FEATURE ARTICLE

Transgender Persons and Catholic Healthcare

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There is no Jew or Greek, servant or free, male or female; for you are all one in Jesus Christ.
Galatians 3:28

According to one study, the prevalence of gender identity disorder in the United States is between 4 and 5 per one hundred thousand persons.[1] This may be a small proportion, but according to an American Hospital Survey in 2013, Catholic health care services across the United States see more than 5.2 million persons per year. This means that those hospitals may care for more than 200 transpersons per year. Some questions arise: How should we treat persons who come to us as patients, whose driver's license still says "John Smith" but who presents herself, in dress and by name, as "Joan"? How about a surgeon, who wishes to perform gender-changing surgery on a patient as part of that person's transition from his or her natal sex to the other? Finally, is there anything within the wisdom of Catholic teaching that can guide us?

The purpose of this article is to outline in broad terms some of the fundamental issues for Catholic health care in the treatment of transgender persons. In order to do that, we first need to understand as much as possible about the actual condition of those persons, and also understand the potential biases we might bring to the discussion. The social landscape of discussions about sexuality has not always been a smooth one in the Catholic Church. At the same time, our profound respect for human dignity and our enthusiastic embrace of all kinds of diversity give us taproots from which to grow.

Before we examine the contours of the issues facing Catholic health care, it is important to establish some common understanding of those assumptions that form the backdrop for further discussion. First, we must get our descriptions, definitions and terminology clear, including the meaning of sex and gender and the relationship between them. We should remind ourselves of how much we know, or do not, about human sexual development, including the many varieties and manifestations of difference. Finally, we will review a tool of moral reasoning, sometimes called the rule or principle of double effect, which can be helpful in thinking through a response.

Descriptions and Definitions

First, although delicate sensibilities often lead people to say "gender" when they are actually referring to sex, there is a difference. Both terms can refer to the male/female division of the human species, but "sex" refers to the reproductive aspects of that difference, while "gender" refers especially to the social or behavioral aspects of it. The opposite of "euphoria," dysphoria means uncomfortable, hopeless or unhappy, a state of unease or generalized dissatisfaction with life. Gender dysphoria is the condition of being uneasy, uncomfortable or unhappy

because of one's gender.[2] Gender dysphoria is the sense of a transgender person that he or she was born into the body of the wrong sex.

Discussion of transgender issues and gender dysphoria in general can be confused by a misunderstanding of the appropriate terminology and what that terminology represents. The words *heterosexual, homosexual* and *bisexual* describe sexual attraction, grounded in biology but affected by culture. Attraction can be fluid and changing, particularly in a culture that privileges heterosexual attraction as "normal" and homosexual or bisexual attraction as abnormal. Statistically, it is true that heterosexual attraction is most common—the propagation of the species depends on it. But whether homosexual or bisexual attraction is simply less usual, like people with red hair, or is considered sinful or sick depends on other assumptions, which are determined by culture and other philosophical commitments.

Medically speaking, these less common manifestations of sexual attraction are not considered disorders. Gender identity, however, is independent of sexual attraction. Some persons who are born female but who feel male are attracted to women, some to men. Some persons who are born male but who feel female are attracted to men, some to women. Catholic teaching on the morality or immorality of homosexual activity is another issue and is not pertinent to moral questions regarding transgender persons.

Some gender dysphoric persons pursue medical treatment in order to transition to the opposite gender from the one they were born into. Treatment consists of counseling, then dressing and living as the other sex, along with hormone therapy affecting secondary sex characteristics. The next step in a transition is "top surgery," i.e., mastectomy for female-to-male (FtM) transpersons or breast augmentation for male to female (MtF) transpersons. The final step is "bottom surgery," which consists of refashioning the urinary and reproductive structures into those of the new sex. Some transitions are complete without surgery, which is expensive and irreversible.

