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Gender Reassignment Surgery: A Catholic Bioethical Analysis

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Abstract

There is no explicit authoritative Catholic teaching on gender reassignment surgery (GRS). Catholic bioethicists have debated the origin of gender dysphoria and the effectiveness of GRS. A further ethical question is whether some forms of GRS involve "mutilation in the strict sense." The principle of totality does not apply to GRS as the reproductive organs are a *cause* of distress only because the *object* of distress. This analysis leaves open the status of GRS which does not compromise biological function.

Keywords

Elizabeth Anscombe, gender reassignment, medical ethics, mutilation, Pope Pius XII, principle of totality, surgery, transgender, transsexual

Over the past decade there has been a marked increase in the number of reported cases of gender dysphoria, of people who are distressed because of a mismatch (or incongruence) between their biological sex and their sense of gender identity.[1] There has also been a wider endorsement, among medical professionals and institutions, of

1. Jon Arcelus et al., "Systematic Review and Meta-analysis of Prevalence Studies in Transsexualism," *European Psychiatry* 30 (2015): 807–15, https://doi.org/10.1016/j.eurpsy.2015.04.005; Calum McKenzie, "Child Gender Identity Referrals Show Huge Rise in Six Years," *BBC News*, February 11, 2016, http://www.bbc.co.uk/news/uk-england-nottinghamshire-35532491.

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gender reassignment surgery (GSR) as a treatment option for some people with gender dysphoria.[2] These developments have led to litigation against Catholic health-care providers who do not offer GRS or who refuse to permit GRS on their premises.[3]

There is an urgent need to clarify whether GRS is compatible with the ethical and philosophical principles that have developed within the Catholic tradition and, if so, in what circumstances.[4] I aim to clarify here whether GRS is compatible or incompatible with the principles of bodily integrity and totality, as expounded by Pope Pius XII, and thus whether such procedures raise serious ethical problems for Catholic hospitals and for Catholic health-care professionals. My aim is not to defend these ethical principles or their general applicability. The question addressed by this article is rather: If one accepts the validity of the principle of totality and its relevance to all forms of surgery, how does this apply to GRS and to related interventions such as hormone therapy and social transitioning?

Official Catholic Teaching on GRS

There is no explicit authoritative Catholic teaching on GRS (whether by that name or under some other description such as "sex change," "transsexual surgery," or "sex reassignment surgery"). The topic has not been addressed directly by any pope or by the Second Vatican Council. It is not addressed overtly by any public teaching document issued by the Congregation of the Doctrine of the Faith (CDF), nor is it covered in the extensive ethical section of the *Catechism of the Catholic Church* (*CCC*). This lacuna is remarkable given the great interest in medical ethics shown by at least two twentieth-century popes.

Pope Pius XII reflected on many actual and potential medical developments including some, such as xenotransplantation, which even today remain highly speculative. However, he made no pronouncement on GRS, even though the first such operations had already

2. World Professional Association for Transgender Health (WPATH), *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Seventh Version* (WPATH, September 2011), http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351.
3. M. Benedict Guevin, "Augmentation Mammaplasty for Male-to-Female Transsexuals," *National Catholic Bioethics Quarterly* 9 (2009): 453–58, https://doi.org/10.5840/20099332; Sandhya Somashekhar, "Transgender Man Sues Catholic Hospital for Refusing Surgery," *Washington Post*, January 6, 2017, https://www.washingtonpost.com/news/post-nation/wp/2017/01/06/transgender-man-sues-catholic-hospital-for-refusing-surgery/; Alexandra Desanctis, "ACLU Sues Catholic Hospital Over Sex-Reassignment Surgery," *National Review*, April 28, 2017, http://www.nationalreview.com/corner/447203/aclu-sues-california-catholic-hospital-discrimination.
4. The focus of the present article is on the ethics of reassignment surgery (and, to a lesser extent, other medical interventions which aim to facilitate gender reassignment) and not on the many other social, ethical, and public policy issues raised by gender identity in relation to equality and employment law, canon law, the theology of marriage, sexual ethics, educational theory and practice, the ethics of social media, pastoral care of persons with gender dysphoria, etc.

been attempted in the 1930s. Not even the transitioning of Christine Jorgensen, which became a cause célèbre in America,[5] prompted any response from the reigning pontiff.

Similarly, Pope John Paul II reflected many times during his pontificate on the fundamental principles of moral reasoning. He was particularly concerned to draw attention to the fact that some acts are wrong in themselves because of their objects and irrespective of their consequences. In *Veritatis Splendor*, he termed such acts *intrinsece malum*. As examples he cited genocide, abortion, euthanasia and voluntary suicide, mutilation, physical and mental torture, arbitrary imprisonment, deportation, slavery, and prostitution, as well as contraceptive practices.[6] However, he made no explicit reference to GRS.

In the United States, the most significant teaching document of the Conference of Catholic Bishops on matters of medical ethics is the *Ethical and Religious Directives for Catholic Health Care Services* (*ERD*), now in its fifth edition. The purpose of this document is "to provide authoritative guidance on certain moral issues that face Catholic health care today."[7] It is the *ERD* that is invoked by Catholic health-care providers to settle disputes as to whether medical or surgical practices are ethical and compatible with the Catholic ethos of the institution. There is no explicit reference to GRS either in the current edition of the *ERD* or in any of the previous editions.

The *ERD* cited most frequently in disputes over the provision of GRS is directive 53, which concerns direct sterilization. However, the applicability of this *ERD* to the practice of GRS is not clear or explicit within the text itself. The interpretation of the directive in relation to GRS thus requires a wider context. It will be considered later in this article.

In 2000, the CDF issued guidelines for national episcopal conferences in relation to certain canon-legal aspects of gender reassignment. This document, prepared by Cardinal Urbano Navarrete, concerned issues such as the legal validity of the marriage or ordination of someone who had undergone GRS. It was not intended as a public teaching document and the text is not publicly accessible. According to an unconfirmed media report, this document contains an analysis of the ethics of GRS suggesting that such surgery "could be morally acceptable in certain extreme cases."[8] Such a judgment would cohere with what Navarrete wrote publicly in the article on which the guidelines are said to have been based:

5. Ben White, "Ex-GI Becomes Blonde Beauty: Operations Transform Bronx Youth," *New York Daily News*, December 1, 1952, http://www.nydailynews.com/new-york/bronx-army-vet-ground-breaking-sex-change-1952-article-1.2198836; Joanne Meyerowitz, "Transforming Sex: Christine Jorgensen in the Postwar U.S.," *OAH Magazine of History* 20 (2006): 16–20, https://doi.org/10.1093/maghis/20.2.16.
6. John Paul II, *Veritatis Splendor* (August 6, 1993), 80, http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html (hereafter cited as *VS*).
7. United States Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (2009), 4, http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.
8. John Norton, "Vatican Says 'Sex-change' Operation Does Not Change Person's Gender," *Catholic News Service*, January 14, 2003, https://www.ncronline.org/news/vatican-says-sex-change-operation-does-not-change-persons-gender.

> I prescind altogether from the many questions of an ethical and moral order that arise in this province, especially with regard to whether or not surgical operations are permissible in extremely serious cases, if operations of this sort are deemed to be an effective means of freeing the patient from an intolerable psychological conflict and obtaining peace of mind.[9]

The only explicit reference to GRS in any public Vatican document is a short passage in an endnote to the 1995 *Charter for Healthcare Workers*. The Charter was written and promulgated not by the CDF but by the Pontifical Council for Pastoral Assistance to Health Care Workers. This document does not have the same status as a document issued by a pope or an ecumenical council or the status of a document promulgated by the CDF. It is not a universal teaching document but a pastoral document aiming to apply, rather than to add to, authoritative teaching. Nevertheless, the text of the *Charter* was approved for publication by the CDF and the views it presents can therefore be taken as a defensible interpretation of received Catholic teaching. The *Charter* links "transsexual surgery" with sterilization and abortion as procedures that cannot be justified because they have a "psychic or spiritual origin":

> The physical integrity of a person cannot be impaired to cure an illness of psychic or spiritual origin … And this is why the principle of totality cannot be correctly taken as a criterion for legitimatizing anti-procreative sterilization, therapeutic abortion and transsexual medicine and surgery. It is different with psychic sufferings and spiritual disorders with an organic basis, that is, which arise from a defect or physical disease: on these it is legitimate to intervene therapeutically.[10]

