the immediacy of the body is mediated. Therefore, in the patient, eccentricity itself is altered. These considerations lie close to the notion of *meta-eccentricity* introduced by Verbeek (2014). Verbeek defines *meta-eccentricity* as:

A position from which humans not only relate to their centres, like in the case of the eccentric position, but also to eccentricity itself, in which they now can actively interfere. (Verbeek, 2014, p. 453)

Meta-eccentricity therefore signifies any attempt of humans to alter the manner in which they relate themselves to their centres. This includes sex reassignment therapy, through which the immediacy of the body becomes mediated in a fundamentally altered manner. However, for Verbeek this notion is closely tied to technologies that interfere with brain functioning and genetics:

But technologies such as psychotropic drugs, deep brain stimulation and genetic intervention play a completely different role in human eccentricity. These technologies all interfere – at least potentially – in human consciousness. Rather than influencing the centre from which humans act and experience, they influence the nature of human eccentricity: the way in which people relate to themselves. By influencing our moods, by altering our ability to concentrate or even by interfering with our character traits, these technologies change eccentricity itself. (Verbeek, 2014, p. 453)

I argue that this scope of meta-eccentricity is too narrow when it comes to the interference of technology used during sex reassignment therapy. Verbeek states that psychotropic drugs as well as deep brain stimulation have a profound impact on human consciousness and the nature of human eccentricity. To align these technologies with consciousness, Verbeek ascribes a primary role to the brain in affecting the eccentric positionality of humans. By referring back to the profound influence of the brain in affecting consciousness and eccentricity, there is a danger of creating a dualist conception that underlies meta-eccentricity. This would, however, be in conflict with the monist character of Plessner's philosophical anthropology, in which no difference is being made between the brain and body in the localization of the eccentric positionality of humans. As seen in the example of sex reassignment therapy, active interference should not only be identified through changes affecting the brain or genetics, but also through explicit bodily changes caused by the use of hormonal replacement therapy and sexual reassignment surgery.

Conclusion

As we have seen, in order to consider health in the philosophical anthropology of Plessner, one has to start with an examination of the eccentric positionality of man. Following the three anthropological laws of Plessner as outlined in the medical-anthropological model, a balance between each of the three spectrums 'mediacy-immediacy', 'naturalness-artificiality', and 'rootedness-eradication' has to exist to preserve and promote health. As the assessment of sex reassignment therapy shows, eccentricity itself is not lost

in sexual reassignment therapy, and therefore adheres to the aim of treating a patient from a perspective in which health remains central. However, the impact of sex reassignment therapy extends further than the notion of eccentricity. The transition of sex implies an alteration of eccentricity itself, because of the rigorous changes it causes to the body. Therefore, sex assignment therapy also follows a meta-eccentric account of interference. The scope of the meta-eccentricity as defined by Verbeek is primarily confined to an account of the brain. However, as the discussion of sex reassignment therapy shows, meta-eccentricity is not a phenomenon that is solely dependent on the brain, but also pertains to the body.

Having covered how eccentricity and meta-eccentricity contribute to the discussion concerning sexual reassignment therapy, I make the case for a more nuanced vision about the distinction between therapy and enhancement, i.e. the distinction between using interventions to restore or sustain health or "to improve human form or functioning beyond what is necessary to restore or sustain health" (Juengst & Moseley, 2016).

Through Plessner's philosophical anthropology, this paper aims to add another position to this debate. As argued above, although there is a distinction between therapy and enhancement, sex reassignment therapy has to be labelled both as therapy and as enhancement. As seen in the previous paragraphs, the principles of both eccentricity – unified with the *preservation* and *restoration* of health – and meta-eccentricity – associated with the *alteration* of eccentricity itself – underlie the sexual transformation of a patient during sex reassignment therapy. Therefore, a patient is treated with the intention to restore or sustain health and "to improve human form or functioning beyond what is necessary to restore or sustain health" (Juengst & Moseley, 2016). Hence, the patient is treated within the context of both therapy and enhancement.

Even though this assessment of Plessner's philosophical anthropology in the context of sex reassignment therapy does not result in a practical guideline with defined acts for clinical practice, it supports a new paradigm in which this group of patients can be seen as taking part in therapy as well as enhancement. As for medical practice, a lot of these cases will therefore fall into a grey area in which both sides, therapy as well as enhancement, have to be taken into account and will be assigned their respective role in the treatment of a patient.

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Notes

1. In medicine four ethical principles form the cornerstone of clinical ethical decision making: respect of autonomy, justice, non-maleficence, and benevolence. Medical enhancement seems to surpass that which is presupposed by the criterium of 'benevolence'.

2. Respectively being the surgical removal of the penis (penectomy) or ovaries (orchiectomy), or the surgical intervention to create a vagina (vaginoplasty) or penis (phalloplasty)

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