In This Issue

John Di Camillo, in "Gender Transitioning and Catholic Health Care," argues that the appropriate response of Catholic health care to cases of gender dysphoria is treatment that stresses the need to accept one's given body identity. Until recently, professional medical organizations identified the claim that one feels that he or she is a member of the opposite sex as a mental disorder, but under the new standard, the biological sex of the body no longer indicates the sex of the person, which derives instead from the person's subjective beliefs and desires. Di Camillo looks at the sociological and subjective origins of such terms as "gender identity," "gender expression," and "transgender."

Stephen Mikochik points out contradictions between Canada's Medical Assistance in Dying Act and the UN Convention on the Rights of Persons with Disabilities. Taking a line from Shakespeare's Macbeth, "Broken to the Hope," he contends that new legislation on physician-assisted suicide and euthanasia places those with disabilities at a significant disadvantage under Canadian law. Health care workers may kill someone without criminal liability if that person suffers from a "grievous and irremediable" condition. The safeguards against the abuse of this practice are minimal and easily circumvented. The law envisions equality for the disabled, not as the enhancement of their dignity, but as the freedom to choose death.

The effort to revive dying patients through cardiopulmonary resuscitation can cause injury. Marissa Mullins, RN, examines this problem in "When Cardiopulmonary Resuscitation Becomes Harmful." The earliest studies of CPR appear to have exaggerated the benefits of the procedure and ignored the many significant side effects, including routine rib and sternum fractures. More recent studies indicate that less than 20 percent of those who undergo CPR survive in a hospital setting. There are good clinical indicators of who is likely to benefit from CPR. The technique should not be used, Mullins argues, when there is a low probability of success.

Frederick White III, MD, in "Lessons from Recent Polls on Physician-Assisted Suicide," looks for insights and biases in tools that assess public opinion. Two recent polls that suggest growing support for physician-assisted suicide serve as examples of

a wider problem. The questions assume a hierarchy of values in which what is legal is nested within the permissible and the moral. The "if–then" structure of the questions hide premises that logically lead to a positive response to physician-assisted suicide. White argues that these types of instruments suffer from various logical fallacies that undermines their accuracy. The result is that public support for physician-assisted suicide is not likely to be as strong as it appears.

The question of what constitutes futile treatment has been widely discussed in the literature, yet obscurity remains. Rev. Francisco Javier Insa Gómez, MD, and Rev. Pablo Requena Meana, MD, in "Is Medical Futility an Ethical or Clinical Concept?," discuss a recent proposal to define futility in purely clinical terms. This approach enables the physician to refuse requested treatment when it is unlikely to have sufficient benefit according to clinical standards. The authors name three proposed definitions of futility: physiological futility, quantitative–qualitative futility, and social futility. The first two provide clinical criteria and are the focus of their analysis. Physiological futility is generally uncontroversial, as it simply states that ineffective treatment need not be given. Quantitative–qualitative futility adds the notions of threshold effectiveness and patient recovery time. These criteria are valuable, but they do not take into account the willingness of certain patients to take higher risks, endure longer periods of recovery, or accept diminished levels of health to preserve their lives.

"The Catholic Tradition on Vital Conflicts," by Joshua Evans, looks at authors Charles Camosy and James Mumford on the topic of vital conflicts, those cases in which the life of an expectant mother is threatened by medical complications caused by her unborn child. Both authors justify the death of the child in such circumstances on several grounds: on a view of the child as a material aggressor, by an appeal to just-war doctrine, and through the concept of self-defense. Unfortunately, the authors omit important previous discussions of these topics and come to conclusions that the Catholic Church has already set aside as unacceptable. Discussion and rejection of the material-aggressor theory has a long history, beginning in 1869. Similarly, killing in warfare is not analogous to killing the unborn. Finally, the authors fail to explore the special relationship between mother and child and the possibility of self-sacrifice for the sake of another.

After a review of Catholic arguments concerning sex reassignment surgery, Jacob Harrison, in "Karol Wojtyla, Sex Reassignment Surgery, and the Body–Soul Union," orients us to the question through the philosophical work of Pope St. John Paul II. Wojtyla sees the person as a psychosomatic unity in which experience of the world is directed toward values under the guidance of objective truth. If the rational soul is essentially the form of the body, then bodily meaning can be expressed only through this unity. Any notion of duality, in which the soul and body stand in opposition to each other, fails to reflect the natural law. All justifications for sex reassignment surgery, Harrison argues, rely on the dualistic understanding. With Wojtyla's analysis in hand, Harrison critiques moralists who have suggested that sex reassignment surgery may be compatible with Catholic teaching.

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