This short passage introduces two themes, both of which have long been debated among Catholic theologians and bioethicists. In the first place, it raises the question of whether gender dysphoria arises purely from psychological causes or from some organic basis, and concomitantly, whether the origin of the condition is relevant to the ethical evaluation of GRS. In the second place, the *Charter* invokes the "principle of totality" in relation to GRS. This principle is an important tool for the ethical analysis of surgery and its development within the Catholic tradition is associated especially with Pius XII.[11] Although he did

9. Urbano Navarrete, "Transsexualism and the Canonical Order," *National Catholic Bioethics Quarterly* 14 (2014): 105–18 at 105–6, https://doi.org/10.5840/ncbq201414151.
10. Pontifical Council for Pastoral Assistance to Health Care Workers (PCPAHCW), *Charter for Health Care Workers* (1995), n145, http://www.ewtn.com/library/curia/pcpaheal.htm. Note, however, that the new edition of the Charter has removed any overt reference to transsexual medicine or surgery. See PCPAHCW, *New Charter for Health Care Workers* (Philadelphia: National Catholic Bioethics Centre, 2017), 88–89.
11. Pius XII, "Address to the First International Congress on the Histopathology of the Nervous System" (September 14, 1952), https://w2.vatican.va/content/pius-xii/fr/speeches/1952/documents/hf_p-xii_spe_19520914_istopatologia.html, transl. at EWTN, https://www.ewtn.com/library/PAPALDOC/P12PSYCH.HTM; Pius XII, "Address to the Twenty-Sixth Congress of the Italian Society of Urology" (October 8, 1953), https://w2.vatican.va/content/pius-xii/fr/speeches/1953/documents/hf_p-xii_spe_19531008_congresso-urologia.html; Gerald A. Kelly, "Pope Pius XII and the Principle of Totality," *Theological Studies* 16 (1955): 373–96, https://doi.org/10.1177/004056395501600302.

not speak directly on the issue of GRS, in his analysis of related ethical issues, Pius XII thus offers resources toward the construction of a Catholic bioethical analysis of GRS.

In sum, official teaching documents of the Church contain no explicit and authoritative ethical analysis of GRS. However, Catholic scholars have debated the issue for more than sixty years. The remainder of this article therefore sets out the main contours of the development of the Catholic scholarly discussion of GRS, focusing on the United States. In the course of expounding this developing tradition, the article will analyze certain key arguments and will defend a clear but limited conclusion.

The Earliest Catholic Discussion of GRS

There is no discussion of GRS by Catholic moralists prior to 1950. It is not included in the extensive catalogue of topics treated by the Latin manuals of moral theology that were popular in the first half of the twentieth century. It is also notable by its absence from the first in a new wave of introductions to medical ethics, written in English for a lay Catholic audience, that appeared in the 1940s and early 1950s.[12]

The first treatment of the topic by a Catholic scholar writing in English, and one of the first treatments by any Catholic scholar is by Edwin Healy in his contribution to the new genre. He considers a case in which a man, who is married and is the father of two children, "contends that he has a female mind or soul" and seeks "corrective" surgery "to be changed into a woman."[13] Healy's judgment is that this would be gravely illicit. The man "clearly belongs to the male sex"[14] as is shown by his having male genitalia and his being the father of two children. Excising his genitalia would constitute grave mutilation of the human body for, according to Healy, "mutilation is only licit when it is necessary to preserve the body's health or integrity or when the conditions required for the licit transplantation of organs are verified."[15] The operation would also be futile in that it would not change a male into a female but only into an emasculated man. It would also have the added harm of rendering him unable validly to marry.

12. Charles McFadden did not discuss GRS in the early editions of his influential work *Medical Ethics*, neither in the first edition (Philadelphia: F. A. Davis, 1946) nor the subsequent revisions until the sixth edition (Philadelphia: F. A. David, 1967). Alphonsus Bonnar makes no reference to it in *The Catholic Doctor*, 5th ed. (London: Bums, Oates and Washbourne, 1951), neither do Frederick L. Good and Otis F. Kelly in *Marriage, Morals, and Medical Ethics* (New York: P. J. Kennedy and Sons, 1951), nor does John P. Kenny in *Principles of Medical Ethics* (Cork: Mercier, 1953). Gerald Kelly mentions the topic of "sex change" operations in his influential article on the ethics of mutilation, "The Morality of Mutilation: Towards a Revision of the Treatise," *Theological Studies* 17 (1956): 322–44 at 335n35, https://doi.org/10.1177/004056395601700302, alluding to a brief discussion by Jules Paquin in *Morale et Médecine* (Montréal: Comité des Hôpitaux du Québec, 1955), 249, but he does not give an opinion on it, nor does he include the topic in his *Medico-Moral Problems* (St. Louis: Catholic Hospital Association of the United States and Canada, 1958).
13. Edwin Healy, *Medical Ethics* (Chicago: Loyola University Press, 1956), 135.
14. Healy, *Medical Ethics*, 135.
15. Healy, *Medical Ethics*, 135.

Healy is unusual among Catholic bioethicists of this early period in having addressed this topic but there is no reason to think that other scholars would have come to a different conclusion. Over the next twenty years, the few Catholic writers who commented on GRS[16] did so in very similar terms.

It was not until 1977 that a significantly new element was added to the Catholic ethical discussion of GRS. Albert Moraczewski took the same line as Healy in arguing against the idea that there could be, for example, a female soul in a male body. Such a radical disjunction of soul and body implies a "Cartesian dualism of mind and body [that] must be rejected."[17] On the other hand, he was much more cautious than Healy in relation to whether someone who has male genitalia "clearly belongs to the male sex." Moraczewski suggested that gender dysphoria might have a genetic cause such that someone who *appeared* to be biologically female *in fact* might be biologically male (or vice versa).

> If the biological interpretation of transsexuality is correct to any considerable degree, then there might be a basis for saying that what appears to be a case of a "man" inhabiting a woman's body is really a case of a man inhabiting what appears to be a woman's body. If such is the correct description of the case, then we could say that God created a male and that a sex change operation would be corrective and be similar to other operations which seek to compensate for, or overcome, a difficulty that is genetic or embryological in origin.[18]

The validity of this argument does not rely on the speculation that Moraczewski entertained at that time about the origin of gender dysphoria: that it might be due to "a Y chromosome in translocation."[19] The key premise of the argument, which he maintained in later works,[20] is that gender dysphoria may have *some* biological basis, whether genetic, hormonal, or neurophysiological. If this premise is conceded then the discordance between body and psyche can be thought of as an error in development, and if the discordance is an error then surgical alteration can be presented as therapeutic, "on the basis that it would correct a defect, to make the individual's anatomy in closer concordance with the person's experienced gender."[21]

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16. Albert Niedermeyer, *Compendium of Pastoral Medicine* (New York: I. F. Wagner, 1960); Charles J. McFadden, *Medical Ethics*, 6th ed. (Philadelphia: F. A. Davis, 1967); Thomas J. O'Donnell, *Medicine and Christian Morality* (New York: Alba House, 1976).
17. Albert S. Moraczewski, "'Sex Change' Operations," *Ethics & Medics* 2 (1977): 4–5 at 4.
18. Moraczewski, "'Sex Change' Operations," 5.
19. Moraczewski, "'Sex Change' Operations," 4.
20. Mark F. Schwartz, Albert Moraczewski, and James Monteleone, eds., *Sex and Gender: A Theological and Scientific Inquiry* (St. Louis: Pope John XXIII Medical-Moral Research Center, 1983), 302–5; Albert S. Moraczewski, "The Church and the Restructuring of Humans," in *Medicine Unbound: The Human Body and the Limits of Medical Intervention*, Emerging Issues in Biomedical Policy 33 (New York: Columbia University Press, 1994), 40–61 at 51.
21. Moraczewski, "The Church and the Restructuring of Humans," 51.

The Ethical (Ir)relevance of Origins

Some Catholic bioethicists[22] have followed Moraczewski in arguing that, if gender dysphoria were shown to have a biological basis then an ethical case could be made for the ethical acceptability of GRS, at least in principle. Others have argued that "the determining causes [of gender dysphoria] are at the psychological level of development"[23] and hence that GRS is not ethically acceptable. This stance seems to be reflected in the *Charter for Healthcare Workers*, which prohibits GRS on the basis that gender dysphoria is "an illness of psychic or spiritual origin" and not one with an "organic basis."[24]

Theologians such as Ashley and O'Rourke are thus opposed to Moraczewski, in that they seek to deny the causal story that he raised as a serious possibility. Nevertheless, in another way they accept the same basic premise. Both sides of this argument hold that the ethical acceptability of GRS depends on whether gender dysphoria has a biological basis and origin or whether it is psychological both in character and in origin. Implicitly both sides of this argument are appealing to a contrast between mental illness on the one hand, and on the other, physiological Divergences of Sexual Development (DSD), also known as "intersex" conditions.

