Catholic Teaching on the Human Person and Gender Dysphoria

Peter J. Cataldo, Ph.D.

Author's Note: This analysis is provided in my individual capacity as an ethicist.

This analysis explores a theological and ethical justification for treating adults with a diagnosis of gender dysphoria within Catholic health care in light of Catholic teaching. It is based on the premise that Catholic teaching on the creation of the human person as being either female or male independent of a person's sense of gender is true. I conclude that, within certain parameters, hormonal and surgical treatment for adults with gender dysphoria is not contrary to Catholic teaching. I am not claiming that this conclusion and its argument are a part of Catholic teaching, but only that this analysis is consistent with Catholic teaching.

I proceed by first giving an overview of Catholic teaching and its metaphysical aspects relevant to the issue and how the teaching can be interpreted in light of scientific evidence about influences on someone's sense of gender. This is followed by an overview of gender dysphoria, the suffering associated with it, and the possibility of ameliorating this suffering through treatment. I then apply Catholic teaching to treatment options and conclude by addressing erroneous assumptions found in some moral analyses.

CATHOLIC TEACHING ON CREATION OF THE HUMAN PERSON

Catholic teaching on the creation of the human person as a unity of body and soul and the place of sexual identity in this unity is the first critical factor for evaluating the question of caring for and treating persons with gender dysphoria. Catholic teaching does not make an absolute distinction between physical sex and sense of gender as is the case in many other-than-Catholic sectors.[1] Even though there is no authoritative teaching on the specific question of providing treatment and care for persons with gender dysphoria, the teaching on the nature of sexual identity within the body/soul unity of the individual human person is directly relevant.

Two components of the teaching on the creation of the human person are especially important for the purposes of evaluating the care and treatment of persons with gender dysphoria in Catholic health care. The first is the composite unity of body and soul by which a person exists. The second is that an individual's act of being in the body/soul unity is as male or female. In Catholic teaching, God creates the individual human person as a composite unity of body and soul:

> The unity of soul and body is so profound that one has to consider the

> soul to be the "form" of the body: i.e., it is because of its spiritual soul that the body made of matter becomes a living, human body; spirit and matter, in man, are not two natures united, but rather their union forms a single nature.[2]

To exist at all, the human creature must be unified, body and soul.[3] Moreover, the "living, human body" of a person, which is made possible by the body/soul unity, is necessarily female or male. In other words, the very act by which a person exists is inextricably bound up with the unity of body and soul and with existence as male or female. The *Catechism of the Catholic Church* affirms this:

> Man and woman have been created, which is to say, willed by God: on the one hand, in perfect equality as human persons; on the other, in their respective beings as man and woman. "Being man" or "being woman" is a reality which is good and willed by God . . . .[4]

> Man and woman are both with one and the same dignity "in the image of God." In their "being-man" and "being-woman," they reflect the Creator's wisdom and goodness.[5]

The *Catechism* also calls attention to Genesis 5:1-2: "When God created man, he made him in the likeness of God. Male and female he created them, and he blessed them and named them Man when they were created."[6] Thus, to come into being as this or that particular human individual created by God, is to come to be as female or male according to Catholic teaching. St. John Paul II wrote about an "anthropological foundation for masculinity and femininity." This anthropology is based on God's plan in the creation of man and woman which, as St. John Paul II states, "is a plan that 'from the beginning' has been indelibly imprinted in the very being of the human person -men and women- and, therefore, in the make-up, meaning and deepest workings of the individual."[7]

It is important to point out that while an individual's act of being is as male or female, this does not entail that the soul, *per se*, is sexed. As the principle by which a human person exists, the soul by itself does not have the individual materiality of a person's sex. It is only this individual *qua* individuation of human nature that is properly described as sexed (that is, the particular body/spirit unity that is this person).[8] Sex is not part of the definition of human essence, but being created as male or female is an *inseparable accident* of the individual existence of a person as a human substance.[9]

It is also important to address potential difficulties regarding the teaching on the creation of the human person as male or female. For instance, is the church's teaching on the role of sexual identity in the creation of the human person question-begging insofar as it assumes that sexual identity is determined by, or is reducible to, one's physical sex characteristics at birth? But what if it is not sufficient to determine sexual identity in this way? Scientific evidence indicates that a person's sense of gender could be influenced by multiple biological and social factors. Such factors include genetic, epigenetic, neuroanatomical and endocrine causes, fetal development, and both positive and negative social experiences.[10] Pope Francis recognizes that "masculinity and femininity are not rigid categories." However, he also states that it "is

true that we cannot separate the masculine and the feminine from God's work of creation, which is prior to all our decisions and experiences," including those experiences that he characterizes as "understandable difficulties," "human weakness," and the "complexities of life."[11] In other words, such factors do not have a bearing on God's creative act of the existence of an individual human person, or on our understanding of the act in its ontological dimension as it is described in Catholic teaching. Similarly, the fact that biologically we might not know the sex of persons with intersex conditions or disorders of sex development, such as Androgen Insensitivity Syndrome (AIS), does not preclude the fact that God creates these individuals as male or female ontologically considered.[12]

The biological, psychological, or social factors that contribute to a person's sense of gender should not be conflated with the ontological reality of God's creative act. That God creates the individual human person as either male or female *qua* ontological reality is not incompatible with that same individual having a different sense of gender *qua* biological, psychological, or social factors nor with the fact that perhaps only five to ten percent of people fall between the two typical phenotypic boundaries of male and female. As a variation on what Elliott Bedford and Jason Eberl have explained in a recent article, creation of the human individual is *per se* as female or male, but this does not necessarily preclude or prevent the *per accidens* reality that the created individual perceives her or his gender as being the opposite of the physical sex characteristics possessed at birth, or that an individual may have an intersex condition.[13] The fact that there is sexual and gender variation among individual human beings known through empirical

The biological, psychological, or social factors that contribute to a person's sense of gender should not be conflated with the ontological reality of God's creative act.

evidence does not mean that the human being has no ontological dimension by which we can also know the individual. The Congregation for Catholic Education, in its *"Male and Female He Created Them" Towards A Path of Dialogue on the Question of Gender Theory in Education*, draws on the work of St. John Paul II, and makes a distinction that is helpful here. The fact that the method of biology is different than the method of metaphysics does not mean that the order of nature is reducible to the order of biology. Rather, the order of nature, through empirical and metaphysical methods, may be understood as encompassing both the "order of biology" and the "order of existence" comprehended in its ontological dimension and its relationship to God the Creator.[14]

To hold that God creates each individual person and also to make the unqualified claim that there is no female/male dichotomy but only a spectrum of possible combinations of physical sex characteristics and gender awareness is to assume that God's creative act of the human individual can be determined by biological, psychological, and social factors post-creation. It is to assume that the creation of the human individual is reducible to reality in its particular biological, psychological, and social dimensions and is a reality absent of an

ontological dimension.[15] However, to determine the sex of an individual by that person's sense of gender post-coming-into-being along a spectrum denies the principle of individuation at the point of creation. Though God sustains a person's act of existence, this act, once in act, does not itself evolve or develop into some other act of existence, and, therefore, neither does the individual's *created existence as female or male*.

The independence of God's action *qua* ontological reality from particular results *qua* biological, psychological, or social reality in any given case is similarly exhibited in how the dignity of the anencephalic child may be viewed in the Catholic moral tradition. The condition of anencephaly does not prevent God's creative act of the fetus, who develops anencephaly accidentally, from being fully human in essence and existence.[16] Anencephaly is a congenital abnormality, which is determined post-creation by biological causes. Yet, this anomaly does not interfere with or alter the ontological dimension of God's creative act of this individual as fully human. The creation of the individual human person as a substance, with a spiritual soul, and as an animal who is male or female, delimits the kind of being according to which God creates. However, precisely as an individual human, each person always has the potency for variation relative to other individual persons.

The difference between the formal principles by which an individual comes to be as a certain kind of being and the material principle by which an individual exhibits particular differences with individuals of the same kind means that the ontological dimension of an individual's existence and the specificity of the person's individuality are not mutually exclusive.

Thus, the teaching on the creation of the human person as male or female *qua* ontological reality is not informed or advanced by any scientific evidence about the complexity of biological, psychological, and social factors that might influence an individual person's sense of gender. Rather, what this evidence informs is the ethical evaluation of the circumstances associated with gender dysphoria and specific options available for alleviating the suffering of gender dysphoria consistent with the teaching on God's creative act as an ontological reality. This is the approach that I will use in the analysis below regarding the moral status of treatment options within Catholic health care. Given these points regarding the empirical evidence about physical sex characteristics, the personal sense of gender on the one hand, and God's creative act of a person on the other, it is not contradictory to claim that a person's sense of gender can be contrary to the ontological dimension of the creation of that person as male or female.

