Catholic Hospitals and Sex Reassignment Surgery

A Reply to Bayley and Gremmels

E. Christian Brugger

Abstract. Catholic health care institutions presently face the question of whether it would be morally legitimate for them to participate in sex reassignment surgery for patients suffering from gender dysphoria. This essay replies to two articles published on this question in the Winter 2016 issue of the Catholic health care journal *Health Care Ethics USA*. It argues that both articles fail to attend to factors necessary for an adequate moral assessment of the question, and thus provide inadequate solutions. It goes on to argue that it would be intrinsically wrong for Catholic hospitals to counsel or perform sex reassignment surgery if in so doing they affirmed certain widely held erroneous assumptions about the nature of sex and gender. The essay ends by asking whether, if those erroneous assumptions were clearly and publically rejected, it could ever be licit to perform surgical amputations or plastic surgical reconstructions to assist persons suffering from severe and intractable cases of gender dysphoria. *National Catholic Bioethics Quarterly* 16.4 (Winter 2016): 587–597.

The public perception of transgenderism has changed drastically and rapidly in recent years. The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-4) of the American Psychiatric Association (APA), published in 1994, designated a psychological pathology called gender identity disorder. The

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diagnosis centered on the experience of persistent and pervasive cross-gender self-identification.[1] In 2013, the DSM-5 replaced the diagnostic term with "gender dysphoria," emphasizing the experience of clinically significant psychological distress—*dysphoria*—felt by some who experience gender identity questions.[2] The APA is clear that it does not consider incongruent feelings, however strong and pervasive, between one's experienced gender and one's "assigned" gender to be a mental disorder.[3] It is not until patients experience distress at this incongruence that the condition is considered problematic. In other words, persistent feelings that cause one to self-identify as a gender other than the one that corresponds with one's biological sex are not *per se* psychologically disordered. Thus, it makes sense that doctors are increasingly treating people with gender dysphoria not by focusing on the overcoming of confused and incongruent feelings about their sex—not by assisting them to accept and live peacefully with their bodies—but by focusing on overcoming the distress they feel, even if this means supporting them in radically altering their bodies to conform with their feelings.

Catholic health care institutions must squarely face the question of whether cooperating in these alterations is consistent with the healing, nurturing, and ultimately flourishing of human nature and so with good medical care.

Two articles in the Winter 2016 issue of *Health Care Ethics USA*, one by Carol Bayley, the other by Becket Gremmels, explore whether sex reassignment surgery (SRS) may be carried out at Catholic hospitals for persons suffering from gender dysphoria.[4]

Bayley identifies four phases of sex reassignment: (1) counseling; (2) hormone therapy affecting secondary sex characteristics, together with cross-dressing and living as the other sex; (3) top surgery, that is, breast removal or augmentation; and (4) bottom surgery, or surgical refashioning of the genitals to correspond with those of the opposite sex.

Bayley and Gremmels both acknowledge that the origins and nature of gender dysphoria are not well understood. Bayley says early research on the genetics, hormones, and brains of affected individuals suggests that "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." This, she says, suggests that a biological substrate underlies the diagnosis of gender dysphoria, making

1. American Psychiatric Association, "Gender Identity Disorder," *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: APA, 1994), 537, nos. 302.6 and 302.85.

2. American Psychiatric Association, "Gender Dysphoria," *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: APA, 2013), 452.

3. The APA website states, "Gender nonconformity is not in itself a mental disorder." American Psychiatric Association, "Gender Dysphoria" factsheet, 2013, www.dsm5.org/.

4. Carol Bayley, "Transgender Persons and Catholic Healthcare," Health Care Ethics USA 24.1 (Winter 2016): 1–5; and Becket Gremmels, "Sex Reassignment Surgery and the Catholic Moral Tradition: Insight from Pope Pius XII on the Principle of Totally," *Health Care Ethics USA* 24.1 (Winter 2016): 6–10.

the condition something that is "not chosen and not socially constructed."[5] Bayley and Gremmels do not ground their arguments in this early research, however. Both articles also note that there is no reliable empirical evidence that SRS ameliorates the psychological suffering of persons with gender dysphoria.[6]