It is useful to make explicit the connotations implicit in this contrast: The former incongruity is psychological in nature, the latter is physiological. The former is a mental health issue, the latter is a physical health issue. The former is subjective, the latter objective. The former is "all in the head," the latter is evident in the outwards appearance of the body. The former is properly addressed by psychotherapy, the latter may need to be addressed by surgery. The former is seemingly changeable by effort of the will while the latter is seemingly an unchangeable aspect of one's physical constitution. The former condition raises a host of ethical and philosophical problems, the latter is presented as ethically and philosophically unproblematic.

This unfortunate list of "mixed antitheses" (to borrow a phrase from Mary Midgley)[25] shows the danger of making too fundamental a contrast between two sets of conditions. Such an approach leads to the conflating of very different distinctions. If mental health problems are, in a sense, more subjective, they are no less real. So also, a psychological diagnosis does not imply an exclusively psychological treatment. Again, conditions that are physical in origin are not free of social, psychological, and indeed ethical challenges. Consider, for example, how to treat a child with a DSD who

22. Orville N. Griese, *Catholic Identity in Health Care: Principles and Practice* (St. Louis: Pope John Center, 1987), 228–9; William May, "Sex Reassignment Surgery," *Ethics & Medics* 13, no. 11 (1988): 1–2.
23. Benedict Ashley, Jean Deblois, and Kevin O'Rourke, *Health Care Ethics: A Catholic Theological Analysis*, 5th ed. (Washington, DC: Georgetown University Press, 2006), 110; similarly Wim Eijk, Lambert J. M. Hendriks, and Janthony A. Raymakers, *Manual of Catholic Medical Ethics* (Ballarat: Connor Court, 2014), 460–66.
24. PCPAHCW, *Charter*, 145.
25. Mary Midgley, *Evolution as a Religion* (New York: Routledge, 2002), 112.

has come to reject his or her assigned gender, a gender that may already have been the basis for surgery.[26] Again consider the following thought experiment: imagine if some cases of gender dysphoria were psychological in origin (shaped by interactions in early childhood) whereas others had an identifiable genetic basis, but that the level of distress was the same, the danger of suicide the same, and the intractability of the condition the same. What difference would the origin of the condition make? Would an incongruent sense of gender identity rooted in very early and irradicable psychological influences be any less "real" because the person lacked some genetic feature share by other gender dysphoric people?

A real danger in giving the contrast between mental illnesses and DSDs an *architectonic* significance in thinking about gender dysphoria is that both sides of the dichotomy risk becoming caricatures.[27] The exclusively mental account renders the condition subjective, unreal, and easily changeable, the exclusively physical account becomes a license for all and any surgery. Once it is admitted that mental illness may have an organic basis and may be addressed by medication and even, in principle, by psychosurgery, and once it is admitted that surgery for DSD needs to accord with the same ethical principles that govern all surgery, then what is at stake in determining whether gender dysphoria has an "organic basis"? The complex nature and origin of gender dysphoria is of relevance for how the condition might be treated. However, an overemphasis on the question of origin, framed as a simple either/or, of nature versus nurture, does not illuminate but obscures the ethical issues at stake.

The current scientific consensus is that "Gender identity is a multifactorial process involving both prenatal and postnatal variables. Psychosexual development is influenced by multiple factors such as exposure to androgens, sex chromosome genes, social circumstances and family dynamics."[28] This conclusion does not fit easily either with the narrative that excludes any biological basis for gender dysphoria or with a narrative that excludes all psychological and social factors. Rather than attempting to answer a question about origins, dubiously framed as an either/or, it is better to turn to questions that have clear and immediate ethical relevance: Is there good clinical evidence that GRS is effective in ameliorating gender dysphoria? Is surgery that destroys physical function to ease psychological distress justifiable by the principle of totality? And, aside from the issue of mutilation, that is, aside from the harm done to bodily integrity, are there other reasons to characterize GRS as *intrinsece malum*?

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26. Ashley, Deblois and O'Rourke, *Health Care Ethics*, 5th ed., 112–13.
27. Susannah Cornwall, "'State of Mind' versus 'Concrete Set of Facts': The Contrasting of Transgender and Intersex in Church Documents on Sexuality," *Theology and Sexuality* 15 (2009): 7–28, https://doi.org/10.1558/tse.v15i1.7.
28. Gönül Öçal, "Current Concepts in Disorders of Sexual Development," *Journal of Clinical Research in Pediatric Endocrinology* 3 (2011): 105–14 at 111, https://doi.org/10.4274/jcrpe.v3i3.22; see also Kenneth J. Zucker, Anne A. Lawrence, and Baudewijntje P. C. Kreukels, "Gender Dysphoria in Adults," *Annual Review of Clinical Psychology* 12 (2016): 217–47, https://doi.org/10.1146/annurev-clinpsy-021815-093034.

Questioning the Evidence of Benefit

A year after Moraczewski's short article on "sex change" operations, Benedict Ashley and Kevin O'Rourke published the first edition of *Health Care Ethics: A Catholic Theological Analysis*. This work, through its several editions, was destined to become an extremely influential text in Catholic bioethics well into the twenty-first century.[29] In the first edition, the discussion of GRS covers a little over four pages, making it easily the most detailed Catholic bioethical analysis of the topic up to that time. The conclusion of that analysis is unambiguous: "It seems this type of surgery is intrinsically outside the limits of ethical medicine, since its purpose is not genuine treatment of a psychological illness, but an illusory adjustment involving a destructive loss of bodily integrity."[30]

In relation to their overall ethical conclusion, Ashley and O'Rourke thus differ little from Healy twenty years previously. However, there are striking differences in the ways in which Healy and Ashley-O'Rourke come to this conclusion. The contrast is well expressed by Richard McCormick: "Healy sees in transsexual surgery only destructive mutilation. He does not even discuss its possibly alleviating effects. Ashley–O'Rourke can conceive of the possibility that such surgery *could be* for the overall good of the person. Their rejection of it is much more a matter of empirical data."[31]

Three quarters of the space Ashley and O'Rourke give to this topic is devoted to empirical questions of etiology and efficacy, benefits and harms. There is also a difference of tone. They repeatedly emphasize the "very genuine suffering"[32] of people with the "puzzling and painful condition called transsexualism or more accurately gender dysphoria syndrome."[33] Nevertheless, having reviewed the current state of clinical opinion, Ashley and O'Rourke argue that, even abstracting from the intrinsic ethics of GRS, there is reason to be skeptical about the *efficacy* of such surgery. They acknowledged that it is difficult to come to a firm judgment about the potential harms and benefits of a

29. For the influence of this text on discussion of GRS specifically, see for example Griese, *Catholic Identity in Health Care*, 228–29; Elizabeth M. Bucar, "Bodies at the Margins: The Case of Transsexuality in Catholic and Shia Ethics," *Journal of Religious Ethics* 38 (2010): 601–15 at 609, https://doi.org/10.1111/j.1467-9795.2010.00454.x; Nicholas Tonti-Filippini, "Sex Reassignment and Catholic Schools," *National Catholic Bioethics Quarterly* 12 (2012): 85–97, https://doi.org/10.5840/ncbq201212176; Eijk, Hendriks, and Raymakers, *Catholic Medical Ethics*, 460–66; and Moira McQueen, "Catholic Teaching on Transgender (Gender Dysphoria)," *Bioethics Matters* 14, no. 1 (2016): 1–4, also at http://www.eeparchy.com/blog/2016/03/22/bioethics-matters-catholic-teaching-on-transgender-gender-dysphoria/.

30. Benedict Ashley and Kevin O'Rourke, *Health Care Ethics: A Catholic Theological Analysis*, 1st ed. (Washington, DC: Georgetown University Press, 1978), 318.

31. Baruch A. Brody et al., "Marriage, Morality, and Sex-Change Surgery: Four Traditions in Case Ethics," *The Hastings Center Report*, 11 (1981): 8–13 at 10, https://doi.org/10.2307/3561335, emphasis in the original.

