## Proportionality of Cardiopulmonary Resuscitation

*To the Editor:* Marissa Mullins's article "When Cardiopulmonary Resuscitation Becomes Harmful" (Summer 2017) argues that health care providers are not morally bound to and, in fact, should not provide clinically inappropriate cardiopulmonary resuscitation[1]—that is, CPR performed when the probability of success is low and the risk of harm outweighs the likelihood of benefit. Even if the patient or the proxy requests CPR, reasons Mullins, the clinician is not obliged to perform extraordinary means and thus could refuse. Needless to say, this topic is one of life and death, and several points raised in the article should be thoroughly scrutinized.

First, the definition of clinically ineffective or inappropriate CPR needs further clarification. In an example Mullins takes from the *British Medical Journal*, it is hard to see why CPR was deemed to be clinically ineffective. The case report specifically states that the patient underwent cardiac arrest, was revived five times in one night, and died three weeks later.[2] If the question is about the effectiveness of the CPR administered, then this must be categorized as a success. In *Applied Ethics,* professor of philosophy David Oderberg points out that futility, or ineffectiveness, "does not mean 'incapable of restoring an adequate quality of life,' but 'incapable of fulfilling its designated function.' A respirator on its own will not repair severe brain damage, nor cure paralysis. But it is not meant to. Its function is to enable someone to breathe, and if it does that is anything but futile."[3] Similarly, the effectiveness of CPR cannot be measured by the quality of life or the length of life after revival, but rather by whether the treatment achieves its intended or desired end, in this case, stopping cardiac arrest.

Understanding effectiveness becomes even more critical when interpreting the empirical data on survival, because as Mullins states, data enable "providers . . . to predict with relative certainty who will survive" (239). For example, Jonas Cooper and colleagues report an 18 percent survival rate in adults after in-hospital cardiac arrest. Vinay Nadkarni and colleagues observe the same effectiveness when using a different metric, survival to discharge. However, the twenty-four-hour survival rate (30 percent) and the rate of return of spontaneous circulation (ROSC; 47 percent) observed by Nadkarni differ considerably from the overall survival rate.[4] Clearly, when the question is whether CPR achieved its desired end, ROSC is the most appropriate descriptor of the three since it does not depend on the length of time a patient survives after the procedure. The 29 percent difference between ROSC and discharge survival is large and could influence the statistical significance of predictors of the effectiveness of CPR. Similarly, the predictors of length of survival reported by Renee Stapleton and colleagues are not relevant to the discussion at hand, because the dependent variable is the patient's average length of survival after CPR.[5] Again, the length of survival or the quality of life after CPR does not influence the effectiveness—and thus the appropriateness—of the intervention. Ultimately, survival to discharge or length of survival are improper metrics because they do not assess the percentage of patients resuscitated through CPR.

Second, the likelihood of success, the risks, and the severity of harms due to CPR need to be discussed in the framework of the principle of double effect. For the sake of brevity, I assume that CPR meets the first three criteria of the double effect: (1) it is not intrinsically immoral, (2) the bad effects are not intended, and (3) the bad effect is not the means to the good effect. Recall that the fourth criterion requires that there be a proportionate reason from the good effect to justify allowing the bad effect. This judgment of proportionality comprises the probability and severity of the bad effect, the importance and likelihood of the good effect, and whether there are alternative courses of treatment.[6] The bad effects are explained well in Mullins's article. These include bruising of the mouth, airway damage, chest bruising, and high probability of fracture of the ribs and sternum. The good effect—the restoration of circulation and breathing—is obviously immense and amounts to the sustained life of the patient. A full discussion of the probabilities of risks and benefits cannot be achieved here, but given the above discussion of proper dependent variables, further review is needed. Given the importance of the effect, CPR would have to have a probability of success equal to that of chance to be considered disproportionate.

Third, the definitions offered by the *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*) would seem to suggest that Mullins should categorize CPR as ordinary means, regardless of the probability of success. Ordinary means, according to the *ERDs*, "are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community."[7] Would not the request for CPR itself indicate a judgment by the patient of a reasonable hope of benefit? If so and if the expenses and burdens are not excessive, then on the plain reading of directive 56, CPR administered to the patient who requests it constitutes ordinary means. More elaboration is needed regarding the definition in the *ERDs* of ordinary and extraordinary means, but clearly they are not distinguished by the subjective decision of a patient prior to a medical emergency.

Mullins's article is thought provoking and raises several legitimate concerns over possible applications of CPR. However, a slow and thorough approach is necessary when deliberating the withdrawal or refusal of what appears to many to be lifesaving care. Given the current culture of death surrounding the medical field, clinicians, scientists, and ethicists must be careful to keep consequentialist quality-of-life calculations from creeping into their analyses. As always, the goodness of human life itself must be upheld.

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1. Marissa L. Mullins, "When Cardiopulmonary Resuscitation Becomes Harmful," *National Catholic Bioethics Quarterly* 17.2 (Summer 2017): 235–245.
2. W.S. Symmers Sr., "Not Allowed to Die," *British Medical Journal* 1.5589 (February 17, 1968): 442.
3. David S. Oderberg, *Applied Ethics: A Non-consequentialist Approach* (Oxford: Wiley-Blackwell, 2000): 84.
4. Jonas A. Cooper, Joel D. Cooper, and Joshua M. Cooper, "Cardiopulmonary Resuscitation: History, Current Practice, and Future Direction," *Circulation* 114.25 (December 2006): 2843–2844, doi: 10.1161/CIRCULATIONAHA.106.610907; and Vinay M. Nadkarni et al., "First Documented Rhythm and Clinical Outcome from In-Hospital Cardiac Arrest among Children and Adults," *JAMA* 295.1 (January 4, 2006): 55, doi: 10.1001/jama.295.1.50.
5. Renee D. Stapleton et al., "Long-Term Outcomes after In-Hospital CPR in Older Adults with Chronic Illness," *Chest* 146.5 (November 2014): 1219, doi: 10.1378/chest.13 -2110.
6. Oderberg, *Applied Ethics*, 78.
7. US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), dir. 56.