Moral Analysis of Bayley's Article

Bayley argues for two related moral conclusions: (1) that everyone, including Catholic health care institutions, should relate to individuals with gender dysphoria according to their gender of choice, and (2) that Catholic institutions may legitimately perform all four phases of sex reassignment. She even cautions these institutions against developing policies that could raise issues of discrimination.[7]

First Argument: The Principle of Respect

Bayley says that although Sacred Scripture and Catholic teaching do not directly address gender dysphoria or SRS, they provide guidance for thinking about them. For example, they teach respect for human persons, admonish us to welcome strangers, praise diversity in nature, and proclaim the goodness of all that God has created. This alone, she asserts, is "sufficient" for us to understand that "in any setting, including our hospitals and health services, [respect] 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."[8] According to this interpretation, respect expresses sensitivity to the point of affirming the gender with which those who have gender dysphoria choose to identify.

Sensitivity to the feelings of others may broadly be considered a dimension of kindness, which for Christians is a fruit of the Holy Spirit. But the fruits of the Spirit, like all fruits, are derivative of the tree from which they come. And in the Thomistic tradition, the health of the tree and its fruits is guaranteed not by the fruits but by the seven-fold gifts of the Spirit. The gifts of the Spirit focus upon two overarching goods: first, the Spirit guides and sustains the believer in all salutary truth through the gifts of wisdom, understanding, counsel, and knowledge; and second, the Spirit disposes the believer to live in the fullness of this truth through the gifts of fortitude, piety, and fear of the Lord. It follows that if some expression of kindness-as-sensitivity affirms something at odds with the truth, it becomes a form of spurious kindness.[9] Although all expressions of harshness and dismissiveness should be rejected, it

5. Bayley, "Transgender Persons and Catholic Healthcare," 2.

6. Ibid., 4. The only thing Bayley says in this regard is by way of mere assertion: "The relief of suffering [bottom surgery] represents is profound."

7. Ibid.

8. Ibid., 3.

9. When speaking of the ministry of salvation, St. Paul mentions kindness as one thing Christians attend to in order to avoid putting obstacles in people's way to hearing the Gospel (2 Cor. 6:3–6). Speaking the truth in love is an integral part of evangelization.

would also be wrong to affirm the falsehood that manifestly biological males are ever females, or vice versa.

Does referring to a transgender individual according to his or her new name necessarily affirm a falsehood? Probably not, just as referring to somebody by a nickname does not necessarily affirm a falsehood. For example, I had a friend in high school whom we all called Hobbit, but we were certainly not asserting that he actually was a hobbit. The use of an assumed name does not necessarily affirm any false propositions. At the same time, if I relate to or affirm a man as a woman because he is under the impression that he is a woman, then I relate to him according to a falsity. This would be wrongful.

The purpose here is not to propose any definitive policy for Catholic health care institutions relating to individuals with gender dysphoria. It is, rather, to critique Bayley's simplistic account of respect, which does not address problems arising from the falsity of a transgender person's dysphoric condition, namely, "My true self is something other than my biological sex." Does not respect also include not leading or confirming others in error? Is it respectful to call a likely expression of profound psychological pathology a healthy expression of self-identity? Do not Catholic institutions have a duty to use the tools of medicine and psychology to help patients conform their lives as much as possible to the truth?

Second Argument: The Principle of Double Effect

Bayley argues for the liceity of performing top and bottom surgeries at Catholic hospitals by appealing to the principle of double effect, which prescribes that the means and intended ends of a deliberate choice must be morally upright. It also stipulates that there be a proportionate reason for tolerating the unintended but foreseeable harm resulting from that choice.

With respect to the decision to counsel, perform, or undergo SRS, Bayley identifies *the end of the act* as relief of serious discomfort and distress, *the means* as a surgical procedure, and *the unintended side effect* as reproductive sterilization. She thus maintains that the end is good, the means are neutral, and the benefits are significant enough that it is reasonable to tolerate the unintended but foreseen bad side effects.

The relief of suffering, in itself and as an end, is a good thing. However, Bayley's assumption that SRS will provide such relief seems unjustified. She admits that "there is a great deal we do not understand" about "the relationship between gender and sex, and how the mind and the body connect them."[10] This includes the long-term consequences of SRS for those who undergo it.