Another potential objection might be that the act of existence of a person as a body/soul unity should not be determinative of what is essential to who the person is, but rather that the human person is relational. The earlier work of Pope Emeritus Benedict XVI might be cited to make the objection. In a 1990 article on the notion of person in theology, then Cardinal Ratzinger argued that "relativity toward the other *is* the human person. The human person *is* the event or being of relativity" (emphasis added).[17] Using this view, it might be objected that the body/soul unity of a person is secondary to defining the human being as relational, and as such, sexual identity ought not to be inextricably tied to the individuation of the body/soul unity of the person. Rather, since

the human being is defined as relationality to others, sexual identity ought to be determined as a relational reality. It is not defined by stagnant ontological strictures, but rather is defined over time as persons relate to others and to their environment.

In response, it could be argued that in Catholic teaching the soul-as-form and the body-as-matter are principles of being that at the moment of creation unify in an individual's act of existence as either female or male. In his article, Cardinal Ratzinger prescinds or excludes from consideration the questions of the soul/body unity and individuation. He does not reject the reality of the human person as a substance constituted by a body/soul unity, but only that the category of substance defines human essence. Insofar as relationality defines the essence of human nature for Cardinal Ratzinger, he does not deny the reality of the individuation of the human person as male or female, which is a reality entirely compatible with the human person as relational. It could be argued that to be "relativity toward the other" is not possible without at the same time being a body/soul unity as male or female.

It is just such an ontological basis of the person as relational that describes another aspect of Catholic teaching on the creation of the human person. This is evident in the statement from the *Catechism* that "God created man and woman *together* and willed each *for* the other."[18] Notice that intrinsic to the creation of individual men and women according to this text is an ordering or tendency toward others of the opposite sex. This reinforces the reality that the individual human person is created as female or male, is created in relation to others, and has an intrinsic ordination toward others of the opposite sex that entails the generation of new life. All of these points are evident in the following texts from the *Catechism*, beginning with Genesis, 1:27:

> 'God created man in his own image . . . male and female he created them'; He blessed them and said, 'Be fruitful and multiply.'[19]

The Catechism elaborates on this biblical teaching in many places, including #2332.

> Sexuality affects all aspects of the human person in the unity of his body and soul. It especially concerns affectivity, the capacity to love and to procreate, and in a more general way the aptitude for forming bonds of communion with others.[20]

The ontological relation between the creation of the human person as female or male and the complementarity of the sexes is also underscored by St. John Paul II: "When the Book of Genesis speaks of 'help' [for Adam], it is not referring merely to *acting,* but also to *being*. Womanhood and manhood are complementary *not only from the physical and psychological points of view,* but also from the *ontological*. It is only through the duality of the 'masculine' and the 'feminine' that the 'human' finds full realization."[21] These texts on the creation of the human person indicate that in Catholic teaching being male or female is integral to the creation and act of existence of an individual person and is a fundamental source of relating to and being in communion with others. The texts also show that the ordination toward the generation of new life within the complementarity of the sexes is integral to the sexual identity of the person as male or female. The intrinsic relationship

between being-female and being-male, the complementarity of the sexes, and the relationality of human persons is emphasized in *Male and Female He Created Them: Towards A Path of Dialogue on the Question of Gender Theory in Education*: "The self is completed by the one who is *other than the self*, according to the specific identity of each person, and both have a point of encounter forming a dynamic of reciprocity which is derived from and sustained by the Creator."[22]

PRIMARY AND SECONDARY SEX CHARACTERISTICS: A PIVOTAL DISTINCTION

The procreative ordination toward the generation of new life as an intrinsic element of the creation of individual humans as female or male forms the basis for understanding the distinction between primary and secondary sex characteristics as representing what is and is not ontologically integral to the creation of the individual human person as female or male. Primary sex characteristics are chromosomes and phenotypic features that are directly related to reproduction and are indicative of biological sex. Secondary sex characteristics are phenotypic features not directly related to reproduction.[23] The primary sex characteristics, the reproductive organs in particular, are integral to the ordination to new life intrinsic to the creation of an individual as female or male. They are ontologically "integral" because together they constitute the material condition by which ontologically an individual is created as female or male, even though biologically there is variation in these characteristics among individuals.

Ontologically, to be male or to be female is to be constituted by certain capacities, the essential differentiating capacity being the reproductive capacity. As the teaching from the *Catechism* indicates, "being-man" and "being-woman" delimits ways or kinds of being, and what makes the specific difference to these particular kinds of being are the primary sex characteristics. The contingency of individual material existence means that there will be variation among the primary sex characteristics of individual females and males, but this does not contradict the fact that being-female and being-male in God's creative act of the individual (at the moment of creation) is defined generally by characteristics that differentiate these ways of being. Thus, even though biologically there may be slight or great variation among the primary sex characteristics of individuals, these characteristics are still ontologically integral to God's creative act of individual persons as female and male, not in their potency for difference among individuals but in the way they delimit the kind of being into which an individual is created. Thus, the claim of their integral status is not disproved, for example, simply because individuals can have the atypical conditions of intersex, or because the primary sex characteristics can be removed, or because a person may be sterile by accident of nature.[24]

It is important to understand that delineating the ontological significance of the primary and secondary sex characteristics for the creation of the human person as female or male, and identifying the primary sex characteristics as ontologically integral to God's creative act, does not reduce human sexuality to the reproductive organs and is consistent with the totality of sexuality as being inclusive of its biological, spiritual, emotional, and psychological dimensions. Human sexuality is a complex reality and different aspects of it can be ordered

differently to different objects but retain their unity in the real person. Just as the conjugal act is integral to the complete and reciprocal gift of spouses to each other does not mean that their relationship is reducible to the conjugal act, so too identifying the primary sex characteristics as integral to God's creative act does not reduce human sexuality to organs.

It is also important to understand that the ontological significance of the difference between the primary and secondary sex characteristics does not divide the human person or entail a dualistic view of the person. Insofar as this distinction is based on a real biological difference among the sex characteristics within one and the same person it cannot be interpreted as being contrary to the unity of the person. Similarly, it is not a dualistic view to hold that not all aspects and characteristics of the human person function equally with respect to the individual's existence. The fact that there is a real distinction between body and soul, or a distinction among the powers of the soul itself, does not mean that the individual human being does not exist as a unified whole. For the same reason, the fact that ontologically a person is created as female or male and that this is contrary to the individual's sense of gender identity does not entail a dualistic view of the human person.[25]

I will argue below that the ontological significance of the distinction between the primary and secondary sex characteristics means that there is a corresponding significant moral difference between directly affecting the primary sex characteristics and directly affecting the secondary sex characteristics for the purpose of treating gender dysphoria. Under certain conditions, directly affecting the secondary sex characteristics in order to treat gender dysphoria may be morally permitted in Catholic health care, particularly because the secondary sex characteristics do not have an integral ontological status. The integral status of the primary sex characteristics, however, means that modifying them for the sole purpose of treating gender dysphoria would not be morally permitted.[26] Before this making this case and applying the ontological distinction between the primary and secondary sex characteristics to the question, a brief overview is needed of what gender dysphoria is, the suffering that it presents, and the prospects for treatment.

GENDER DYSPHORIA AND ITS SUFFERING

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5) defines the diagnosis of gender dysphoria in adolescents and adults in the following way:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

    1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the

development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.[27]

A recent review by Ellen Marshall and her colleagues of 31 studies in the scientific literature on the rates of non-suicidal self-injury and suicide among transgender persons "found a strong association between gender dysphoria, non-suicidal self-injury (NSSI) and suicidality (suicidal thoughts, suicide attempts and suicide rates)."[28] The review also reports that "studies investigating prevalence rates of suicidality among trans people showed an increase of suicide ideation, suicide attempts and suicide rates, even after transition and sex reassignment surgery when compared to the cisgender population [people whose gender identity matches their biological sex]."[29] In another literature review, Cecelia Dhejne and her colleagues "found that trans people attending transgender health-care services present with a high prevalence of psychiatric disorders and psychopathology."[30] This suggests the need for better access to psychiatric and psychological care for many individuals. Indeed, a number of studies have suggested that gender dysphoria is an independent risk factor for suicidality and that lifetime suicide attempts may be as high as 46% among trans men 42% among trans women.[31] A study by Gunter Heylens and his colleagues found that the rate of affective and anxiety disorders was higher among persons with gender dysphoria than the general population. The study observed that "the incongruence between gender identity and social life and/or bodily characteristics experienced by individuals diagnosed with gender identity disorder can cause much distress that may lead to affective and anxiety problems and even disorders."[32] The suffering of transgender persons can also be caused by social stigma. One recent study by Walter Bockting and his colleagues showed "in comparison with norms for nontransgender men and women, our transgender sample had disproportionately high rates of depression, anxiety, somatization, and overall psychological distress."[33]