32. Ashley and O'Rourke, *Health Care Ethics*, 1st ed., 319.

33. Ashley and O'Rourke, *Health Care Ethics*, 1st ed., 315.

relatively new mode of treatment. However, they cite psychiatrists who are strongly opposed to surgery on purely clinical grounds, and suggest that "it is *prima facie* unlikely that persons who experience psychic anguish because of this feeling of incongruence can ever achieve permanent relief by an effort to realise their fantasies."[34]

In subsequent editions of this work (from 1982 onwards), Ashley and O'Rourke maintain this empirical focus, providing four evidence-based criticisms of GRS:

- First, they argue that there is no clear biological cause of gender dysphoria and therefore that it is psychological in character and should be treated psychotherapeutically.
- Second, they point out that, when candidates for surgery were required to undergo psychotherapy in preparation for surgery, many were found to be ambiguous about wanting it.
- Third, even in the fifth edition in 2006, they can find no robust evidence that GRS "does much good"[35] or offers any advantage over psychotherapy. They cite among other things, the decision of Johns Hopkins, after a review of the evidence, to cease offering GRS.[36]
- Fourth, they argue that GRS does not "solve these persons' existential problems"[37] because it does not enable people to achieve sexual normality, to contract a valid marriage or to beget children.

Ashley and O'Rourke therefore conclude that "based on the present state of knowledge, Catholic hospitals or health care professionals are not justified in recommending or engaging in this type of surgery."[38]

In the course of expounding the fourth point, Ashley and O'Rourke continue to argue that GRS is intrinsically wrong, because "the good of the person cannot be achieved at the expense of the destruction of a basic human function, in this case the sterilization of the person, except to save the person's life."[39] However, this intrinsic

34. Ashley and O'Rourke, *Health Care Ethics*, 1st ed., 316.
35. Ashley, Deblois and O'Rourke, *Health Care Ethics*, 5th ed., 111.
36. Ashley, Deblois and O'Rourke, *Health Care Ethics*, 5th ed., 111, citing Jon K. Meyer and Donna J. Reter, "Sex Reassignment: Follow-up," *Archives of General Psychiatry* 36 (1979): 1010–15, https://doi.org/10.1001/archpsyc.1979.01780090096010; and Paul McHugh, "Psychiatric Misadventures," *The American Scholar* 61 (1992), though it should be noted that this decision has recently been reversed; see Amy Ellis Nutt, "Long Shadow Cast by Psychiatrist on Transgender Issues Finally Recedes at Johns Hopkins," *Washington Post*, April 5, 2017, https://www.washingtonpost.com/national/health-science/long-shadow-cast-by-psychiatrist-on-transgender-issues-finally-recedes-at-johns-hopkins/2017/04/05/e851e56e-0d85-11e7-ab07-07d9f521f6b5_story.html.
37. Benedict M. Ashley and Kevin D. O'Rourke, *Health Care Ethics: A Catholic Theological Analysis*, 2nd ed. (Washington, DC: Georgetown University Press, 1982), 315.
38. Ashley and O'Rourke, *Health Care Ethics*, 2nd ed., 315; a conclusion repeated word for word in the fifth edition, Ashley, Deblois, and O'Rourke, *Health Care Ethics*, 5th ed., 111.
39. Ashley, Deblois and O'Rourke, *Health Care Ethics*, 5th ed., 111.

objection is merely stated as a "consideration" and is not explored in any depth or defended against possible counter-arguments. Instead Ashley and O'Rourke rely primarily on empirical arguments based on "the current state of knowledge" and emphasize the weakness of the evidence for efficacy.

The efficacy or inefficacy of medical and surgical procedures is clearly of great ethical relevance. It is the hope of benefit that justifies the risks of surgery and this benefit needs to be greater and more secure in proportion to the harm that surgery would inflict on the body. In the case of GRS, in the absence of strong evidence of benefit, "the destruction of physically sound organs, including their reproductive capacity … is at least disproportionate."[40] Furthermore, the history of medicine contains many examples of treatments or procedures which were based more on fashion than evidence and which did more harm than good. There is also a pragmatic reason to focus on arguments based on clinical evidence, in that these may convince people who disagree about philosophical or ethical principles. It is therefore unsurprising that Catholic bioethicists and clinicians have followed Ashley and O'Rourke in discussing GRS primarily from an empirical perspective.[41]

On the other hand, arguments based only on evidence of the physical and psychological benefits and harms of a procedure fail to address some fundamental ethical issues. Healy argued that GRS constituted grave mutilation of the human body and therefore that it was unethical *in principle*. While Ashley and O'Rourke maintained this stance, they obscured this in-principle objection by their focus on clinical evidence. This confuses the issue, for clinical considerations typically admit of exceptions. For example, where other procedures have failed, then more extreme treatment options may be tried even if their benefits are uncertain. It is also the case that the evidence in this area is highly disputed, with clinicians interpreting the available evidence in very different ways.[42]

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40. McQueen, "Catholic Teaching on Transgender," 4.
41. Guevin, "Augmentation Mammaplasty"; Richard P, Fitzgibbons, Philip M. Sutton, and Dale O'Leary, "The Psychopathology of 'Sex Reassignment' Surgery," *National Catholic Bioethics Quarterly* 9 (2009): 97–125, https://doi.org/10.5840/ncbq20099183; Richard P. Fitzgibbons, "Transsexual Attractions and Sexual Reassignment Surgery: Risks and Potential Risks," *Linacre Quarterly* 82 (2015): 337–50, https://doi.org/10.1080/00243639.2015.1125574; McHugh, "Psychiatric Misadventures"; Paul McHugh, "Surgical Sex," *First Things*, November 2004, https://www.firstthings.com/article/2004/11/surgical-sex; McHugh, "Transgender Surgery Isn't the Solution: A Drastic Physical Change Doesn't Address Underlying Pychosocial Troubles," *Wall Street Journal*, June 12, 2014, https://www.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120; Lawrence S. Mayer and Paul McHugh, "Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences," *New Atlantis* 50 (2016): 86–116, https://www.thenewatlantis.com/docLib/20160819_TNA50SexualityandGender.pdf.
42. Contrast Fitzgibbons, "Transsexual Attractions"; Mayer and McHugh, "Sexuality and Gender" with WPATH, *Standards of Care*; Zucker, Lawrence and Kreukels, "Gender Dysphoria."

The recommendation of Ashley and O'Rourke, that Catholic health-care providers refuse permission, in advance and for all cases, for GRS to occur on its premises, seems to require a stronger reason than merely a difference of clinical opinion. If GRS cannot be shown to contravene any inherent ethical principle then it is difficult to justify a blanket prohibition on such procedures.

The Principle of Integrity and Direct Sterilization

While there is no magisterial teaching specifically on GRS, there is clear, repeated, and authoritative teaching in relation to sterilization. In 1930, Pope Pius XI issued a sharp denunciation of programs of forced sterilization that had been instituted not only in Germany but also in Sweden and the United States. Furthermore, the pope made it clear that the moral prohibition of sterilization for contraceptive reasons was not limited to involuntary sterilization. Rather it was based on a more general moral duty to respect the integrity of the human body, such that people "are not free to destroy or mutilate their members, or in any other way render themselves unfit for their natural functions."[43]

This teaching, sometimes framed as a "principle of integrity," prohibits all direct and deliberate destruction of bodily function, but procreative function especially so because of the profound human and moral significance of procreation. The relevance of these considerations for GRS is expressed with admirable clarity by Nicholas Tonti-Filippini: "It is inconceivable that the Church could endorse the destruction of healthy biological functions, particularly when the Church attaches meaning to the gift of sexual intimacy in part because of the procreative meaning of that intimacy."[44] It was reflection on this same principle that caused Ashley and O'Rourke to regard GRS as intrinsically outside the limits of ethical medicine: "The surgery is correctly considered a *mutilation in the strict sense* because it destroys the bodily integrity of individuals with regard to a basic function, rendering them permanently sterile."[45]

It may be said that some individuals seek to retain their fertility after GRS by freezing eggs, sperm, or reproductive tissue. There have even been cases of female-to-male transsexuals who have kept their internal organs and become pregnant while legally male.[46] However, maintaining fertility after "bottom surgery"[47]—that is, after the radical reconstruction of the genitals—is dependent on assisted reproductive technologies. After hysterectomy it would require use of a surrogate mother. Conception by means

43. Pius XI, *Casti Connubii* (December 31, 1930), 71, https://w2.vatican.va/content/pius-xi/en/encyclicals/documents/hf_p-xi_enc_19301231_casti-connubii.html.
44. Tonti-Filippini, "Sex Reassignment," 94.
45. Ashley and O'Rourke, *Health Care Ethics*, 1st ed., 318, emphasis added.
46. Richard Alleyne, "Sex Change British Man Gives Birth to Son," *Telegraph*, February 12, 2012, http://www.telegraph.co.uk/news/health/news/9077506/Sex-change-British-man-gives-birth-to-son.html.
47. Carol Bayley, "Transgender Persons and Catholic Healthcare," *Health Care Ethics USA*, Winter 2016, 1–5, https://www.chausa.org/docs/default-source/hceusa/transgender-persons-and-catholic-healthcare.pdf?sfvrsn=2.