What We Don't Know

Unlike the categories of sexual attraction, lack of concordance between one's physical sexual characteristics and one's gender identity is considered a pathology, although too little is known about how biology intersects with environment to understand it as thoroughly as we do, say, diabetes or cancer. The first and foremost aspect of gender dysphoria that is not well understood is the condition itself. What does it mean to "feel" male or female, apart from one's social conditioning? If gender is at least partly constructed, what part of it is given or innate? Researchers have begun to study the genetics of transgender persons,[3] which show differences from other men and women. There is also mounting physical evidence that gender identity is constructed by an interaction between hormones and the developing brain,[4] and there are structural differences in transgender persons' brains that make them look more like the brains of their desired sex than like those of other people in their natal sex.[5] Genetic, hormonal and structural evidence, then, seem to suggest that this psychiatric diagnosis has a biological substrate, not chosen and not socially constructed. Even with the explosion of technology for understanding the genetics and neuroscience of human biology, there is a great deal we do not understand. The relationship between gender and sex, and how the mind and the body connect them, is one example.

Certain aspects of human development are another example. We do know that in the progression from an embryo to a fetus to a born baby to a grown man or woman, there are stages of differentiation into male and female. The first stratum is the genetic

disposition. Most women have two X chromosomes and most men have an X and a Y. But some of us don't fall into those categories. There are individuals with XXY chromosomes and those with XYY or even XYYY. There are mosaic distributions of chromosomes that endow intersex individuals with both male and female characteristics. We do not fully understand how these non-typical chromosomes appear or why.

Persons with the typical XX or XY configuration go through one surge of feminizing or masculinizing hormones in utero and another one in adolescence. Some transgender theories posit that accidents in these surges can result in a person with the genetic endowment and physical characteristics of one sex but the internal disposition and feelings of the other. How these surges go wrong and how they change either brain structures or subsequent hormone releases are questions that are also poorly understood.

Insights from Catholic Teaching

As anyone knows who has tried to research the teachings of the Catholic Church on the questions of transgenderism, these are questions on which the Church has not written directly or publicly. At the same time, there is much in scripture and in Catholic teaching about welcoming the stranger, about the respect for human persons, no matter who they are or what they look like, about the abundance of diversity in nature and the goodness of everything God creates. These alone are sufficient to understand the necessity of treating transpersons with respect. In any setting, including our hospitals and health services, that means using the pronoun and form of address the person prefers, respecting the person's presentation in the gender of choice, respecting the privacy of the person even if this is the first time we've known we are encountering someone who is different in this particular way.

But a hospital is also a special setting. In another service industry, we might respect a person's (chosen) social identity with comparative ease, by respecting form of address for example. In a hospital, however, caregivers see patients in varying states of vulnerability, including seeing their undressed bodies, and also have access to medical records containing facts that a patient would expect to be held in confidence. It is human to be curious and equally human to discuss curiosities with friends. In this case, the professional commitments of caregivers call them to rise above 'human nature,' and respect persons by not discussing them.

But what about surgery? Should a Catholic hospital perform top and bottom surgeries, to allow transgender persons to physically match their preferred sex? In the case of breast augmentation or mastectomy, we must think carefully before we deny such surgery. If we perform either of these surgeries for natal women who are dissatisfied with their natural endowment, or who have lost a breast due to pathology, we should probably allow it. Transpersons are persons who, it can be argued, are either missing normal breasts (MtF), or have them accidentally (FtM), due to a different kind of pathology. As we have seen above, evidence suggests changes in genetics, hormone delivery and brain structures are related to the incidence of gender dysphoria; it is not a choice.

Regarding bottom surgery, which can render a person sterile,[6] Catholic teaching gives us a long-used tool of moral analysis, i.e., the rule or principle of double effect. This tool allows us to think through whether a negative outcome is morally permissible when it is foreseen but not intended. The action undertaken must be good or at least neutral; the desired effect must be good; the bad effect must not be the means to the good effect and the action undertaken must be proportionate to the desired good outcome. A classic

example is in the case of a woman with uterine cancer who will die without a hysterectomy, but who is found to be pregnant before undergoing it. The loss of fetal life is a regretted, foreseen but undesired and unintended outcome. The rule of double effect justifies the hysterectomy and the loss of fetal life.