Studies also show that psychopathology and psychiatric disorders associated with gender dysphoria are amenable to improvement with treatment.[34] With respect to hormone therapy, a recent systematic review concluded that "when treated with hormone therapy, gender dysphoria individuals reported less anxiety, dissociation, perceived stress, social distress, and higher mental health-related quality of life and self-esteem."[35] With respect to surgery for gender dysphoria, it is recognized that we "need more studies with appropriate controls that

examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment."[36] At the same time, a recent study has found that "generally SRS [Sex Reassignment Surgery] may reduce psychological morbidity for some individuals while increasing it for others."[37] The Sweden cohort study concluded that "surgery and hormonal therapy alleviates gender dysphoria" but that these therapies are "apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons." The study authors concluded that it is "important to note that the current study is only informative with respect to transsexuals [sic] persons' health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism. In other words, the results should not be interpreted in such a way as to suggest that sex reassignment *per se* increases morbidity and mortality."[38] The World Professional Association for Transgender Health makes the general observation that "while many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria. . . . Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well-being, cosmesis, and sexual function."[39]

INTERVENTIONS INVOLVING SECONDARY SEX CHARACTERISTICS AND THE PRINCIPLE OF TOTALITY

Given Catholic teaching on the creation of the human individual examined here, and the relevance of the primary/secondary sex characteristics distinction for understanding what is ontologically integral and what is not integral for the creation of the individual person as female or male, certain interventions as direct treatment specifically for gender dysphoria in adults can be ethically justified. Interventions for the treatment of gender dysphoria can be justified by the principle of totality, if, and only if, the services are restricted to secondary sex characteristics. Pope Pius XII expressed the principle in this way: "It declares that the part exists for the whole, and that, consequently, the good of the part remains subordinated to the good of the whole: that the whole is that which determines the part and can dispose of it in its own interest."[40] Consistent with the principle of totality, the loss or alteration of secondary sex characteristics through hormonal or surgical treatment may be justified for the good of the whole person for the following reasons: (1) the presence of secondary sex characteristics may, in a given case, represent a serious harm to the well-being of the patient; (2) the intervention can be effective for the patient; and (3) the good of restoring well-being and avoiding grave harm is proportionate to the loss.[41]

…we "need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine long-term benefits of surgical treatment."

Evidence for the first two conditions has been indicated. Proportionality is also key to this argument. Interventions on secondary sex characteristics directed to the good of the whole of the person are proportionate means to remedy the lack of psychological and emotional cohesiveness and even suicidality. They are also proportionate since the sex characteristics affected do not have an integral role for the body/soul unity of the individual human person as female or male. These interventions can be accomplished without being directed toward eliminating primary sex characteristics that are integral to who the person is as a created being.[42]

Similarly, the use of hormonal therapy, even though it can have a sterilizing effect in the long term, is permissible for the purpose of treating gender dysphoria. Any sterilizing effect on the primary sex characteristics would be foreseen but unintended.[43] Moreover, the sex hormones affected in hormonal therapy for gender dysphoria considered in themselves are neither primary nor secondary sex characteristics. They are causes of primary and secondary sex characteristics, but as causes, and because they are found in both males and females (their different levels in each sex notwithstanding), they do not qualify as sex characteristics *per se*.[44] For these reasons, hormonal treatment for gender dysphoria is not deliberately directed at eliminating a primary sex characteristic that is integral to the creation of the person as female or male.

A RESPONSE TO THE VIEW THAT TOTALITY CANNOT BE APPLIED

A recent article by David Albert Jones reviews the history of Catholic teaching and theological opinion on the principle of totality and its use to justify treatment of gender dysphoria.[45] His review focuses on Catholic teaching and theological opinion from the 1940s to the present. In my view, there are three flaws in Jones' analysis of these historical sources. These flaws are based on misconstruing the distinction between historical interpretation of the principle and the intelligibility of the principle itself.

The first flaw in the historical interpretation of the principle is that the focus and object of the principle is reducible to the physical integrity of the person, such that the intelligibility of the principle is identified with the preservation of the physical whole of the person. This does not mean that Catholic theologians have historically rejected the notion that the human person is a body/soul unity, or that they rejected the fact that people may experience psychological conditions that are in some way related to the body; but what some have assumed is that the object of the principle of totality *qua* moral guide for evaluating actions that directly cause harm to the body is delimited to physical parts and the physical integrity of the person. For Jones and his most of his sources, the part-whole relationship specified by the principle is conceptualized strictly as a relationship of organic part to physical whole.[46] In this understanding of the principle, integrity is reduced to physical integrity that can be justifiably preserved through the sacrifice of physical parts. Thus, the only ethically justifiable physical interventions to treat psychological conditions on this view are treatments for conditions that have a basis in organic disease.

However, since the whole of the human person is constituted by the composite unity of body and soul, aspects of a person that are

immaterial qualify as parts of the whole just as the physical aspects qualify. Thus, to modify organic parts to preserve the psychological well-being of a person, whether those physical parts are diseased or not, is not contrary to the principle. Pope Pius XII described and applied the principle of totality with an understanding of human integrity as encompassing both physical and psychic integrity. Even when he referenced the "destruction or . . . mutilation of anatomic or functional character," he did not reduce the meaning and application of the principle to physical integrity.[47] His text bears this out:

> . . . he [the patient] does not possess unlimited power to allow acts of destruction or of mutilation of anatomic or functional character. But, in virtue of the principle of totality, of his right to employ the services of the organism as a whole, he can give individual parts to destruction or mutilation when and to the extent that it is necessary for the good of his being as a whole, to assure its existence or to avoid, and naturally to repair, grave and lasting damage which could otherwise be neither avoided nor repaired.[48]

The concepts of "services of the organism as a whole" and "being as a whole" are related but distinct as they function in this text. Because Pius does not restrict the meaning of "being as a whole" to physical integrity, his use of "services of the organism of the whole" legitimately includes modification on organic parts for the good of the whole of the individual understood as a unified physical and psychic composite.[49] Pius' prohibition against mutilation of the body that follows his text quoted here is limited to medical experiments that gravely affect a person's freedom to the extent of turning the person into "an automaton."[50] Thus, Pius' limits on the application of the principle of totality were not generated from a view of the principle that reduced the notions of integrity and part-whole relations to the physical dimension of the person. The fact that the principle was applied to the relationship of the individual to the state also indicates that the notions of a whole and relation of part to whole as they function in the principle are not reducible to physical reality.[51]

Consistent with this view of Pius' application of the principle of totality is the fact that he used the term "organism" in three different senses, only one of which is limited to the physical. For Pius, "organism" can apply to the physical organs and their integrated physical function, to the organism of the whole person as unity of body and soul, and to the "moral organism" of humanity. Pius used the term "organism" to mean an integrated whole of parts, whether that whole is material, immaterial, or a composite of the two. Here is a sampling of how he used these terms:

> The physical organism of the "the man" is one complete whole in its being. The members are parts united and bound together in their very physical essence. They are so absorbed by the whole that they possess no independence. They exist only for the sake of the total organism and have no other end than that of the total organism.
>
> It is entirely a different matter in the case of the moral organism that is humanity. This constitutes a whole only in regard to act and finality.[52]

In an address to country doctors, Pius uses the term "whole organism" to describe the human person as a composite unity of body and soul:

> You [the doctor] are in a position to consider man in his own nature of body and soul subject to reciprocal influence, coexisting in the human composite. According to nature, body and soul are not in opposition, but in intimate and constant collaboration. And so when, as often happens, you can be of aid to souls, you must act with the conviction that thus you render a sound service to the whole man, not only to his spiritual part, for often this will contribute to the greater efficiency of the whole organism.[53]

Similarly, Pius describes the "physical organism" of the person as a "subsisting unity," which is the substantial unity of body and soul: "What follows with regard to the physical organism? The master, the person who uses this organism, which possesses a subsisting unity, can dispose directly and immediately of the integrant parts, the members and organs, within the framework of their natural finality."[54] For Pius, the "physical organism" of the human individual is not intelligible apart from the subsisting unity of the individual. In an address to the Italian Medical-Biological Union of St. Luke, Pius pointed out that while the work of physicians directly affects "the body with its members and organs, [this work] will nevertheless concern too the soul and its faculties" due to the "compenetration of matter by spirit in the perfect unity of the human composite."[55]

Insofar as Pius' use of the terms "organism," "physical organism," "whole organism," "total organism," and "body" includes the immaterial dimension of the human person, his understanding and application of the principle of totality ought not to be interpreted exclusively in terms of material integrity or physical part-whole relations of the human person.[56] There may be reasons why medical intervention is not justified for gender dysphoria, such as when the intervention directly violates some essential aspect of human nature or a person's existence, but a reason based on a physicalist interpretation of totality is not one of them.

