

Response to Bayley and Gremmels on Transgender Ethics

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I offer here a reply to two articles from the Winter 2016 edition of *Health Care Ethics USA*, the first by Carol Bayley and the second by Becket Gremmels, on whether it is morally legitimate for Catholic healthcare institutions to perform “sex reassignment surgery” (SRS) on persons experiencing gender dysphoria (GD).

Bayley argues for two related conclusions: first, that Catholic healthcare institutions, indeed everyone, should relate to GD individuals according to their “gender of choice”; and second, that Catholic institutions should perform SRS on at least some patients who ask for it. I will argue that both her conclusions should be rejected.

Bayley grounds her first conclusion in what might be called the principle of respect. She says that although Sacred Scripture and Catholic teaching do not directly address the problem of GD, there

is much in these sources to help us think about them. For example, she says they teach respect for individuals, admonish us to welcome strangers, praise diversity in nature, etc. This alone, she says, is “sufficient” to make us understand “the necessity of treating transpersons with respect.”

Bayley’s use of Scripture to ground her conclusion is simplistic. Revelation teaches that God creates human beings as males or females. In cases where maleness or femaleness is unambiguously expressed in one’s anatomy and genetic make-up (i.e., where one either has female primary sex characteristics and two copies of the X chromosome at the 23rd pair, or male sex characteristic and one X and one Y chromosome) the Christian presumption is that the *whole person*, body and psyche, is that sex. Until recently “gender” was a synonym for “sex”. Bayley says the two are distinguishable. Gender, she says, refers

to “the social and behavioral aspects” of sex. But whether we follow her understanding or the traditional one, it would be inconsistent with Divine Revelation to affirm that at the level of human identity—not mere feelings, but ontological nature—a man can ever be “trapped” in a woman’s body or vice versa. Unless we concede an unsound body-self dualism, one’s sex—i.e., one’s embodied reality as male or female—is defining of one’s whole self. This then can be used to interpret the problem of gender dysphoria. If it is true that the whole self exists as either male or female, any deep and intractable mental distress at being one’s given sex is expressive of a disharmony between one’s affect and reality. The assumption, therefore, is that the experience is an expression of a disorder, which deserves understanding, treatment and prevention, not reinforcement.

Moreover, since we do not have persuasive evidence that GD is not a psychological disorder; and we have good evidence to the contrary; hospitals and practitioners that treat GD as if it is a healthy expression of personal identity are willing if wrong to treat serious pathology as a healthy condition. This is irresponsible, grossly so. It’s like treating an intra-cranial growth that hasn’t been ruled out as a brain tumor as if it clearly is *not* a brain tumor. Any responsible clinician (and healthcare institution) would rule

out reasonable doubt that some condition is not seriously harmful before treating it as healthy or benign, and for heaven’s sake, before prescribing treatments that strengthen it. And at present we certainly cannot rule out that GD is an extreme expression of body-identity hatred, more severe even than anorexia nervosa or body dysmorphic disorder.

Bayley’s second conclusion is that Catholic hospitals may legitimately carry out all four phases of SRS on GD individuals, including so-called “top” and “bottom” surgeries. Appealing to “double effect” reasoning, she argues that the “end” of this kind of surgical intervention is good, namely, relief from serious discomfort and distress; that the means is also good or at least neutral, namely, a surgical procedure; and that the tolerated but unintentional harm, i.e., reproductive sterilization, is reasonable to accept in light of the sought-after benefits.

In itself, the relief of suffering is a good thing. Bayley’s assumption, however, that patients who undergo SRS will experience such relief seems unjustified. She herself concedes that “there is a great deal we do not understand” about the relationship between gender and biological sex (p. 2), and both she and Gremmels note that there is no reliable empirical evidence that SRS ameliorates the sufferings of persons with GD.

In fact, there is good evidence that the long-term effects are deleterious. Dr. Paul McHugh, former psychiatrist in chief at Johns Hopkins Hospital, who had significant clinical experience with individuals who underwent SRS, wrote in the *Wall Street Journal* in 2014:

Most of the surgically treated [i.e., SRS] patients described themselves as “satisfied” by the results, but their subsequent psycho-social adjustments were no better than those who didn’t have the surgery. And so at Hopkins we stopped doing sex-reassignment surgery, since producing a “satisfied” but still troubled patient seemed an inadequate reason for surgically amputating normal organs.¹

McHugh refers to a 30-year longitudinal study in Sweden published in 2011 that followed 324 SRS patients. The study revealed that “beginning about 10 years after having the surgery, the transgendered began to experience increasing mental difficulties. Most shockingly, their suicide mortality rose almost 20-fold above the comparable non-transgender population.”

Finally, Bayley refers only to a single harm caused by SRS when she assesses proportionate reason, namely, “contraceptive sterilization”. This seems terribly superficial. What about the anatomical harm caused by mutilating healthy sex organs? What about the harm to relationships that persons undergoing SRS risk, especially harms to their children? What about the danger of scandal, and the risk of reinforcing another individual in delusional ideas about his self-identity, and contributing to the cultural advance of what Pope Francis calls “gender ideology”, etc.?