## Sex Reassignment Surgery and Dissimulation

*To the Editor:* In a culture where discussion of gender is becoming increasingly muddled, John Di Camillo's essay "Gender Transitioning and Catholic Health Care" (Summer 2017) is invaluable in its clear distinctions between the terms "disorders of sex development," "gender dysphoria," and "transgender."[1] His conclusion that gender-transitioning interventions, including sex reassignment surgery, can never be morally justified, because of the way in which they reject a true understanding of the person, is well argued and provides a clear principle for Catholic health care ministries to follow. Of particular interest is his observation that the diagnosis of gender dysphoria emphasizes the emotions and beliefs of the individual over his or her biological sex.

Those who experience gender dysphoria may choose gender-transitioning interventions in order to ease anxiety or depression. Di Camillo makes a profound statement about the moral consequence of these interventions in passing, but it deserves elaboration. Specifically referring to hormonal and surgical mutilation, he states, "A firm conviction that my body is somehow wrong manifests disdain for that gift [of bodily life]. Acting to radically reshape it, *making it speak falsely*, dishonors it" (220, emphasis added). This claim, that sex reassignment surgery can make the body speak falsely, calls to mind Pope St. John Paul II's notion of the "language of the body."

As John Paul II explains, the "body speaks a 'language' of which it is not the author."[2] This language, then, is objective, tracing its origin back to the very mystery of creation, and it must be reread in truth by each person as male or female. This language is not subjectively determined by a person's emotions and self-perception. Jacob Harrison notes that, for John Paul II, the integration of the human person necessitates that one's sensitivity be subordinated to truth.[3] The body speaks a language, then, by its very nature, which reaches its highest and truest expression in the marital act, since this act not only unites man and woman in a total and mutual gift of self but also signifies the great mystery of Christ's love for the Church.

To seek sex reassignment surgery is to attempt to conform this language to one's emotions and self-perception. It is not possible to change the objective truth of the language of the body, however, so such interventions cause the body to speak falsely. The body lies about its nuptial meaning expressed in masculinity and femininity and obscures God's original will in calling humanity to express love in a bodily way.

This "false speech" of the body is what St. Thomas Aquinas refers to as the sin of dissimulation. To make clear the connection with the language of the body, it is worth quoting his argument:

> It belongs to the virtue of truth to show oneself outwardly by outward signs to be such as one is. Now outward signs are not only words, but also deeds. Accordingly just as it is contrary to truth to signify by words something different from that which is in one's mind, so also is it contrary to truth to employ signs of deeds or things to signify the contrary of what is in oneself, and this is what is properly denoted by dissimulation. Consequently dissimulation is properly a lie told by the signs of outward deeds.[4]

Sex reassignment surgery is an act of physical dissimulation insofar as it is an external act that signifies something other than the true sex of the individual and the language that his or her body is called to express. Since such surgery cannot alter one's chromosomes or gametes, it cannot be a complete alteration and thus necessarily remains a dissimulation. The individual, however, in spite of this objective reality, may nevertheless not intend such an act as dissimulation but rather the contrary: an act that brings the body into true conformity with one's feelings. Herein lies the greater danger. As embodied souls, our knowing begins in sensitive apprehension, which is heavily influenced by our bodily disposition. Gender dysphoria already implies a distrust of sensitive apprehension, claiming that a person's emotional experiences are contrary to or exist in spite of the natural experiences to which his or her body is inclined.

Such suspicion creates an obstacle in the path of understanding truth, since our intellectual knowledge is abstracted from our sensitive apprehension of things. Rather than trying to help the individual again trust his or her apprehensive powers through bodily acceptance, sex reassignment surgery reinforces the notion that the experiences resulting from the body cannot be trusted, and so the body must be altered. Since neither the sex of the person nor the language of the body can be truly changed, these procedures further obscure the truth of the body and one's access to that truth. By altering the bodily disposition of the individual, one becomes more inclined to reason and choose on the basis of a falsehood. A person's suspicion of his or her true sex and apprehensive powers can become a *habitus*, thereby creating an ingrained obstacle to the pursuit of virtue. Di Camillo notes how such an inclination orders one to dis-integration, which is the precise effect of vice (220).

Di Camillo is right to note that, when treating such cases pastorally, it is important to distinguish inclinations from sins and to admit varying levels of ignorance and culpability (220–221). Nevertheless, it is worth noting that gender-transitioning interventions, particularly sex reassignment surgery, are not merely immoral acts but acts that start individuals down a path of habituating mistrust of their natural ability to pursue truth. While perhaps not precluding the possibility of attaining virtue, this certainly introduces a grave and unnecessary obstacle.

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1. John A. Di Camillo, "Gender Transitioning and Catholic Health Care," *National Catholic Bioethics Quarterly* 17.2 (Summer 2017): 213–223.

2. John Paul II, *Man and Woman He Created Them: A Theology of the Body*, trans. Michael Waldstein (Boston: Pauline, 2006), 539.

3. Jacob Harrison, "Karol Wojtyla, Sex Reassignment Surgery, and the Body–Soul Union," *National Catholic Bioethics Quarterly* 17.2 (Summer 2017): 296–297.

4. Thomas Aquinas, *Summa theologiae* II-II .111.1.