A second flaw in Jones' analysis is that the ontological meaning of the distinction between the primary and secondary sex characteristics is not recognized. Partly because the interpretation of the principle considered by Jones did not take into account the ontological significance of the sex characteristic distinction, it focused on treatment that affects the reproductive organs. As a result, use of the principle of totality to justify treatment for gender dysphoria has historically been rejected. Even Jones' recognition of the possible ethical justification of "minor medical procedures" for gender dysphoria that do not destroy "biological function" is not grounded in an ontological distinction. [57] However, recognition of this distinction makes a critical difference to the proportionality of goods and evils weighed by the principle, as has been shown.

The third flaw, related to the first, is that the historical interpretation does not take account of the fact that the psycho-social effects of a dysphoric condition may be legitimately considered in an application of the principle. Since application of the principle is not reducible to physical totality, its use to evaluate the moral status of treating gender dysphoria is

…psycho-social suffering is a legitimate part of the whole individual who has gender dysphoria, and is a part that threatens the health of the whole person.

not restricted to whether or not the origins of the condition reside in organic disease. Rather, psycho-social suffering is a legitimate part of the whole individual who has gender dysphoria, and is a part that threatens the health of the whole person. Therefore, this suffering is a legitimate factor in the application of the principle to determine whether a physical part may be sacrificed or altered to heal the part that is threatening the whole.

Jones explicitly argues that the distress of gender dysphoria is an "intentional object of a mental state" and as such cannot be in a "part-to-whole relation" that could be evaluated by the principle of totality.[58] The distress is *about* a physical aspect of the person, it is not the physical object itself. He concludes that as a result of this fact the principle of totality cannot be used to justify what he calls "serious and lasting harm at the level of function," which he does not define.[59] The assumption behind this claim is that only physical objects have the nature necessary to be parts of the whole that is the person as considered in the principle of totality. However, this is the very thing in question. The fact that the distress of gender dysphoria is *about* a physical object and is not the physical object itself does not disqualify the reality of the distress as a legitimate part of the whole of the person as a body/soul unity. The suffering of gender dysphoria is as much a legitimate part of the whole person as is any other type of suffering, just as virtue and vice and human behavior itself also constitute parts in the part/whole relation of the person. In the case of interventions on the secondary sex characteristics, they have an intrinsic relation to the suffering of gender dysphoria precisely because they are sex characteristics; therefore, the removal or altering of these characteristics represents, consistent with the principle of totality, the sacrificing of one part to heal another part for the sake of the whole in such a way that does not violate the individual's created existence as female or male.

INTERVENTIONS INVOLVING PRIMARY SEX CHARACTERISTICS

Due to the integral nature of the primary sex characteristics with respect to sexual identity as a component of the body/soul unity of the individual human person, interventions directed specifically toward and only for the purpose of removing such an integral sex characteristic are not justified by the principle of totality. The reason is that the sole immediate end (moral object) in this case is the removal of an integral sex characteristic, precisely and insofar as it is a primary sex characteristic. While it is true that its presence is a cause of severe psychological pain, this pain is inextricable from the fact that it is a reproductive organ of a certain sex (a primary sex characteristic); as such, its removal cannot be justified by the principle of totality because it is essential to the whole of the person as male or female. In contrast, in the case of sacrificing a reproductive organ that is a pathophysiological threat to the whole organism (whether or not the reproductive organ itself is functioning normally), the moral

object of the act is the cessation of the threat precisely insofar as there is either a disease involving the organ, or a known threat being caused by a healthy organ, not precisely and specifically the removal of the organ as an integral sex characteristic.[60] An example of this distinction is the provision of a hysterectomy solely and only to treat gender dysphoria and a hysterectomy to treat a pathophysiological condition of the uterus, whether or not the patient has gender dysphoria. While the ontological individuation of the individual person as female or male cannot be changed by removing sex characteristics that are integral to an individual's unity, to remove them strictly for the purpose of treating gender dysphoria is directly to prevent the functionality of this integral component precisely as it represents the individuation of the person as male or female. For a Catholic health care institution to approve such procedures would be to share in the same object of eliminating a sex characteristic integral to the creation of the person for its own sake.

CONVERGING INTENTIONS

What if clinical indications, e.g., a reproductive organ with a pathophysiological condition, coincide with the patient's desire for gender transition? May we treat this patient for the pathology, knowing that it will indirectly assist gender transition? While the alignment of the intervention with the subjective intention of the patient for gender transition is foreseen by the institution, the moral object (immediate end), intention, and relevant circumstances of the institution's actions are defined by, and can be properly characterized as, the direct treatment of a present pathophysiological condition or risk of one. Examples of this distinction are transgender persons who have hysterectomies or orchiectomies directly to treat pathophysiological conditions of the uterus or testes but which happen to coincide with their desire for gender transition.

Foreseeing the intent of the patient does not of itself mean that the Catholic institution shares that intention or approves gender transition. Foreseeing and intending are not mutually inclusive. Though foreseeing and intending can be related in specific actions, they arise from different powers of the soul—foreseeing from the intellect, and intending from the will. Moreover, if merely foreseeing the consequence of an action entailed the intention of it, then the traditional principle of the double effect would not be possible. When we treat a pathophysiological condition that affects primary sex characteristics, we intend treatment of the condition. Foreseeing that the institution's actions will coincide with the patient's intention for gender transition in both cases does not undermine the moral legitimacy of the interventions.

St. Thomas Aquinas addresses this problem when he raises the possibility that one physical act may represent more than one moral act:

> It is possible, however, that an act which is one in respect of its natural species, be ordained to several ends of the will: thus this act "to kill a man," which is but one act in respect of its natural species, can be ordained, as to an end, to the safeguarding of justice, and to the satisfying of anger . . . .[61]

The fact that there is one exterior act that the patient may intend for gender transition, which intention a Catholic health care institution might foresee, does not preclude the Catholic

institution from using the very same act for different purposes, both proximate and remote. Moreover, for the same reasons, the fact that in any given case the procedure might be only one part of a larger process of gender transition involving additional surgeries that is reasonably foreseen by the Catholic institution does not establish an explicit or implicit intention or approval by the institution for that process and its parts, even if actions carried out in the Catholic institution indirectly affect the primary sex characteristics .[62]

IDENTIFICATION OF AND RESPONSE TO ASSUMPTIONS

The distinction between primary and secondary sex characteristics as it relates to Catholic teaching on the creation of the human person is also ethically significant for addressing what I believe are some erroneous views about the involvement of Catholic health care in the treatment of gender dysphoria. One such view argues that any surgical or hormonal intervention on any sex characteristic–primary or secondary–to treat gender dysphoria is to deny God's act of creating the body/soul unity of the human person, and "perpetuates the lie" that sexual identity can be changed. This view assumes the very thing in need of proof. The erroneous assumption in play here is that the integral role of sexual identity for the body/soul unity of the individual human person is fully and equally present in all sex characteristics.[63] It is only the primary sex characteristics that are the sufficient condition for the individuation of the body/soul unity in the creation of particular person as female or male.

Moreover, when an institutional Catholic health care provider acts on secondary sex characteristics in the treatment of gender dysphoria or on primary characteristics because of a pathophysiological condition and acts within ethical parameters presented here, it is not trying to change the sexual identity of persons, nor does it agree with the erroneous view of sexuality held by the patient. The Catholic provider is not perpetuating or joining in on a lie or a delusion, but rather it is treating the suffering of individuals by morally legitimate means.

The Catholic provider is not perpetuating or joining in on a lie or a delusion, but rather is treating the suffering of individuals by morally legitimate means.

Questions about cooperation also need to be addressed.[64] First, it is not clear that a person suffering from gender dysphoria and seeks relief by modification of the secondary sex characteristics legitimately qualifies as a principal agent in whose wrongdoing a Catholic health care institution cooperates. However, assuming for the sake of argument that the gender dysphoria patient is a principal agent, there still would be no illicit cooperation in providing treatment affecting secondary sex characteristics. There are several factors that would preclude formal cooperation by a Catholic health care institution: (1) treating gender dysphoria involving secondary sex characterizes can be considered morally good through an application of the principle of totality; (2) directly treating a pathophysiological

condition or risk of one can be justified through an application of the principle of the double effect; and (3) in such cases *foreseeing* that the interventions will indirectly assist a person in gender transition is not *intending* gender transition. Allowing treatment affecting the secondary sex characteristics to relieve suffering constitutes neither formal nor immediate material cooperation in gender transition, either with respect to treatment affecting secondary sex characteristics or any future surgeries involving the primary sex characteristics. As for interventions affecting the secondary sex characteristics, there would be no immediate material cooperation because what are essential circumstances from the patient's perspective for gender transition are from the institution's perspective essential only for relieving the suffering of gender dysphoria. If there is any cooperation at all, it would be remote, mediate, material cooperation for a justified reason.