of sexual union is no longer possible. Reproduction is thus separated from sexual union and the child is conceived outside the body of his or her mother and is vulnerable, while an embryo, to being frozen, discarded, or manipulated. The use of such technologies is contrary to the moral teaching of the Catholic Church.[48] Furthermore, genital reconstruction destroys not only the possibility of natural conception but also the possibility of sexual union—or at least, of that authentically human sexual union by which a sacramental marriage can validly be consummated.[49]

The ethical category of mutilation, understood as the direct and deliberate destruction of bodily function (including sexual and procreative function), thus has immediate relevance for the ethical evaluation of GRS. It is therefore appropriate that disputes in the United States in relation to the provision of GRS by Catholic hospitals have made appeal to the *ERD* concerning sterilization: "Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available."[50]

Consideration of this directive and of a related directive[51] nevertheless raises a number of questions. What is meant by "direct sterilization"? If this connotes procedures that are "directed to a contraceptive end,"[52] then it seems questionable whether GRS is "direct" sterilization. Such surgery is not intended as a form of contraception. On the other hand, if "direct" is not specified by reference to a contraceptive intent, how is it specified? A related question is whether GRS might be justified because it is intended for the "alleviation of a present and serious pathology" for which "a simpler treatment is not available,"[53] that is, the pathology of gender dysphoria.

The *ERD* of the United States Catholic Bishops are characteristic of Catholic prohibitions on mutilation, in that they typically contain an explicit exception to accommodate

48. Congregation for the Doctrine of the Faith, *Donum Vitae* (February 22, 1987), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html; Congregation for the Doctrine of the Faith, *Dignitas Personae* (September 8, 2008), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html.
49. That is, where "the spouses have performed between themselves in a human fashion *a conjugal act which is suitable in itself for the procreation* of offspring, to which marriage is ordered by its nature and by which the spouses become one flesh," Canon 1061 §1, emphasis added.
50. USCCB, *Ethical and Religious Directives*, 23, dir. 53 citing Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters" (July 31, 1993), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_31071994_uterine-isolation_en.html.
51. USCCB, *Ethical and Religious Directives*, 37, dir. 70.
52. USCCB, *Ethical and Religious Directives*, 41n44, citing Congregation for the Doctrine of the Faith, "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" (1975), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19750313_quaecumque-sterilizatio_en.html.
53. USCCB, *Ethical and Religious Directives*, 23, dir. 53.

physical or functional harms that occur in the course of necessary therapeutic interventions. Mutilation is prohibited "*except* when no other provision can be made for the good of the whole body"[54] or "*except* for one's own good"[55] or "*except* when performed for strictly therapeutic medical reasons"[56] or "*except* to save the person's life"[57] or *except* "when it is necessary to preserve the body's health or integrity"[58] or *except* "when and to the extent necessary for the good of his being as a whole."[59]

It is widely acknowledged that gender dysphoria results in a significantly increased risk of suicide, and thus presents a risk to the person's life and the good of the whole body. The question then becomes: If GRS were shown to reduce the danger to the whole body, could the prospect of this benefit constitute an exception to the rule on mutilation, justifying the immediate destruction of sexual and procreative function?

The Principle of Totality and Indirect Sterilization

From the mid-twentieth century until the present, the predominant approach taken by Catholic moral theologians to the ethics of surgery has appealed to "the principle of totality."[60] The roots of this principle are to be found in the writings of Thomas Aquinas:

> Since a member is part of the whole human body, it is for the sake of the whole, as the imperfect for the perfect. Hence a member of the human body is to be disposed of according as it is expedient for the body. Now a member of the human body is of itself useful to the good of the whole body, yet, accidentally it may happen to be hurtful, as when a decayed member is a source of corruption to the whole body. Accordingly, so long as a member is healthy and retains its natural disposition, it cannot be cut off without injury to the whole body.[61]

54. Pius XI, *Casti Connubii*, n71, emphasis added.
55. Kelly, "The Morality of Mutilation," 342, emphasis added.
56. *Catechism of the Catholic Church*, 2297, emphasis added, http://www.vatican.va/archive/ENG0015/_P80.HTM.
57. Ashley, Deblois and O'Rourke, *Health Care Ethics*, 5th ed., 111, emphasis added.
58. Healy, *Medical Ethics*, 135.
59. Pius XII, "Histopathology of the Nervous System," 13.
60. See, among others Pius XII, "Histopathology of the Nervous System"; Pius XII, "Italian Society of Urology"; Kelly, "Pope Pius XII and the Principle of Totality"; Kelly, "The Morality of Mutilation"; Ashley, Deblois, and O'Rourke, *Health Care Ethics*, 5th ed., 104, 114–15; Becket Gremmels, "Sex Reassignment Surgery and the Catholic Moral Tradition: Insight from Pope Pius XII on the Principle of Totality," *Health Care Ethics USA*, Winter 2016, 6–10, https://www.chausa.org/docs/default-source/hceusa/sex-reassignment-surgery-and-the-catholic-moral-tradition.pdf?sfvrsn=2; Travis Stephens, "The Principle of Totality Does Not Justify Sex Reassignment Surgery," *Ethics & Medics* 41, no. 11 (November 2016): 1–4, https://www.ncbcenter.org/files/5214/7672/4389/NCBC_EthicsMedics_November2016.pdf. This approach is implicit in USCCB, *Ethical and Religious Directives*, 29, expressed as people's "duty to protect and preserve their bodily and functional integrity."
61. Aquinas, *Summa Theologiae* 2–2, q. 65, a. 1, co.

Pope Pius XII refined this principle and applied it to the practice of surgery: "By virtue of the principle of totality … the patient can allow individual parts to be destroyed or mutilated when and to the extent necessary for the good of his being as a whole."[62] While Aquinas only considers the case of an organ or member that is diseased, for example a gangrenous leg, Pius XII is clear that the "decisive point" is not whether an organ is diseased or healthy but is whether "its retention or functioning either directly or indirectly brings about a serious threat to the whole body."[63] Nor indeed is this principle confined to threats to physical health. Many Catholic bioethicists considered the practice of lobotomy, and while they were generally cautious about the risks and benefits, none condemned the practice as intrinsically unethical. Kelly, for example, cites the second edition of the *Ethical and Religious Directives for Catholic Hospitals*, which he had a hand in writing: "Lobotomy and similar operations are morally justifiable when medically indicated … the welfare of the patient himself, considered as a person, must be the determining factor."[64]

The principle of totality can be thought of as a further restriction of the principle of double effect in the context of medical treatment or surgery (a point not recognized by Carol Bayley).[65] The principle of double effect distinguishes between direct effects that are intended (either as an end or as the means to an end), and side effects, which are not intended though they may have been anticipated.[66] The classical example is killing in warfare. The targeting of civilians is morally prohibited but causing the deaths of civilians may be morally permissible if it is the side effect of a just action that is done for a grave reason. In the case of medical interventions, the principle of totality adds the further specification that the good that is done and the harm that is tolerated are the good of and harm to the health or well-being of the *same* person. What is excluded by this principle is harming one person for the sake of another, for example by live organ donation. Donation from a living person is only morally permissible if it respects the bodies of both donor and recipient.

Becket Gremmels argues that "Pope Pius XII's insights on the principle of totality show that simply because SRS [Sex Reassignment Surgery] removes healthy, non-pathological body parts and results in sterility does not mean it is unjustified. These are morally relevant but not morally determinative factors when assessing SRS."[67] In a later article, Gremmels cites the classic work of Gerald Kelly on the morality of

62. Pius XII, "Histopathology of the Nervous System," 13.
63. Pius XII, "Italian Society of Urology," trans. Gremmels, "Sex Reassignment Surgery," 7.
64. Kelly, "The Morality of Mutilation," 340.
65. Bayley, "Transgender Persons," 3.
66. Gertrude Elizabeth Margaret Anscombe, "Medalist's Address: Action, Intention and 'Double Effect'," *Proceedings of the American Catholic Philosophical Association* 56 (1982): 12–25, https://doi.org/10.5840/acpaproc19825611; Daniel P. Sulmasy, "'Reinventing' the Rule of Double Effect," in *The Oxford Handbook of Bioethics*, ed. Bonnie Steinbock (Oxford: Oxford University Press, 2007).
67. Gremmels, "Sex Reassignment Surgery," 8.

mutilation[68] which provides historical background that strengthens Gremmels's case. Because the sterility is not intended, and because it is caused by surgery that is intended to alleviate a serious pathology, then it seems that is not "mutilation in the strict sense," nor therefore is it *intrinsece malum.* Nevertheless, Gremmels argues against provision of GRS on the basis that the evidence of effectiveness is insufficient to justify the evident harms and risks of the surgery.