In fact, there is empirical evidence that the long-term effects of SRS are deleterious. In a 2014 commentary published in the *Wall Street Journal*, Paul McHugh, MD, former psychiatrist in chief at Johns Hopkins Hospital, reveals that "most of the surgically treated [SRS] patients described themselves as 'satisfied' by the results, but their subsequent psychosocial adjustments were no better than those who didn't

10. Bayley, "Transgender Persons and Catholic Healthcare," 6.

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."[11] McHugh refers to a Swedish study, published in 2011, in which data from 324 people who underwent SRS were gathered over thirty years. The study reveals 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."[12] Currently, we can say no more than that the long-term effects of SRS are inconclusive.

In addition, Bayley refers only to a single harmful effect of SRS when assessing proportionality, namely, contraceptive sterilization. This is superficial. Does not a biological male suffer objectively serious anatomical harm by having his penis and testicles surgically removed? What about the interpersonal effects of SRS, especially on children? What about the danger of scandal, the risk of reinforcing delusional ideas about self-identity, and the support for the cultural advance of what Pope Francis calls gender ideology?[13]

Finally, Bayley grounds her conclusion in a simplistic interpretation of Scripture. Divine Revelation teaches that God creates each human being as male or female. In cases where maleness or femaleness is unambiguously expressed in one's anatomy and genetic make-up—female primary sex characteristics and XX chromosomes, or male sex characteristic and XY chromosomes—the Christian presumption is that one's sex comprises the whole person, body and psyche. According to Bayley, gender is not a synonym for sex; it is rather the externalized social expression and subjective experience of it. If we accept her definition, what can we say about gender dysphoria? Beginning with the premise that God makes human beings male or female, and solicitously avoiding the dualistic conclusion that there is a distinction between the body and the whole self, one's gender should be in harmony with one's physical sexual identity. If a person's psychological experience of biological sex is enduringly repugnant, the assumption is that the experience is an expression of a disorder, which in McHugh's words "deserves understanding, treatment and prevention."[14]

The rare case of an intersex child who is born with ambiguous primary sex characteristics (e.g., a penis and ovaries) or genetic abnormalities (e.g., XXY sex chromosomes) is not an exception to the biblical teaching but rather an instance of biological anomaly that makes it difficult to determine which sex God created the child. The idea that some children are born as true hermaphrodites (both male and female)

11. Paul McHugh, "Transgender Surgery Isn't the Solution: A Drastic Physical Change Doesn't Address Underlying Pychosocial Troubles," *Wall Street Journal*, June 12, 2014, http://www.wsj.com/.

12. Ibid. The study described but not named by McHugh is Cecilia Dhejne et al., "Long-Term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLOS ONE* 6.2, e-pub February 22, 2011, e16885, doi: 10.1371/journal.pone.0016885.

13. See, for example, Francis, Dialogue with the Bishops of Poland (July 27, 2016).

14. McHugh, "Transgender Surgery Isn't the Solution."

or born sexless (neither male nor female) or with a male body and a female soul or vice versa poses very serious problems for sound Christian theological anthropology.

Moral Analysis of Gremmels's Article

Drawing on the teaching of Pope Pius XII, Gremmels appeals explicitly to the principle of totality and implicitly to double-effect reasoning to argue for two conclusions: (1) since SRS is not an instance of wrongful mutilation or sterilization, it is not intrinsically evil; but (2) the procedure is not morally justifiable, because there is insufficient evidence that SRS significantly benefits persons suffering from gender dysphoria.