With respect to insurance coverage, any coverage that involves gender dysphoria identified in diagnostic codes, or any use of utilization management documentation that refers to guidelines for treatment of gender dysphoria for interventions affecting secondary sex characteristics, does not constitute illicit cooperation. The object, intention, and circumstances of such actions are directed toward the treatment of the dysphoria by means that do not undermine the sexual identity component integral to the body/soul unity of the person.

The reality of government mandates affecting coverage for interventions involving the primary sex characteristics solely and only for treatment of gender dysphoria is a significant factor for evaluating the ethics of this coverage within Catholic organizations. Because such mandates are government-originated and controlled and because they represent significant duress, there may be warrant to conclude that the Catholic health care institution does not engage in formal cooperation by complying with the mandates. The involvement of third party administrators is also an important factor in reducing the risk of illicit cooperation. While providing insurance coverage under these circumstances would be traditionally described as "necessary cooperation" (since without the insurance the procedure would probably not occur), this does not entail that the cooperation is illicit. Although the insurance contributes to the occasion of the procedure it does not represent a condition specific to the performance of the action *per se*, and therefore is not evidence of an intention for approval of the procedure.

Providing objective medical information about treatment for gender dysphoria, or transferring the general care of patients with gender dysphoria, does not constitute illicit cooperation or an illicit referral. Such actions do not constitute the specific conditions that have an intrinsic relation to acts of sex reassignment that would establish an intention for those actions. Moreover, transferring a patient to a specialty center for the treatment of gender dysphoria does not of itself contain the specificity to establish an intention or approval by an institution of an attempt to change sexual identity. Likewise, ensuring standards regarding patient preferences in personal health information or other accommodations for all transgender persons does not constitute illicit cooperation on the part of Catholic health care. Such actions include education of staff, use of preferred gender pronouns, appropriate room assignments, accurate information and correct identification in the EMR, fully informed plans

of care, and accurate communication and ordering on behalf of the patient. These kinds of actions do not establish the specific conditions with an intrinsic relation that makes possible the performance of removing sex characteristics integral to the individuation of a particular person as male or female, nor are they essential. What they do is offer compassionate and respectful care directed at the suffering of these patients. To argue that such actions constitute illicit cooperation misconstrues the relation between foreseeing and intending with respect to alleviating suffering through hormonal or surgical treatment and the gender transition of the patient. As a result of this problem, there is a risk that the principle of cooperation in general will be misconstrued as the prohibition of any association with wrongdoing.

CONCLUSION

The evaluation of this argument should be made strictly on its merits. It should not be prejudiced by the fact that there exists a gender ideology that rejects a binary view of gender and sexual identity. Any consideration of the analysis provided here needs to recognize the independence of its merits from any societal ideology of this sort. The case for the conclusion of this analysis is carefully built on existing evidence about gender dysphoria and a faithful presentation and application of Catholic teaching and tradition. Pope Francis makes a distinction between being "understanding of human weakness and the complexities of life" and responding to "what are at times understandable aspirations" associated with persons in gender transition on the one hand, and, on the other, accepting "ideologies that attempt to sunder what are inseparable aspects of reality."[65]

Consistent with Pope Francis' distinction, to treat the suffering of people with gender dysphoria in accordance with Catholic teaching does not entail an acceptance or approval of ideologies of gender that are contrary to that teaching. The Congregation for Catholic Education makes an important distinction that bishops, ethicists, theologians, and leaders of Catholic health care would do well to consider: "If we wish to take an approach to the question of gender theory that is based on the path of dialogue, it is vital to bear in mind the distinction between the ideology of gender on the one hand, and the whole field of research on gender that the human sciences have undertaken, on the other."[66] Not all listening, reasoning, and proposing on the question of treating gender dysphoria is *ipso facto* condoning or promoting gender ideology.

Moreover, there is a real possibility that some might dismiss any attempt to justify care and treatment of persons with gender dysphoria within the parameters of Catholic teaching on the grounds that such patients may support this ideology and be a cause of theological scandal. However, to hold such a view is contrary to accepted and justified practices within Catholic health care. Consider the fact that Catholic health care does not prohibit the care of patients with racist beliefs simply because they subscribe to an ideology that is antithetical to Catholic teaching, or because there would be a perceived approval of that ideology. Although these two cases are different in that treatment for a racist patient would have no direct relation to racism itself, to refuse care to such a patient based on a perceived connection to ideology would be the same in both cases. Similarly, just as the respectful treatment of gay individuals within Catholic institutions is not a

cause of theological scandal regarding Catholic teaching on human sexuality, so too it is not necessarily a legitimate cause of scandal that Catholic health care provides treatment for gender dysphoria simply because there is a gender ideology whose tenets are contrary to Catholic teaching. The inherent human dignity of these patients requires a more fair consideration.

When approaching the issue of caring for persons with gender dysphoria in Catholic health care we do well to apply the teaching of Pope Francis. He taught that we should "avoid a cold bureaucratic morality in dealing with more sensitive issues . . . for although it is quite true that concern must be shown for the integrity of the Church's moral teaching, special care should always be shown to emphasize and encourage the highest and most central values of the Gospel, particularly the primacy of charity as a response to the completely gratuitous offer of God's love."[67] Using the distinction between the primary and secondary sex characteristics in the way I am suggesting is not to deny or ignore the reality of biological variation in sex, or the very real psychological and social dimensions of how transgender persons view themselves. Catholic health care responds to that experience and to those who suffer from gender dysphoria as it responds to any need or request—from its institutional conscience. This conscience rests in part upon Catholic teaching on the creation of the human person as either female or male. The argument here for the ontological significance of the distinction between the sex characteristics recognizes the reality of Catholic teaching and attempts to reconcile that teaching with the Catholic theological, metaphysical, and moral traditions and relevant science. The hope of this approach is that a path might emerge for continued dialogue about how Catholic health care can work to alleviate the suffering of persons with gender dysphoria and generally give care to transgender persons consistent with that teaching. [68]

PETER J. CATALDO, Ph.D.
Senior Vice President, Theology and Ethics
Providence St. Joseph Health
Renton, WA
Peter.cataldo@providence.org

Creating Dialogue

1. How would you summarize the key points of Cataldo's argument?

2. The principle of totality is used widely in health care ethics (e.g. everytime surgery is performed). Do you agree that it can be applied to transgender interventions as well (p.9-10)?

3. Can you think of other cases in which subjective suffering justifies medical intervention?

ENDNOTES

[1]The Congregation for Catholic Education (CCE) in its *"Male and Female He Created Them" Towards A Path of Dialogue on the Question of Gender Theory in Education* (February 2, 2019, n. 11) states that "it is clear that sex and gender are no longer synonyms or interchangeable concepts, since they are used to describe two different realities. . . . The problem here does not lie in the distinction between the two terms, which can be interpreted correctly, but in *the separation of sex from gender*."

[2] *Catechism of the Catholic Church*, 365, http://www.vatican.va/archive/ENG0015/__P1B.HTM. See Vatican II, *Gaudium et spes*, 14: "Though made of body and soul, man is one"; Fourth Lateran Ecumenical Council, Chapter 1, *The Catholic Faith*, DS 800: "the human creature [is] . . . composed of spirit and body." http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html; see also n. 3; First Vatican Ecumenical Council, c. 1: ". . . humanam quasi communem ex spiritu et corpore constitutam," http://www.vatican.va/archive/hist_councils/i-vatican-council/documents/vat-i_const_18700424_dei-filius_la.html; St. John Paul II, *Evangelium Vitae*, 60.

[3] See Staley, Kevin. *New Catholic Encyclopedia*, Supplement 2012–2013, Ethics and Philosophy, s.v. "Soul, Human" Farmington Hills, MI: Gale Cengage Learning, 2013.

[4] *Catechism*, 369, http://www.vatican.va/archive/ENG0015/__P1B.HTM.

[5] *Catechism*, 369, http://www.vatican.va/archive/ENG0015/__P1B.HTM.

[6] *Catechism*, 2331, http://www.vatican.va/archive/ENG0015/__P1B.HTM.

[7] St. John Paul II, Apostolic Exhortation *Christifideles Laici*, December 30, 1988, 50, http://w2.vatican.va/content/john-paul-ii/en/apost_exhortations/documents/hf_jp-ii_exh_30121988_christifideles-laici.html. Additional confirmation of the ontological basis of this anthropology is found in the connection made by him between this anthropology and "the whole history of salvation." See also St. John Paul II, Apostolic Letter *Mulieris Dignitatem*, August 15, 1988, 1, 6, 10, http://w2.vatican.va/content/john-paul-ii/en/apost_letters/1988/documents/hf_jp-ii_apl_19880815_mulieris-dignitatem.html.