Christian Brugger, in a critique of Gremmels, points out that the same logic would seem to justify amputation of a healthy limb to alleviate body dysmorphic disorder.[69] This example may be intended as a *reductio ad absurdum* but the conclusion is affirmed by at least one author. Robert Song argues that the principle of totality as expounded by Pius XII and Gerald Kelly provides a moral justification for amputation to alleviate body dysmorphic disorder.[70] By implication, it seems the same justification could apply to GRS.

Brugger argues that GRS need not involve any intrinsically wrong intention. He imagines a case in which GRS was performed only to help the patient find "some semblance of psychological stability" and suggests that such a case "would meet Pius' first condition for totality … namely, that the function of a particular organ constituted a threat to the whole,"[71] though he does not think it would meet the condition of efficacy.

Assertions that GRS constitutes mutilation are ubiquitous within the Catholic moral tradition beginning with Healy.[72] This judgment also operates implicitly when the US Bishops' *ERD* on sterilization is invoked in relation to GRS. However, the judgment that GRS constitutes mutilation in the strict sense is more often asserted than defended and it faces a major challenge in the analyses presented by Gremmels, Brugger, and Song. If their analyses stand then the most important intrinsic argument against GRS falls.

Physical Causes and Intentional Objects

The basis of the principle of totality, evident in the very name, is the subordination of a part to the whole. A part may be sacrificed for the sake of the whole. In relation to human health the relevant whole is not simply the whole body but the whole person, encompassing both physical *and* mental health. This is the reason that medication and

68. Kelly, "The Morality of Mutilation," cited in Becket Gremmels, "More Insight from Pius XII, a Reply to Brugger and Brehany, and a Clarification," *Health Care Ethics USA*, Fall 2016, 7–17 at 11, https://www.chausa.org/docs/default-source/hceusa/more-insight-from-pius-xii-a-reply-to-brugger-and-brehany-and-a-clarification.pdf?sfvrsn=0.
69. E. Christian Brugger, "Catholic Hospitals and Sex Reassignment Surgery: A Reply to Bayley and Gremmels," *National Catholic Bioethics Quarterly* 16 (2016): 587–97 at 593, https://doi.org/10.5840/ncbq201616456.
70. Robert Song, "Body Integrity Identity Disorder and the Ethics of Mutilation," *Studies in Christian Ethics* 26 (2013): 487–503, https://doi.org/10.1177/0953946813492921.
71. Brugger, "Catholic Hospitals," 593.
72. Healy, *Medical Ethics*, 135–36.

even surgery may be used to treat mental health problems. Nevertheless, it is important in this context to distinguish psychosurgery from surgery for psychological reasons.

Consider first the example of brain surgery to reduce the severity and frequency of migraines. Compare this with cosmetic surgery in the case of someone who is so distressed about the shape of his nose that he lacks self-confidence and avoids public places. Let us imagine that the distress is real and serious in both cases, that it has not proved possible to alleviate it by simpler means, and that, in both cases, the proposed intervention is effective in alleviating the distress.

In the first case, the aim of the surgery on the brain is to address the physical cause of the pain and distress. In the second case, the nose is not the physical cause of the man's distress but is the object of the distress—it is what he is distressed *about*.

The man's nose is, of course, a part of the body, and he is distressed over the fact that it is a part of his body, but it is not being part of the body *as such* that makes his nose an object of distress. We might say that the man has his nose "in mind" or that he is distressed "about" his nose. However, he might as easily have his wife's nose in mind, or might be distressed about something entirely unconnected to the body, such as the slaughter of battery chickens or the rate of inflation. What someone has in mind, what he or she is concerned *about*, may happen to be a part of a whole but this is *per accidens* to the relationship of "being in mind." About-ness, the relation of being the intentional object of an emotional or mental state, is not *as such* a part-to-whole relation.

Elizabeth Anscombe highlighted the importance of distinguishing the object of an emotion (such as fear, hope, or distress) from the cause of an emotion, notwithstanding that the emotional object might also function as a cause. "The object of fear may be the cause of fear, but, as Wittgenstein remarks, is not *as such* the cause of fear."[73]

In a perceptive but overlooked passage, Pius XII drew attention to the importance of establishing the relevant facts about the part-to-whole relations before applying the principle of totality:

> We respect the principle of totality in itself but, in order to be able to apply it correctly, one must always explain certain premises first. The basic premise is that of clarifying the *quaestio facti*, the question of fact. Are the objects to which the principle is applied in the relation of a whole to its parts? … The principle of totality itself affirms only this: where the relationship of a whole to its part holds good, and in the exact measure it holds good, the part is subordinated to the whole and the whole, in its own interest, can dispose of the part. Too often, unfortunately, in invoking the principle of totality, people leave these considerations aside, not only in the field of theoretical study and the field of application of law, sociology, physics, biology and medicine, but also of logic, psychology and metaphysics.[74]

In the case of psychosurgery, the brain relates to the whole person as a part to the whole, and the principle of totality is applicable to the surgery. If effective, it might be justified even if it also caused harm to some other function. In contrast, with cosmetic

73. Elizabeth Anscombe, *Intention* (Oxford: Blackwell, 1957), 16 §10, citing Ludwig Wittgenstein, *Philosophical Investigations* (New York: Macmillan, 1953), 476.

74. Pius XII, "Histopathology of the Nervous System," 35.

surgery, the parts of the body are a cause of distress precisely because they are the object of the distress. Injuries may of course be both a physical cause of distress, as a part of the whole, and the emotional object of the distress. In such cases the principle of totality will apply, but it will apply because of the physical relation of causality and not because of the intention–object relation.

It is because a physical object can be the "object of distress" (note the two different senses of "object" here) that removing, avoiding, or adapting such physical objects may alleviate distress, at least to some extent. The fact that some aspect of a person's physical appearance has become an object of that person's distress can provide someone with a reason for acting. However, because the intentional object of a mental state is not, per se, in a part-to-whole relation, the principle of totality is not available as a justification for harm to the body. This limits which interventions are ethically acceptable. Surgery to remove or disguise the object of distress may be justifiable, but only if it would not cause serious and lasting harm to the body at the level of function.[75]

By the same logic, the principle of totality does not apply to GRS or to amputation for body dysmorphic disorder. This is not to deny that gender dysphoria and body dysmorphia may have an organic basis. They may have genetic, physiological, or developmental causes as well as psychological and social causes. It is imaginable that genetic, neurological, or pharmacological interventions might one day address these organic causes. However, the offending limbs in body dysmorphia or the sexual organs in gender dysphoria are causes of distress precisely because they are objects of the distress. As such they do not relate to the person as a part-to-the-whole and the principle of totality does not justify their removal or their functional destruction.

This distinction also illuminates the discussion of GRS in the Charter for Healthcare Workers. That document stated that the principle of totality cannot correctly be taken as a criterion for GRS because this surgery seeks to cure "an illness of psychic or spiritual origin" rather than sufferings or disorders "with an organic basis."[76] I have argued here that the presence or absence of an organic basis for gender dysphoria does not have the pivotal significance that is often attributed to it. Nevertheless, I have also argued that the principle of totality does not apply to GRS as the sexual organs are a cause of distress because the object of the distress. This could also be expressed by saying that the relation of the sexual organs to the dysphoria is intentional, that is, "psychic or spiritual," rather than "organic" or part-to-whole.

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75. A similar analysis applies in the case of live organ donation, an issue with which Pius XII was concerned. Here the principle of totality does not apply for a different reason—in live organ donation the physical harm is to one person and the health benefit to another. Such surgery is nevertheless commendable when it does not cause serious or lasting harm and when the donor is motivated by human solidarity. However, it is not permissible for the sake of organ donation to remove an organ that is necessary for vital function. That would constitute mutilation and should not be done even if the donor consents. Hence a man may donate his (paired) kidney but may not donate a second (unpaired) kidney.
76. PCPAHCW, *Charter*, 145.

As the principle of totality does not apply to GRS, the immediate harm to sexual and procreative function is contrary to the principle of integrity. On this basis, where surgery destroys function, it cannot be justified by reference to a further good intention.[77] It therefore constitutes "mutilation in the strict sense."[78] Mutilation in the strict sense may be defined as deliberate destruction of biological function that is *either* intended as such (as in the case of sterilization for contraceptive reasons) *or* is an immediate consequence of surgery and is not justified by the principle of totality (as in amputation for body dysmorphia).