Becket Gremmels, drawing on the teaching of Pope Pius XII, appeals to the “principle of totality” to argue (1) that SRS is not intrinsically evil; and (2) that because its efficacy is not well assured, the surgery is not presently justifiable. He argues that according to Pius’ account of totality, an organ need not be pathological to justify its amputation or destruction. It needs simply to pose a serious threat to the “being of the whole” (p. 8). For persons suffering from GD, Gremmels says, the presence and normal functioning of healthy body parts, “contributes to and exacerbates” the dysphoric condition (p. 7); therefore, “SRS could be justified from a Catholic moral perspective” if it was chosen to benefit the patient’s health, and the sterilization it causes was merely tolerated as an “indirect, unintended, but foreseen side-effect”. But, he says, we would also

¹ Available at <http://www.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120>

need reasonable certitude of the efficacy of the procedure in treating the condition. Gremmels argues that presently “evidence on the effectiveness of SRS” is lacking. Therefore, although SRS is not intrinsically evil, it is presently not morally acceptable.

Gremmels’ first conclusion cannot be accepted as argued. He nowhere acknowledges that changing our biological sex is impossible. Our sex is written into every one of our 60 trillion or so cells. SRS is therefore a pretender’s game. Whether Gremmels thinks that one’s sex really can be “reassigned” is unclear. What is clear is he believes that reassignment surgery could be morally acceptable. But to counsel, perform or accept for oneself any surgery believing or asserting that what’s happening is that a person is changing (“reassigning”) his biological sex would always be contrary to the truth and therefore always impermissible. In other words, to participate in SRS following the assumptions about sex and gender held today by secular culture *would be intrinsically evil*.

Could one ever participate in so-called “top” or “bottom” surgery in a way that is fully consistently with truth? It seems to me possible. A doctor and other caregivers would have to be convinced on reasonable grounds that a particular patient could never find psychological peace aside

from the surgery, that is, it would have to be a last resort. And they would have to be truthful that what’s going on is not a sex change or a gender change, but a gravely disfiguring surgical procedure aimed at realizing whatever psychic stability is possible in this life. Whether such a disabled person truly could be benefited by these surgeries, is still uncertain.

But even if the surgeries were performed in a way that was consistent with the truth, other conditions, not mentioned by Gremmels, would need to be met before Catholic hospitals could rightly perform them. Without trying to be exhaustive, I mention a few.

1. The problem of scandal

People seeing Catholic hospitals or practitioners participating in these types of surgeries might be led to approve of the false assumptions about sex and gender underlying many attempts at gender manipulation today, or to engage wrongfully or encourage others to engage wrongfully in actions flowing from the assumptions. Leaders of Catholic healthcare institutions therefore would have a grave responsibility to ensure that any participation in these surgeries *do not cause scandal*.

2. Contributing to culturally flawed attitudes about sex and gender

If a Catholic hospital or practitioner were to recommend or carry out “top” and “bottom” surgeries, even under the narrow conditions set forth above, it would likely give the impression that they agree with the flawed assumptions about sex and gender that stand behind much of today’s “gender ideology”. Therefore, those involved in the decision or procedures would have an obligation to do what they could to ensure that their participation would *not* contribute to culturally flawed attitudes about these important areas.

3. The problem of non-marital and homosexual behavior

Bayley dismisses the question of the relevance of Catholic teaching on homosexuality for the problems of GD and SRS (p. 2). But this fails to consider the situation of a GD individual who has begun to “identify” with the opposite sex and begins to act out sexually with individuals of the sex with which he or she has ceased to “identify”. Apparently, this is not uncommon. Catholic hospitals and

clinicians would have a duty to soberly assess whether any kind of participation in “top” or “bottom” surgeries would wrongfully contribute to GD individuals experiencing heightened temptations to engage in non-marital sexual behavior.

4. Bad effects on the cooperator

If Catholic hospitals begin to perform these surgeries, it may result in hospital leaders and employees growing indifferent to the serious issues at stake in the larger “transgender” question. Leaders of Catholic institutions would therefore have a duty to ensure that their cooperation over time does not lead to the coarsening of themselves or their employees in relation to moral truths pertaining to sex and gender.

5. Unfairness towards vulnerable dependents and relationships

A very grave issue that neither author considers is unfairness towards those for whom persons with gender confusion have special moral responsibilities. The spouses and especially the children and other immature dependents of those who begin publically to “identify” as the opposite sex, and worse, attempt to alter their bodies to

appear like the opposite sex, can be harmed terribly and unfairly by their loved-one's decisions. This is probably the locus of the gravest evils arising from "gender ideologies". In my opinion, for those with vulnerable dependents and other relations, the cases where undergoing these surgeries would not be unfair and so immoral are extremely rare if not practically non-existent.

6. Christian witness of Catholic hospitals

As apostolates of the Catholic Church, Catholic healthcare institutions have a duty to bear witness to the truths of the Gospel, and against those evils that are especially harmful to people's temporal and eternal welfare. "Gender ideology" is certainly one of those evils. Catholic healthcare institutions have an especially serious obligation to witness to the truth that God 'made them male and female,' and against the popular but erroneous notion that biological sex, "gender identity", and

"sexual orientation" have no intrinsic coherence.

7. The duties of medical practitioners

Neither article addresses the grave duty of medical practitioners to avoid faddism in treatment plans and to act reasonably towards patients, respecting the goods of their bodies and souls, and only recommending harmful procedures when they have good reasons to believe that such procedures offer significant hope of benefit to suffering patients.