[8] For a sampling of Thomas Aquinas' view of the principle of individuation see *Summa Theologica*, I, q. 3, a. 3; I, q. 29, a. 2, ad. 3; I, q. 75, a. 4; I, q. 76, a. 6; III, q. 77, a. 2; *Quaestio disputata de anima*, 9. See also Jeffrey E. Brower, "Matter, Form, and Individuation" in Brian Davies and Eleonore Stump, eds., *The Oxford Handbook of Aquinas* (Oxford: Oxford University Press, 2012): 94–100; Eleonore Stump, *Aquinas* (New York: Routledge): 47–50.

[9] See St. Thomas Aquinas, *Quaestiones Disputatae de Anima*, a. 12, ad 7: "There are three genera of accidents: some are caused by the principles of the species, and are called proper accidents, for example, risibility in man; others are caused by the principles of the individual, and this class is spoken of [in two ways]: first, those that have a permanent cause in their subject, for example, masculine and feminine, and other things of this kind, and these are called inseparable accidents; secondly, those that do not have a permanent cause in their subject, such as to sit and to walk, and these are called separable accidents. Now no accident of any kind ever constitutes part of the essence of a thing, and thus an accident is never found in a thing's definition. Hence we understand the essence (quod quid est) of a thing without thinking of any of its accidents. However, the species cannot be understood without the accidents which result from the principles of the species [i.e., the proper accidents], although the species can be understood without the accidents of the individual, even the inseparable accidents. Indeed, there can be not only a species but also an individual without the separable accidents. Now the powers of the soul are accidents in the sense of properties. Therefore, although the essence of the soul is understood without them, still the existence of the soul is neither possible nor intelligible without them." See also Aquinas, *De Ente et Essentia*, 6: "Among the accidents that are consequences of matter there is found a certain diversity. Some accidents follow from the order the matter has to a special form, as the masculine and the feminine in animals, the difference between which is reduced to the matter, as the Philosopher says in X *Metaphysicae* cap. 9 (1058b21-23)," https://sourcebooks.fordham.edu/basis/aquinas-esse.asp, trans. Robert T. Miller; see also Elliott Louis Bedford and Jason T. Eberl, "Actual Human Persons Are Sexed, Unified Beings," *Ethics & Medics* 42, (2017): 1–3.

[10] See Kevin Fitzgerald, S.J., "Viewing the Transgender Issue from Catholic and Personalized Health care Perspectives," *Health care Ethics USA*, 24 (2016): 7–10 at 7.

[11] *AL* 286 and 56.

[12] For a definition of these conditions see I. A. Hughes, C. Houk, S. F. Ahmed, P. A. Lee, and LWPES1/ESPE2 Consensus Group, "Consensus Statement on Management of Intersex Disorders," *Archives of Disease in Childhood,* 91(2006): 554–563 at 554, http://dx.doi.org/10.1136/adc.2006.098319: "congenital conditions in which development of chromosomal, gonadal, or anatomical sex is atypical." See Ieuan A Hughes, John D Davies, Trevor I Bunch, Vickie Pasterski, Kiki Mastroyannopoulou, Jane MacDougall, "Androgen insensitivity syndrome," *Lancet* 380 (2012), 1419: "Androgen insensitivity syndrome in its complete form is a disorder of hormone resistance characterised by a female phenotype in an individual with an XY karyotype and testes producing age-appropriate normal concentrations of androgens. Pathogenesis is the result of mutations in the X-linked androgen receptor gene . . . .," http://dx.doi.org/10.1016/S0140-6736(12)60071-3.

[13] See Elliott Louis Bedford and Jason T. Eberl, "Is the Soul Sexed? Anthropology, Transgenderism, and Disorders of Sex Development," *Health care Ethics USA*, 24 (2016): 18–33 at 21.

[14] CCE, *"Male and Female He Created Them" Towards A Path of Dialogue on the Question of Gender Theory in Education*, n. 23.

[15] See, for example, Luke Timothy Johnson, *The Revelatory Body*: *Theology as Inductive Art* (Cambridge: William B. Eerdmans, 2015): 180–188.

[16] For a definition of anencephaly see *Merck Manual*: *Professional Version* (Kenilworth, NJ: Merck Sharp & Dohme Corporation, 2018): "Anencephaly is absence of the cerebral hemispheres. The absent brain is sometimes replaced by malformed cystic neural tissue, which may be exposed or covered with skin. Parts of the brain stem and spinal cord may be missing or malformed. Infants are stillborn or die within days or weeks," https://www.merckmanuals.com/professional/pediatrics/congenital-neurologic-anomalies/anencephaly.

[17] Cardinal Joseph Ratzinger, "Concerning the Notion of Person in Theology," *Communio* 17 (1990): 439–454 at 542; see also Daniel Daly, "Who Counts as a Person?" in *Incarnate Grace: Perspectives on the Ministry of Catholic Health care*, ed. Charles Bouchard, O.P. (St. Louis, MO: Catholic Health Association of the United States): 89–91.

[18] *Catechism*, 371.

[19] *Catechism*, 2331.

[20] *Catechism*, 2332; see also *Catechism*, 2333, 2334, 2335, 370, 372, 2337.

[21] St. John Paul II, *Letter to Women*, June 29, 1995, 7, http://w2.vatican.va/content/john-paul-ii/en/letters/1995/documents/hf_jp-ii_let_29061995_women.html. The use of multiple texts from the *Catechism* in this analysis is important for two reasons. First, the *Catechism* is formally recognized "as a full, complete exposition of Catholic doctrine," and as a "genuine, systematic presentation of the faith and of Catholic doctrine" (St. John Paul II, Apostolic Letter, *Laetamur Magnopere*, August 15, 1997, http://w2.vatican.va/content/john-paul-ii/en/apost_letters/1997/documents/hf_jp-ii_apl_15081997_laetamur.html). Second, in addition to quoting from key scriptural passages, the texts provide critical linguistic and conceptual precision.

[22] CCE, *"Male and Female He Created Them" Towards A Path of Dialogue on the Question of Gender Theory in Education*, n. 31; see also ns. 4, 10, 21, 27–28, 32–36.

[23] For a biological explanation of the primary and secondary sex characteristics, see "Sex" at http://genderedinnovations.stanford.edu/terms/sex.html. It is important to note that while the secondary sex characteristics are essential for mating, this fact does not make the secondary sex characteristics integral to being male or female *qua* God's creative act, but rather makes them integral *qua* propagation of the species. Having primary sex characteristics sufficient to be created as female or male is not the same as being able to mate as male or female. The fact that the two types of sex characteristics are related with respect to mating does not entail that they are the same with respect to the ontological dimension of God's creative act.

[24] The bodily location of the primary and secondary sex characteristics also has no relevance to integral status of the primary sex characteristics for God's creative act *qua* ontological reality.

[25] This view also does not entail that everybody's gender identity is called into question. To assert this is to assume that gender identity is determined by each individual's sense and that God does not create each individual as female or male independent of an individual's sense.

[26] The thesis argued here does not entail that there is a moral obligation *not to remove* the uterus and ovaries of a person with AIS, and conversely it does not entail that there is a moral obligation *to remove* these organs because the person has the primary sex

characteristic of male chromosomes. Such an inference is an attempt at *reductio ad absurdum* argumentation but can succeed only by assuming the very thing in need of proof; namely, that individual variation in physical sex and gender awareness precludes an ontological dimension to the creation of the human person as male or female, and, additionally, that there is a moral obligation for a person with AIS to have only one set of primary sex characteristics. Neither of these assumptions is true.

[27] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), "Gender Dysphoria in Adolescents and Adults" (2013), 302.85 (F64.0).

[28] Ellen Marshall, Laurence Claes, Walter Pierre Bouman, Gemma L. Witcomb and Jon Arcelus, "Non-Suicidal Self-Injury and Suicidality in Trans People: A Systematic Review of the Literature," *International Review of Psychiatry*, 28 (2016): 58-69, https://doi.org/10.3109/09540261.2015.1073143.

[29] Ellen Marshall et al., "Non-Suicidal Self-Injury and Suicidality in Trans People: A Systematic Review of the Literature," 66.

[30] Cecilia Dhejne, Roy Van Vlerken, Gunter Heylens and Jon Arcelus, "Mental Health and Gender Dysphoria: A Review of the Literature," *International Review of Psychiatry* 28 (2016): 44-57 at 52, https://doi.org/10.3109/09540261.2015.1115753; see also Edward McCann and Danika Sharek, "Mental Health Needs of People Who Identify as Transgender: A Review of the Literature," *Archives of Psychiatric Nursing* 30, 2 (April 2016): 280-28.