Anthropology as a Basis for an Intrinsic Objection to GRS

From 1956 to the early twenty-first century, Catholic discussion of GRS and of gender dysphoria tended to focus on the question of whether GRS constituted mutilation, due to causing sterility. Alongside this in-principle discussion, Catholic scholars frequently addressed two empirical questions in relation to GRS: First, does gender dysphoria have an organic basis? Second, is GRS effective in alleviating gender dysphoria? These themes have remained prominent even up to the present, but in the last decade, a new form of argument has also been developed, partly in response to a shift in the characterization of gender dysphoria by medical professionals in the period leading up to 2010.

Medical professional bodies no longer describe gender incongruence, the mismatch between a person's biological sex and his or her sense of gender identity, as a "disorder." It is now only the "dysphoria," the distress associated with gender incongruence, which is treated as a mental health problem.[79] A key element in the new conceptualization of gender dysphoria is the distinction between sex, as a biological differentiation of male and female, and gender role/gender identity as a social or psychological category. On this view, someone who is biologically male might have the "gender identity" of a woman, an identity that could be "affirmed" by GRS.

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77. A case could be made for direct sterilization if the intentional destruction of procreative function were only an "ontic" or "pre-moral" evil (see Richard A. McCormick, "Sterilization and Theological Method," *Theological Studies* 37 [1976]: 471–77, https://doi.org/10.1177/004056397603700306) and analogous reasoning would seem to provide at least a prima facie case in support of GRS (thus Robert H. Springer, "Transsexual Surgery: Some Reflections on the Moral Issues Involved," in *Sexuality and Medicine 2*, ed. E. E. Shelp, Philosophy and Medicine 23 [Dordrecht: Springer, 1981], 233–47; and May, "Sex Reassignment Surgery," citing Anthony Kosnik et al., *Human Sexuality: New Directions in American Catholic Thought* [New York: Paulist, 1977], 232–34). However, to characterize the *intention* to sterilize as "pre-moral" neglects the moral significance of intentions, and the methodologies which McCormick cites in 1976 were subsequently condemned by Pope John Paul II in 1993 (*VS* 75). In any case, the bioethical analysis developed in the present article takes as a premise the validity of the principles of bodily integrity and totality as traditionally understood, which exclude direct sterilization, and applies these principles to the practice of GRS.
78. Ashley and O'Rourke, *Health Care Ethics*, 1st ed., 318.
79. WPATH, *Standards of Care*.

Pope Benedict XVI, concerned by this new philosophy of sex and gender, condemned the view that sex is merely "a social role that we choose for ourselves."[80] Similarly, Pope Francis has condemned "so called gender theory"[81] as a form of "ideological colonization."[82] More positively, he has taught that "the acceptance of our bodies as God's gift is vital for welcoming and accepting the entire world as a gift from the Father and our common home"; the virtuous acceptance of the body includes acceptance of one's sexual identity as male or as female: "valuing one's own body in its femininity or masculinity is necessary if I am going to be able to recognize myself in an encounter with someone who is different."[83] Here Francis echoes a teaching already present in the *Catechism of the Catholic Church* that "Everyone, man and woman, should acknowledge and accept his sexual identity."[84]

Neither Benedict XVI nor Francis related their anthropological critique of "gender theory" to the specific moral analysis of GRS. However, Catholic moral theologians and bioethicists are increasingly doing just this, arguing that "the anthropological reality—that a person's innate sexual identity cannot be changed—has moral consequences."[85]

Consideration of theological anthropology has provided the basis for a new kind of argument against GRS as *intrinsece malum*, quite apart from the issue of sterilization. "Such procedures are not only immoral because they render the patient sterile, but also because they reject the God-given personhood that is manifest through one's sexuality."[86] Another way to frame this point is to say that GRS involves dishonesty or, at least, untruthfulness, in that it implies agreement either with the view that sexual identity can be changed or with the view that gender identity can be separated from sexual

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80. Benedict XVI, "Address to the Roman Curia" (Vatican City, December 21, 2012), http://w2.vatican.va/content/benedict-xvi/en/speeches/2012/december/documents/hf_ben-xvi_spe_20121221_auguri-curia.html.
81. Francis, "Catechesis" (Vatican City, April 15, 2015), https://w2.vatican.va/content/francesco/en/audiences/2015/documents/papa-francesco_20150415_udienza-generale.html; Francis, *Amoris Laetitia* (March 19, 2016), 56, https://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20160319_amoris-laetitia.html.
82. Francis, "The Pope Speaks to Journalists on his Return Flight to Rome" (press conference, October 3, 2016), https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2016/10/03/161003a.html.
83. Francis, *Laudato Si'* (May 24, 2015), 155, https://w2.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20150524_enciclica-laudato-si.html.
84. *Catechism*, 2333, http://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a6.htm.
85. National Catholic Bioethics Center (NCBC), "Brief Statement on Transgenderism," *National Catholic Bioethics Quarterly* 16 (2016): 599–603 at 601, https://doi.org/10.5840/ncbq201616457.
86. Stephens, "The Principle of Totality," 2. An analogous argument has been developed in a Christian but non-Catholic context by Todd T. W. Daly, "Gender Dysphoria and the Ethics of Transsexual (i.e. Gender Reassignment) Surgery," *Ethics & Medicine* 32 (2016): 39–53, drawing on Oliver O'Donovan, "Transsexualism and Christian Marriage," *The Journal of Religious Ethics* 11 (1983): 135–62, and writing in response to Song, "Body Integrity Identity Disorder."

identity. The ethical concern here is not primarily the physical harm done by the surgery but the erroneous anthropology implicit in the desire to transition: "If I relate to or affirm a man as a woman because he is under the impression that he is a woman, then I relate to him according to a falsity."[87]

As early as 1977 Moraczewski suggested that some accounts of gender reassignment seemed to imply a Cartesian dualism of mind (or soul) and body of a sort which were incompatible with a sound anthropology, though both the charge of Cartesianism and the rejection of that view require more argument than Moraczewski provides. Similarly, Ashley and O'Rourke argued that "to follow such procedures [as GRS] cooperates with illusion and magical thinking which we should not encourage in any sufferer and certainly not in society."[88] Nevertheless, neither Moraczewski nor Ashley and O'Rourke developed such arguments at any length. In the early period of Catholic reflection on this issue, such considerations functioned as auxiliary arguments for why the destruction of function involved in GRS was not offset by genuine therapeutic benefit. The emphasis was on the physical harm done by GRS and the lack of justifying benefit rather than on anthropology as the basis for an absolute prohibition.

In contrast, a recent statement by ethicists of the US-based National Catholic Bioethics Center characterizes the very *intention* "to transition one's given bodily sex into a 'new' one" as an attempt "to alter what is unalterable, to establish a false identity in place of one's true identity, and so to deny and contradict one's own authentic human existence as a male or female body–soul unity."[89]

If the intention to transition to a new gender role is inherently wrong, being based on a falsehood, then it follows that acts done with this intention "may *never* be legitimately carried out or approved."[90] These acts include: "sex reassignment surgeries *of any kind* … the administration of cross-sex hormones as a means of gender transitioning … and the adoption of behaviors, clothing, mannerisms, names, or pronouns typical of the opposite sex with claims to be (and therefore demands to be treated as) a person of the opposite sex."[91] This argument, if valid, would resolve a great number of ethical issues, including the ethical status of GRS where there is no destruction of function (as for example in mammoplasty in male-to-female reassignment). However, the argument is both novel and overly ambitious and it is open to a number of counter-arguments.

The ethical premise of this argument is that "to establish a false [social] identity in place of one's true [biological] identity" is "to deny and contradict one's own authentic

87. Brugger, "Catholic Hospitals," 590.
88. Ashley and O'Rourke, *Health Care Ethics*, 1st ed., 319.
89. NCBC, "Brief Statement," 601; see also Edward J. Furton, "A Critique of 'Gender Dysphoria' in DSM-5," *Ethics & Medics* 42, no. 7 (2017): 1–4, https://www.ncbcenter.org/files/4915/0651/5526/EM_July2017_FINAL.pdf. A similar argument seems to be at work in John F. Brehany, "Pope Pius XII and Justifications for Sex Reassignment Surgery," *Health Care Ethics USA*, Fall 2016, 18–21, https://www.chausa.org/docs/default-source/hceusa/pope-pius-xii-and-justifications-for-sex-reassignment-surgery.pdf?sfvrsn=0.
90. NCBC, "Brief Statement," emphasis added.
91. NCBC, "Brief Statement," 601–2, emphasis added.

human existence."[92] However, it is not clear that acting and speaking *as though* a certain biological state or relationship held, is always and necessarily untruthful or dishonest. Consider the practice of legal adoption where children who are not biological offspring are *treated as* true sons or daughters. This example shows that a well-understood legal fiction need not be deceptive and need not be harmful to the common good. The fundamental basis of parenthood as a biological relationship can be acknowledged, while allowing, as an exception, that some parents and children may be granted a social and legal status that is modeled on that biological relationship. In relation to persons with gender dysphoria who transition between social gender roles, the relevant issue is whether there are exceptional circumstances that justify such a legal fiction, and whether this can be done without harm to the human institutions of marriage and family. These questions cannot be resolved a priori simply by appeal to the fact that a person's biological sex does not change when he or she transitions.