First Conclusion: SRS Is Not Intrinsically Evil

Gremmels introduces the principle of totality, which states that when the good of the whole body requires the sacrifice of a part, the part legitimately may be sacrificed for the sake of the whole. He elaborates on this principle according to three conditions set forward by Pius XII in 1953 governing the licit surgical removal, suppression, or destruction of some part or function of the body: (1) the particular part seriously threatens the welfare of the whole organism; (2) there is reasonable certitude that removing, damaging, or suppressing that part will significantly benefit the whole; and (3) there is reasonable certitude that the benefits achieved by the procedure will compensate for the harm caused by removal.[15]

Gremmels argues that, according to the first condition, SRS is not necessarily an instance of wrongful mutilation or sterilization. According to Pius XII's criteria, an organ does not need to be diseased in order to justify its amputation or destruction. It simply needs to pose a serious threat to the welfare of the whole. For persons with gender dysphoria, the normal functioning of healthy body parts—genitals, breasts, hormones, etc.—"contributes to and exacerbates" the gender dysphoric condition.[16] Therefore, although Gremmels does not explicitly refer to the double effect, he implies that if the end is improved health and the means a medically indicated medical procedure, then neither is *intrinsece malum*.

This conclusion cannot be accepted as argued. Gremmels does not acknowledge that changing our biological sex is impossible—except in the rare condition known as mosaicism, our sex is written into every one of our roughly sixty trillion cells. SRS is, therefore, a pretender's game. Whether Gremmels thinks that one's sex really can be reassigned is unclear, but he certainly believes that reassignment surgery *could* be morally acceptable. Nevertheless, counseling, performing, or accepting any surgery with the intent to change or reassign one's biological sex is always contrary to the truth and, therefore, always impermissible. In other words, it is intrinsically evil to participate in SRS under current assumptions about sex and gender.

Could a person ever participate in top or bottom surgery in a way that is fully consistently with the truth? It seems possible. A doctor and other caregivers would

15. Pius XII, Address to the Twenty-Sixth Congress of Urology (October 8, 1953).
16. Gremmels, "Sex Reassignment Surgery and the Catholic Moral Tradition," 7.

have to be convinced, on reasonable grounds, that it is the last resort, that the patient can never find psychological peace aside from the surgery. And they would have to acknowledge that the procedure is not a sex change or a gender change, but a gravely disfiguring surgery meant to facilitate some semblance of psychological stability. In such a case, the procedure would meet Pius' first condition for totality: the surgical intervention would be necessary for the health of the individual. The end would be the person's health, and the means would be a medically indicated, manifestly therapeutic medical procedure. The harm—the loss of anatomical integrity—would be tolerated, but not intended as either ends or means. In Aquinas's vocabulary, the harm would be *praeter intentionem*.

Something similar might be argued to justify the amputation of a healthy arm from someone suffering a severe and intractable case of body dysmorphic disorder, the intrusive belief that one's own anatomical integrity is grotesquely and unacceptably flawed—for example, that one cannot live peacefully with two arms. It seems that as a *last resort* an amputation of a healthy limb could be justified if there were reasonable certitude that it was *necessary* to help the patient live more peacefully. The patient's psychological health would be intended as the end; a medically indicated, manifestly therapeutic surgical procedure would be intended as the means; and the unintentional harm to anatomical integrity would be justified by the *iusta causa* that the patient's psychological stability could not reasonably be otherwise achieved. But even if this were not an instance of wrongful mutilation, it would be wrong to affirm that the mentally ill person's bodily integrity was in fact anatomically flawed.

But even if (1) participation in top or bottom surgeries were consistent with the good of truth, and (2) Pius's first condition were met—namely, that the function of a particular organ constituted a threat to the whole—it seems clear that presently the surgeries would not meet Pius XII's second condition: that the efficacy of the procedure is well assured. This leads us to Gremmels's next argument.

Second Conclusion: SRS Is Not Currently Justifiable

When applying Pius XII's second condition, Gremmels argues that "it is still unclear" whether SRS significantly relieves the distress caused by gender dysphoria. He references studies that suggest it does but says they are of poor quality or based on "self-reported satisfaction," which "does not appear to be a sufficient measure for success, especially since many of those who undergo SRS continue to have related mental health problems."[17] He concludes that presently the evidence does not support the claim that the benefits of SRS are reasonably well assured.