[31] Ann P. Haas, Philip L. Rodgers, and Jody L. Herman, *Suicide Attempts among Transgender and Gender Non-Conforming Adults*, The Williams Institute, (2014): 1–18 at 2, https://williamsinstitute.law.ucla.edu/research/suicide-attempts-among-transgender-and-gender-non-conforming-adults/; S.E. James, J.L. Herman, S. Rankin, M. Keisling, L. Mottet, and M. Anafi, *Executive Summary of the Report of the 2015 U.S. Transgender Survey* (Washington, DC: National Center for Transgender Equality, 2016), http://www.ustranssurvey.org/reports#USTS.

[32] Gunter Heylens, Els Elaut, Baudewijntje P. C. Kreukels, Muirne C. S. Paap, Susanne Cerwenka, Hertha Richter-Appelt, Peggy T. Cohen-Kettenis, Ira R. Haraldsen and Griet De Cuypere, "Psychiatric Characteristics in Transsexual Individuals: Multicentre Study in Four European Countries," *The British Journal of Psychiatry* 204 (2014): 151-156 at 154, https://doi.org/10.1192/bjp.bp.112.121954; see also Gemma L. Witcomb, Walter Pierre Bouman, Laurence Claes, Nicola Brewin, John R. Crawford, Jon Arcelus, "Levels of Depression in Transgender People and Its Predictors: Results of A Large Matched Control Study with Transgender People Accessing Clinical Services," *Journal of Affective Disorders* 235 (2018): 308–315; and Sarah E. Valentine, and Jillian C. Shipherd, "A Systematic Review of Social Stress and Mental Health Among Transgender and Gender Non-Conforming People in the United States," *Clinical Psychology Review* 66 (December 2018): 24-38.

[33] Walter O. Bockting, Michael H. Miner, Rebecca E. Swinburne Romine, Autumn Hamilton, and Eli Coleman, "Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population," *American Journal of Public Health* 103 (2013): 943–951 at 948, http://doi.org/10.2105/AJPH.2013.301241; see also Jillian C. Shipherd, Shira Maguen, W. Christopher Skidmore and Sarah M. Abramovitz, "Potentially Traumatic Events in a Transgender Sample: Frequency and Associated Symptoms," *Traumatology* 17 (2011): 56–67, https://doi.org/10.1177/1534765610395614; and Gia Chodzen, Marco A. Hidalgo, Diane Chen, and Robert Garofalo "Minority Stress Factors Associated with Depression and Anxiety among Transgender and Gender-Nonconforming Youth," *Journal of Adolescent Health* 64, 4 (2019): 467-471. There is also evidence that transgender persons suffer higher rates of disability and multiple chronic conditions; see, for example, Janelle M. Downing, and Julia M. Przedworski, "Health of Transgender Adults in the U.S., 2014–2016," *American Journal of Preventive Medicine* 55, 3 (2018): 336–344.

[34] See, for example, Cecilia Dhejne, Roy Van Vlerken, Gunter Heylens and Jon Arcelus, "Mental Health and Gender Dysphoria: A Review of the Literature," 53–54; Gunter Heylens et al., 154; Tim C. van de Grift, Els Elaut, Susanne C. Cerwenka, Peggy T. Cohen-Kettenis and Baudewijntje P. C. Kreukels, "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-up Study," *Journal of Sex & Marital Therapy* 44 (2018): 138-148, https://doi.org/10.1080/0092623X.2017.1326190; and Marco Colizzi, Rosalia Costa, and Orlando Todarello, "Dissociative Symptoms in Individuals with Gender Dysphoria: Is the Elevated Prevalence Real?" *Psychiatry Research*, 226, 1 (2015): 173-180.

[35] Rosalia Costa and Marco Colizzi, "The Effect of Cross-Sex Hormonal Treatment on Gender Dysphoria Individuals' Mental Health: A Systematic Review," *Neuropsychiatric Disease and Treatment* 12 (2016): 1953–1966 at1964, http://doi.org/10.2147/NDT.S95310; see also Hiroyuki Oda and Toshihiko Kinoshita, "Efficacy of Hormonal and Mental Treatments with MMPI in FtM Individuals: Cross-Sectional and Longitudinal Studies." *BMC Psychiatry* 17 (2017): 1–8, http://doi.org/10.1186/s12888-017-1423-y; Mohammad Hassan Murad, Mohamed B. Elamin, Magaly Zumaeta Garcia, Rebecca J. Mullan, Ayman Murad, Patricia J. Erwin, and Victor M. Montori, "Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes," *Clinical Endocrinology* 72 (2010): 214–231; AudreyGorin-Lazard, Karine Baumstarck, LaurentBoyer, Aurélie Maquigneau, Stéphanie Gebleux, Jean-Claude Penochet, Dominique Pringuey, Frédérique Albarel, IsabelleMorange, AndersonLoundou, JulieBerbis, Pascal Auquier, Christophe Lançon, and Mireille Bonierbale, "Is Hormonal Therapy Associated with Better Quality of Life in Transsexuals? A Cross-Sectional Study," *The Journal of Sexual Medicine* 9, 2 (February 2012): 531-541; Esther Gómez-Gil, Leire Zubiaurre-Elorza, Isabel Esteva, Antonio Guillamon, Teresa Godás, M. Cruz Almaraz, Irene Halperin, Manel Salamero, "Hormone-Treated Transsexuals Report Less Social Distress, Anxiety and Depression," *Psychoneuroendocrinology*, 37, 5 (2012): 662-670; Marco Colizzi, Rosalia Costa, and Orlando Todarello, "Transsexual Patients' Psychiatric Comorbidity and Positive Effect of Cross-Sex Hormonal Treatment on Mental Health: Results From A Longitudinal Study," *Psychoneuroendocrinology* 39, (2014): 65–73.

[36] Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha, and Guy G. T'Sjoen, "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology Metabolism* 102 (2017): 3869–3903 at 3895, https://doi.org/10.1210/jc.2017-01658; see

also Ebba K. Lindqvist, Hannes Sigurjonsson, Caroline Möllermark, Johan Rinder, Filip Farnebo, and T. Kalle Lundgren, "Quality of Life Improves Early After Gender Reassignment Surgery in Transgender Women," *European Journal of Plastic Surgery* 40 (2017):223–226; and Annette Kuhn, Christine Bodmer, Werner Stadlmayr, Peter Kuhn, Michael D. Mueller, and Martin Birkhäuser, "Quality of Life 15 Years After Sex Reassignment Surgery for Transsexualism," *Fertility and Sterility* 92, 5 (November 2009): 1685–1689.

[37] Simonsen RK Giraldi A E Hald, GM, "Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity and Mortality," *Nordic Journal of Psychiatry* 70 (2016): 241-247 at 246, https://doi.org/10.3109/08039488.2015.1081405; see also, Chantal M.Wiepjes, Nienke M.Nota, Christel J.M.de Blok, MaartjeKlaver, Annelou L.C.de Vries, S. AnnelijnWensing-Kruger, Renate T.de Jongh, Mark-BramBouman, Thomas D.Steensma, PeggyCohen-Kettenis, Louis J.G.Gooren, Baudewijntje P.C. Kreukels, and Martinden Heijer, "The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets," *The Journal of Sexual Medicine* 15, 4, (April 2018): 582-590, https://doi.org/10.1016/j.jsxm.2018.01.016; Tim C. van de Grift, Els Elaut, Susanne C. Cerwenka, Peggy T. Cohen-Kettenis, Griet De Cuypere, Hertha Richter-Appelt, and Baudewijntje P.C. Kreukels, "Effects of Medical Interventions on Gender Dysphoria and Body Image: A Follow-Up Study," *Psychosomatic Medicine*, 79 (September 2017): 815-823; Tim C. van de Grifta, Els Elautb, Susanne C. Cerwenkac, Peggy T. Cohen-Kettenisd, and Baudewijntje P. C. Kreukelsd, "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-up Study," *Journal of Sex & Marital Therapy* 44, 2 (2018): 138–148; Grace Poudrier, Ian T. Nolan, Tiffany E. Cook, Whitney Saia, Catherine C. Motosko, John T. Stranix, Jennifer E. Thomson, M. David Gothard, Alexes Hazen, "Assessing Quality of Life and Patient-Reported Satisfaction with Masculinizing Top Surgery: A Mixed-Methods Descriptive Survey Study," *Plastic and Reconstructive Surgery* 143, 1 (January 2019): 272-279; T.A. Ainsworth, and J.H. Spiegel, "Quality of Life of Individuals With and Without Facial Feminization Surgery or Gender Reassignment Surgery," *Quality of Life Research* 19, 7 (2010):1019– 1024; Luk Gijs and Anne Brewaeys, "Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges," *Annual Review of Sex Research*, 18,1 (2007): 178-224.

[38] Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Langstrom, Mikael Landen, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," PLoS ONE 6 (2011): 1–8 at 7, https://doi.org/10.1371/journal.pone.0016885.