In the case of bottom surgery that will sterilize the person, I believe that we can use the rule of double effect in a similar way. The surgery itself is neutral. The good effect, from the perspective of the person undergoing it, is that his or her body will come to present to the world the person in the gender he or she experiences inside. The relief of suffering this represents is profound. The inability to bear or father a child is a regrettable and foreseen consequence, but it is not a means to the good end. Indeed, some transpersons desperately wish their reproductive function did not have to be sacrificed, and in fact some go through a transition in such a way as to preserve it. Sterilization, then, is a side effect of correcting what amounts to a birth defect. It is an unintended but foreseen consequence.

Conclusion

In summary, gender dysphoria is a pathological condition in which the sex and gender of a person do not match. Science is beginning to understand the etiology of gender dysphoria, but it is still in the early stages of knowledge. Due to advances in endocrinology, plastic surgery and urology, this condition is sometimes treated with hormones and surgery. The result of these can be to render a person sterile, but this is a side effect of treating an all-pervasive birth defect, not an intentional contraceptive sterilization.

Because this condition is relatively rare, and also because it affects socially freighted aspects of our humanity—sex and gender—many in Catholic health care are unfamiliar with it. That should not prevent us from rendering compassionate care. Furthermore, Catholic health care institutions should be cautious about developing practices that could violate their own policies of non-discrimination, particularly in light of the federal government's recognition of transgender individuals as members of a protected class.[7]

What do you think? If you'd like to comment on this article please email your thoughts to HCEUSAeditor@chausa.org. We'll collate responses for the next issue.

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[1]: John R. Blosnich, George R. Brown, Jillian C. Shipherd, PhD, Michael Kauth, Rebecca I. Piegari, and Robert M. Bossarte. "Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care." *American Journal of Public Health*: October 2013, Vol. 103, No. 10, pp. e27-e32

[2] In 2013, the Diagnostic and Statistical Manual, published by the American Psychiatric Association, updated its entry from "gender identity disorder" to "gender dysphoria." Its inclusion in the manual reflects the way it is treated and the way that treatment gets paid for.

[3] Hare, L; Bernard, P; Sanchez, F; Baird, P; Vilain, E; Kennedy, T; Harley, V (2009). "Androgen Receptor Repeat Length Polymorphism Associated with Male-to-Female Transsexualism". *Biological Psychiatry* **65** (1): 93–6 (2009); Bentz, E; Hefler, L; Kaufmann, U; Huber, J; Kolbus, A; Tempfer, C (2008). "A polymorphism of the CYP17 gene related to sex steroid metabolism is associated with female-to-male but not male-to-female transsexualism". *Fertility and Sterility* **90** (1): 56–9 (2008).

[4] "A Sex Difference in the Human Brain and its Relation to Transsexuality." J.-N. Zhou, M.A. Hofman, L.J.G. Gooren and D.F. Swaab. *Nature*, 378: 68-70 (1995).

[5] Chung, WC; De Vries, GJ; Swaab, DF."Sexual Differentiation of the Bed Nucleus of the Stria Terminalis in Humans May Extend Into Adulthood". *The Journal of Neuroscience 22 (3): 1027–33.(2002);* Garcia-Falgueras, A.; Swaab, D. F. "A Sex Difference in the Hypothalamic Uncinate Nucleus: Relationship to Gender Identity". Brain

131 (Pt 12): 3132–46.(2008); Luders, Eileen; Sánchez, Francisco J.; Gaser, Christian; Toga, Arthur W.; Narr, Katherine L.; Hamilton, Liberty S.; Vilain, Eric "Regional gray matter variation in male-to-female transsexualism". *NeuroImage 46 (4): 904–7(2009).*

[6] but doesn't always. Some FtM transpersons keep ovaries and uterus, allowing them to become pregnant.

[7]http://www.washingtonblade.com/content/files/2015/03/259302140-0-14-cv-02037-31.pdf