Gremmels attaches a similar caveat to the third condition, conceding that it is not at all clear that the benefits of SRS compensate for the sterilization and mutilation it causes. He thinks that SRS could be justified if it were necessary to save or extend life, but gender dysphoria is not a fatal condition. Gremmels equivocates on this point and contends that, given the gravity of gender dysphoria, SRS could be justified if all other remedies have failed and if its efficacy were known with reasonable

17. Ibid.

certitude. However, since the effectiveness of SRS is not certain, it does not meet this last condition. Although Gremmels eventually concludes that SRS is not morally justifiable, he entertains the possibility that "the outcome of further research" could demonstrate its efficacy and, therefore, its legitimacy.[18]

This second argument seems sound in a qualified sense. As stated above, it must be rejected if the surgery is considered a sex reassignment or sex change. If we presume, for the sake of argument, that the surgery is carried out in accord with the good of truth, as outlined above, then it need not be intrinsically illicit, although we would still need proportionately strong reasons to tolerate the harms it would cause. One of those reasons is formulated in Pius XII's second principle: we must have a high degree of empirically grounded certitude that the surgery will provide significant psychological benefits to the patient, which at present we do not have. Therefore, even if the conditions for conformity with the truth were met, it would still be gravely wrong to participate in top or bottom surgeries to treat gender dysphoria.

Truth telling and therapeutic benefit are not the only conditions required for this moral analysis. Before Catholic hospitals could licitly perform top or bottom surgeries, conformity with the following moral conditions must be met:

1. *Avoiding scandal*. People who see 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 these assumptions. Leaders of Catholic health care institutions therefore would have a grave responsibility to ensure that any participation in these surgeries does not cause scandal.

2. *Avoiding support for 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 be likely to 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 can to ensure that their participation does *not* contribute to culturally flawed attitudes about these important areas.

3. *Avoiding support for nonmarital sexual and homosexual behavior*. Bayley dismisses the relevance of Catholic teaching on homosexuality in the context of gender dysphoria and SRS. "Catholic teaching on the morality or immorality of homosexual activity is another issue and is not pertinent to moral questions regarding transgender persons."[19] This statement fails to consider individuals with gender dysphoria who identify with the opposite sex and engage in nonmarital sexual activities with members of the sex with which they have ceased to identify." Apparently, a significant percentage of those who identify as transgender say they are also homosexual or

18. Ibid., 8.

19. Bayley, "Transgender Persons and Catholic Healthcare," 2.

bisexual.[20] Although society at large sees no problem with all kinds of nonmarital, consensual sexual behavior, Catholics and Catholic hospitals have a duty to assess whether performing top or bottom surgeries contributes to heightened temptations for those with gender dysphoria to engage in nonmarital sexual behavior.

4. *Avoiding bad effects on cooperators*. If Catholic hospitals perform these surgeries, hospital leaders and employees may over time grow 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 does not lead over time to the coarsening of themselves or their employees in relation to moral truths about sex and gender.

5. *Avoiding harm to vulnerable dependents*. Neither Bayley nor Gremmels considers the effects of SRS on those for whom transgender persons have special moral responsibilities. The spouses and especially the children and other immature dependents can be harmed terribly and unfairly by their loved one's decision to live publically as the opposite sex and, worse, alter their body to appear like the opposite sex. This is probably the gravest evil arising from gender ideologies. For those with vulnerable dependents and other close relations, undergoing these surgeries would be unfair and immoral in most, if not all, cases.

6. *Witnessing to the Gospel*. As apostolates of the Catholic Church, health care institutions have a duty to bear witness to the truths of the Gospel and oppose those evils that are especially harmful to people's temporal and eternal welfare. Gender ideology is certainly one of those evils. Catholic institutions have a serious obligation to witness to the truth that God made human beings male and female, despite the popular but erroneous notion that biological sex, gender identity, and sexual orientation have no ontological coherence. In the face of widespread confusion, Catholic institutions are especially well situated to witness to the anthropological truths taught in Sacred Scripture, revealed in the person of Jesus, and held and taught by the Church.

7. *Staying accountable to God for our stewardship of our embodied nature*. In an address to medical practitioners in 1952, Pius XII turned to the question of the moral duties of patients. He taught that no one is an "absolute master" of himself who can "freely dispose of himself as he pleases. … The patient is bound to the immanent teleology laid down by nature. He has the right of use, limited by natural finality, of the faculties and powers of his human nature. Because he is a user and not a proprietor, he does not have unlimited power to destroy or mutilate his body and its functions."[21]

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20. Jaime M. Grant et al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (Washington, DC: National Gay and Lesbian Task Force and National Center for Transgender Equality, 2011), 18. In a survey of 6,436 individuals who identified themselves as transgender, 21 percent stated they were homosexual, and 23 percent stated they were bisexual.