[39] The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 7th Version (2011): 54–55, https://www.wpath.org/publications/soc.The WPATH Standards do not delineate the types of surgery that it characterizes as "sex reassignment surgery." It must be acknowledged that the studies to date indicate that hormonal and surgical treatment are effective for some but not all individuals suffering from gender dysphoria.

[40] Pope Pius, XII, Address to the First International Congress of Histopathology (September 13, 1952), in Monks of Solesmes, ed., *The Human Body: Papal Teachings* (Boston: Daughters of St. Paul, 1960): 206; see also: "The principle of totality itself affirms nothing except this: where the relationship of whole to part is verified, and in the exact degree to which it is verified, the part is subordinated to the whole, which latter can in its own interest dispose of the part" (ibid.). Notice that Pius specifies the "principle of totality itself" indicating that it is not reducible to one particular kind of application.

[41] See Becket Gremmels, "Sex Reassignment Surgery and the Catholic Moral Tradition: Insight from Pope Pius XII on the Principle of Totality," *Health care Ethics USA* 24 (2016): 6–10, and "More Insight from Pius XII, a Reply to Brugger and Brehany, and a Clarification," *Health care Ethics USA* 24 (2016): 7–17.

[42] See Benedict Ashley, O.P., *Theologies of the Body*: *Humanist and Christian*, Pope John XXIII Medical-Moral Research and Education Center (Braintree, MA: The Pope John Center, 1985): 422 on the differentiation between actions justified by principle of totality and those not justified by the principle. Under the principle, the fact that "a non-essential part is sacrificed for the sake of the whole" ought not to be confused with an action in which "an essential part . . . is sacrificed not for the sake of the whole but for the sake of another part, with injury to the whole." Consistent with this distinction is the fact that sacrificing the primary sex characteristics precisely as such is sacrificing an essential part while doing injury to the whole.

[43]For recognition of the potential sterilizing effects of hormone therapy see Hembree et al, "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," 3869–3903. Some make the claim that puberty suppressing drugs are fully reversible and that feminizing and masculinizing drugs are partially reversible: see, The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 7th Version (2011): 17–20, https://www.wpath.org/publications/soc.

[44] The fact that levels of each hormone are greater or less depending upon the sex does not change the fact that the hormones are causes of sex characteristics as effects and are not the characteristics themselves. For an explanation of the physiological functions of testosterone and estrogen respectively see "Male Reproductive Endocrinology," *Merck Manual Professional Version*, https://www.merckmanuals.com/professional/genitourinary-disorders/male-reproductive-endocrinology-and-related-disorders/male-reproductive-endocrinology, and "Female Reproductive Endocrinology," *Merck Manual Professional Version*, https://www.merckmanuals.com/professional/gynecology-and-obstetrics/female-reproductive-endocrinology/female-reproductive-endocrinology.

[45] David Albert Jones, "Gender Reassignment Surgery: A Catholic Bioethical Analysis," *Theological Studies* 79 (2018): 314–338, https://doi.org/10.1177/0040563918766711.

[46]For Jones' view, see David Albert Jones, "Gender Reassignment Surgery: A Catholic Bioethical Analysis," 330–332.

[47] The discussion of the principle of totality, and in particular Pius XII's view of it, is not intended to be a complete study of the concept, nor does it need to be for the purposes of this paper.

[48] Pope Pius, XII, Address to the First International Congress of Histopathology (September 13, 1952), Monks of Solesmes, ed., *The Human Body: Papal Teachings*, 199.

[49] See Becket Gremmels, "Sex Reassignment Surgery and the Catholic Moral Tradition: Insight from Pope Pius XII on the Principle of Totality," 8, and Becket Gremmels, "More Insight

from Pius XII, a Reply to Brugger and Brehany, and a Clarification, 7–17 for another account of how Pius' view of the principle is not physicalistic.

[50] Pope Pius, XII, Address to the First International Congress of Histopathology (September 13, 1952), Monks of Solesmes, ed., *The Human Body: Papal Teachings*, 199. Pius repeatedly refers to the whole of the person as inclusive of the powers and operations of body and soul; see also Pius XII, Address to the Italian Society of Plastic Surgery (Oct. 4, 1958).

[51] See, for example, Pope Pius XII, Address to the Italian Medical-Biological Union of St. Luke (November 12, 1944), Monks of Solesmes, ed., *The Human Body: Papal Teachings*, 55–56.

[52]Pope Pius, XII, Address to a group of eye specialists (May 14, 1956), Monks of Solesmes, ed., *The Human Body: Papal Teachings*, 375.

[53] Pope Pius, XII, Address to a group of country doctors (October 4, 1953), Monks of Solesmes, ed., *The Human Body: Papal Teachings*, 276.

[54] Pope Pius, XII, Address to the First International Congress of Histopathology (September 13, 1952), Monks of Solesmes, ed., *The Human Body: Papal Teachings*, 205.

[55] Pope Pius, XII, Address to the Italian Medical-Biological Union of St. Luke (November 12, 1944), Monks of Solesmes, ed., *The Human Body: Papal Teachings*, 53.

[56] This explanation of Pius' use of these terms resolves what may appear to be an inconsistency in the way he understood the principle of totality; for example, Scaria Kanniyakonil, *Living Organ Donation and Transplantation: A Medical, Legal, and Moral Theological Appraisal* (Oriental Institute of Religious studies India, Department of Publications of Paurastya Vidyapithan, 2005): 164 outlines the appearance of this inconsistency.

[57] David Albert Jones, "Gender Reassignment Surgery: A Catholic Bioethical Analysis," 336.

[58] David Albert Jones, "Gender Reassignment Surgery: A Catholic Bioethical Analysis," 331.

[59] David Albert Jones, "Gender Reassignment Surgery: A Catholic Bioethical Analysis," 331.

[60] See, Pius XII, Address to Delegates at the Twenty-Sixth Congress of Urology (October 8, 1953), Monks of Solesmes ed., *The Human Body: Papal Teachings*, 277–279; see also, Colloquium Participants, "Medical Intervention in Cases of Maternal–Fetal Vital Conflicts: A Statement of Consensus," *National Catholic Bioethics Quarterly* 14 (2014): 477–489, https://doi.org/10.5840/ncbq20141439; Becket Gremmels, Dan O'Brien, Peter J. Cataldo, John Paul Slosar, Mark Repenshek, Douglas Brown, MD, and Susan Caro, RN, "Opportunistic Salpingectomy to Reduce the Risk of Ovarian Cancer," *National Catholic Bioethics Quarterly* 16 (2016): 99–131, https://doi.org/10.5840/ncbq201616110.

[61] Aquinas, *Summa Theologiae*, 1-2, q. 1, a. 3, ad, 3 (hereafter cited as *ST*); see also *ST*, 1-2, q. 20, a. 3.

[62]For an example of the view that contributing to the gender transition process is morally wrong see, Benedict M. Guevin, "Augmentation Mammaplasty for Male-to-Female Transsexuals: A Case Study for Catholic Hospitals, *The National Catholic Bioethics Quarterly* 9 (2009): 457–458, https://doi.org/10.5840/20099332.

[63] For example, consider this statement: "Given this understanding of what it means to be a human person, a body–soul unity whose innate sexual identity is reflected in the person's biology, it should be clear that no surgical, hormonal, or other intervention directed toward the body is capable of altering that innate sexual identity," The National Catholic Bioethics Center, "Brief Statement on Transgenderism," *National Catholic Bioethics Quarterly* 16 (2016): 599–603, https://doi.org/10.5840/ncbq201616457. For other examples of this fundamental error see John A. Di Camillo, "Gender Transitioning and Catholic Health care," *National Catholic Bioethics Quarterly* 17 (2017): 213–223, https://doi.org/10.5840/ncbq201717221; Edward J. Furton, "A Critique of 'Gender Dysphoria' in *DSM*-5," *Ethics & Medics* 42 (2017): 1–4; see also Benedict M. Guevin, "Sex Reassignment Surgery for Transsexuals: An Ethical Conundrum?" *The National Catholic Bioethics Quarterly* 5 (2005): 719-734 at 733, https://doi.org/10.5840/ncbq2005547.

[64] See, for example, National Catholic Bioethics Center, "Brief Statement on Transgenderism."

[65] Pope Francis, *Amoris Laetitia* (March 19, 2016), 56, http://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20160319_amoris-laetitia.html (hereafter cited as *AL*).

[66] CCE, *"Male and Female He Created Them" Towards A Path of Dialogue on the Question of Gender Theory in Education*, n. 6.

[67] Pope Francis, *AL*, 312 and 311.

[68] *I am very grateful for the many helpful comments on earlier versions of this paper, especially those by Dan O'Brien, Ron Hamel, Fr. Charlie Bouchard, O.P., Dan Dwyer, and the members of the CHA Task Force on Transgender Health.*