In the second place, the argument imputes to all who seek GRS a false and socially damaging anthropology. This begs the question. There certainly are false beliefs in this area, but these do not exhaust the possibilities of thinking about gender dysphoria. If someone conceptualizes being transgender as a female soul imprisoned in a male body, "this does not make being transgender incompatible with Catholicism; it just makes her self-conception incompatible."[93] It is possible, for example, that someone with gender dysphoria could acknowledge that "I am not female nor ever will be"[94] or, more subtly, "I'm not a ciswoman. I might wish I was … But I don't claim that I am a ciswoman. I'm a transwoman, and that's not the same thing."[95] To assume that everyone with gender dysphoria holds the same anthropological beliefs is to underestimate not only the diversity of views among people but also the extent to which thought in this area is evolving very rapidly. Furthermore, it is only in the last decade or so that Catholic theologians have given serious consideration to the relationship between gender dysphoria and theological anthropology. It would be rash to suppose that the philosophical and conceptual tools needed to understand these phenomena already exist. There is a clear need in this area for further philosophical and theological thought. This will require attentive dialogue with believers and sympathetic non-believers who have experienced gender dysphoria.

In the third place, even if someone who seeks GRS has a philosophically confused self-understanding, and even if he or she has a wrongful intention, it is not clear that

92. NCBC, "Brief Statement," 601.

93. Anna Magdalena Patti, "Are Transgender People Gnostic? An Answer to Robert Barron," *CatholicTrans*, February 12, 2016, https://catholictrans.wordpress.com/2016/02/12/are-transgender-people-gnostic/.

94. Aoife Hart quoted by Dan Hitchens, "What's the Truth about Transsexuality?" *Catholic Herald*, December 11, 2015, http://magazine.catholicherald.co.uk/magazine-post/whats-the-truth-about-transsexuality/pugpig_index.html.

95. Sophie Grace Chappell, "Being Transgender and Transgender Being" (conference paper, Forum on Futures for Feminism, London School of Economics, February 2016), cited with permission.

this precludes a doctor from providing treatment where the doctor judges that this treatment would be beneficial. The doctor could state that he or she did not share the views of the patient, but was providing treatment for quite different reasons. Brugger argues that a doctor might cooperate "in a way that is fully consistently with the truth" if "convinced, on reasonable grounds, that it is the last resort, that the patient can never find psychological peace aside from the surgery."[96] Such actions would be material cooperation with the person seeking GRS for the wrong reasons, but these actions might nevertheless be justified on the part of the clinician, if the treatment was likely to be beneficial and if it did not contradict any inherent ethical principles.

In the fourth place, the proposed argument has consequences that seem unduly rigorist. If sound it would imply that it was always and everywhere impermissible to use "pronouns or sex-specific identifiers that are explicitly contrary to a person's biological sex."[97] Among those who fail to meet this strict stipulation is Pope Francis himself.

> Last year I received a letter from a Spanish man who told me his story from the time when he was a child. He was born a female, a girl, and he suffered greatly because he felt that he was a boy but physically was a girl. He told his mother, when he was in his twenties, at 22, that he wanted to have an operation and so forth. His mother asked him not to do so as long as she was alive. She was elderly, and died soon after. He had the operation … he wrote me a letter saying that it would bring comfort to him to come see me with his bride: he, who had been she, but is he. I received them.[98]

By using the phrase "he, who had been she, but is he," Francis acknowledges the social transition the man has made, notwithstanding that this person remains female biologically. The possibility of such pastoral accommodation for individuals who seek to live in the opposite gender role does not justify GRS where this would result in the destruction of sexual or procreative function. However, this pastoral concern is relevant to the question of whether to provide or permit non-destructive forms of GRS, cross-sex hormones, "and the adoption of behaviors, clothing, mannerisms, names, or pronouns typical of the opposite sex."[99]

The National Catholic Bioethics Center statement criticizes transitioning as "affirming a false identity and, in many cases, mutilating the body in support of that falsehood."[100] I have argued here that, if one accepts the principle of totality then, where GRS involves mutilation in the strict sense, then it is *intrinsece malum*, irrespective of whether it involves "affirming of a false identity." On the other hand, it is far from clear that social transitioning itself, or minor medical procedures that facilitate transitioning without destroying biological function, are always and everywhere wrong. This has yet to be demonstrated.

96. Brugger, "Catholic Hospitals," 592–93.
97. NCBC, "Brief Statement," 601–2.
98. Francis, "The Pope Speaks to Journalists."
99. NCBC, "Brief Statement," 601.
100. NCBC, "Brief Statement," 600.

A Clear but Limited Conclusion

There is no authoritative Catholic teaching directly on GRS. However, there is very clear and repeated Catholic teaching against direct sterilization and against mutilation of the body, and this teaching has often been applied to GRS. The present article has established that the principle of totality does not apply to causes of mental or emotional states where they are causes because they are the *objects* of those states, and thus the principle of totality cannot provide a justification for the immediate harm to fertility or sexual function involved in some forms of GRS. Where it involves destruction of function then, on a traditional Catholic understanding, GRS is mutilation in the strict sense.

The US Catholic Bishops' *ERD* against direct sterilization is therefore applicable to GRS, where GRS destroys sexual or procreative function or where it implies or presupposes such destruction. In addition to the value of long-established precedent, another benefit of appealing to *ERD* 53 (and *ERD* 70) is that this rationale does not single out any category of patient as being excluded from treatment. The directive against sterilization is based on respect for bodily integrity and applies equally to men and to women, heterosexual and homosexual, cis and trans. Hence the decision not to offer or permit GRS on the basis of *ERD* 53 does not constitute direct discrimination against persons with gender dysphoria.

This analysis applies whether gender dysphoria has a purely psychological origin or whether it has an organic basis. The principle of totality is relevant to all surgery, including surgery for conditions of evident physiological ambiguity. As Tonti-Filippini astutely observes, the aim of surgery in cases of Divergence of Sexual Development is or ought to be "to restore as much normal function of one gender as possible."[101] Surgical interventions made to address ambiguity about sexual identity due to a DSD would not justify serious and lasting harm to existing sexual or procreative function.

In recent years a new form of argument has been developed which, if sound, would prohibit as *intrinsece malum* all and any interventions undertaken with the intention of facilitating the transition to a new gender role. However, consideration of such arguments shows that they either rely on doubtful premises, or fail to establish crucial steps, or both. The conclusions of such arguments seem unduly rigorist.

In some cases, requests for non-destructive forms of GRS, hormone treatment, or other interventions auxiliary to gender reassignment will be "part and parcel"[102] of a larger project and involve commitment to the destruction of sexual and procreative function. In such cases, the interventions are not compatible with the principle of totality or with the *Ethical and Religious Directives* that govern Catholic health-care services in the United States. However, not all persons seeking hormone treatment or surgery have committed to going so far.

In the case of non-destructive interventions (such as augmentation mammoplasty in male-to-female reassignment), and in the absence of intrinsic objections, the decision

101. Tonti-Filippini, "Sex Reassignment," 85.
102. Brody et al., "Marriage, Morality, and Sex," 11.

to provide or not to provide the intervention should depend on the clinical judgment of the treating physician in dialogue with the patient. Despite assertions to the contrary from both sides, it seems that the evidence of harm, benefit, and risk from gender reassignment procedures is sufficiently ambiguous that different physicians and different patients in good conscience might reasonably take different views. The situation is thus very similar to that described by Gerald Kelly in the mid-1950s and his words remain apposite:

> It is well to keep in mind that, like theologians, physicians also have their "schools"; and it is my opinion that scientific men, as a group, are much less tolerant of opposing views than are theologians. It seems to me that in medically debatable cases we have to allow a physician liberty, provided his own view has sound backing and that he conforms to accepted rules for consultation and has the enlightened consent of his patient.[103]

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103. Kelly, "The Morality of Mutilation," 335.