21. Pius XII, Address to the First International Congress on the Histopathology of the Nervous System (September 14, 1952), n. 13.

The Pope is speaking about interventions that destroy the integrity of the body for reasons unjustified by the principle of totality. His reference to our being "bound to the imminent teleology laid down by nature" should prompt us to ask what duties we have, including to those suffering from gender dysphoria, to affirm ourselves precisely as the sex that nature lays down for us.[22] The caution that we do not have "unlimited power" to mutilate our body is a sobering admonition against hastily underwriting conclusions that stem not from empirical evidence or the practice of medicine but from what the *Compendium of the Social Doctrine of the Church* refers to as "*theories that consider gender identity as merely the cultural and social product of the interaction between the community and the individual, independent of personal sexual identity without any reference to the true meaning of sexuality*."[23]

Pius XII concludes that "the patient, then, has no right to involve his physical or psychic integrity in medical experiments or research when they entail serious destruction, mutilation, wounds or perils."[24] This verdict, of course, presumes that such experiments are not compatible with the therapeutic principle of totality, which is a question that is not settled for surgical interventions aimed at treating SRS. Nevertheless, the Pope's assertion may help us to think about what is at stake when mutilating interventions are undertaken to treat gender dysphoria.

The Duties of Medical Practitioners

Neither Bayley nor Gremmels addresses the duty of medical practitioners to avoid fads in treatment plans and to act reasonably toward patients, respecting the goods of their bodies and souls and recommending harmful procedures only when those procedures offer significant and empirically demonstrable hope of benefit. Referring to the limits imposed on physicians by the moral law, Pius XII teaches that the moral limit on doctors is "fixed by the judgment of sound reason, which is set by the demands of the natural moral law, which is deduced from the natural teleology inscribed in beings and from the scale of values expressed by the nature of things."[25] He warns practitioners against the "apodictic assurance" of popular opinion that sways practitioners to adopt more invasive or consequential practices than are necessary.[26]

The popularity of an opinion is no guarantee whatsoever of its verity. The "transgender moment" apparently ushered in by Bruce Jenner's public revelations[27] has led to an almost manic fixation among Western progressives to affirm the rightness, goodness, and naturalness of cross-gender identification, the nonmarital sexual

22. The *Catechism of the Catholic Church* teaches, "Everyone, man and woman, should acknowledge and accept his sexual *identity*" (n. 2333, original emphasis).

23. Pastoral Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (Washington, DC: USCCB, 2004), n. 224, original emphasis.

24. Ibid., n. 14.

25. Ibid., n. 18.

26. Ibid., n. 17.

27. Rebecca Juro, "Bruce Jenner and America's Transgender Moment," MSNBC, April 25, 2015, http://www.msnbc.com/.

behavior of everyone who experiences it, and radical surgical interventions aimed at conforming the bodies of those who experience it to their psyches.

There is a great danger that practitioners and administrators at Catholic hospitals will too succumb to this intense social pressure to affirm, or at least not oppose, erroneous assumptions about human nature, sex, gender, and psychology and so begin prescribing and performing practicably irreversible surgical interventions that are defensible by neither good morals nor good medicine. Gender identity confusion and the dysphoria that accompanies it are a complex and tragic condition, and adequately understanding the condition is a long, painstaking journey into the manner of its causation. We must not hastily affirm radical treatments for a condition we do not adequately understand.

In their recent special report on sexuality and gender, Lawrence Mayer and Paul McHugh corroborate the contention that there is little scientific evidence illuminating the etiology and nature of transgenderism: "Yet despite the scientific uncertainty, drastic interventions are prescribed and delivered to patients identifying, or identified, as transgender."[28] Catholic hospitals must resist this temptation, even if in so doing they experience criticisms from their secular counterparts.

28. Lawrence S. Mayer and Paul R. McHugh, "Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences," *New Atlantis* 50 (Fall 2016): 115.