June 20, 2017

Catholic Medical Association  
29 Bala Avenue, Ste 205  
Bala Cynwyd, PA 19004-3206  

Re: 2017 Outstanding Guild Award  

Dear Sir:

I would like to offer for your consideration the work of the members of the St. Louis Guild of the Catholic Medical Association at the request of our Archbishop here in St. Louis, the most Reverend Robert J. Carlson. In early 2016, Archbishop Carlson requested of our Guild advice on how to respond to several concerns voiced in the Archdiocese concerning the use of aborted fetal cell lines in immunizations and a proper Catholic response to same. This request was undertaken by two of our members, Dr. Kathleen Burchelmann and Dr. Elizabeth Abraham, who met on many occasions and ultimately put together an educational meeting which was very well attended by our membership and by many of the students in the medical schools in our area. The presentation they had on morally licit options for immunization schedules in pediatrics is to be presented in lecture form at the 2017 National Catholic Medical Association conference.

The second, and larger, request that we had from Archbishop Carlson had to do with a Catholic approach to the problem of the care of transgender patients and the treatment of gender dysphoria in a truly Catholic way. One of our Catholic pediatric hospitals was involved in gender dysphoria treatment with hormone treatment to induce sterilization, to arrest puberty and also surgery for sterilization with oophorectomy, orchiectomy and hysterectomy for the purpose of gender transition. If this weren’t bad enough, SSM Health Systems (a multi-state health system in the Midwest), had enacted a policy recommending treatment options for gender dysphoria in adolescents and adults which was not in keeping with the ethical and religious directives for Catholic health care services. Nearly at the same time as these two hospital system policies were taking shape, a new ordinance was proposed by the Board of Alderman urging the City of St. Louis to make illegal psychiatric treatment for gender dysphoric individuals who wish to become comfortable with their biological assigned gender, instead of going through with hormone treatments for their gender dysphoria. This St. Louis board bill would have made “conversion therapy” illegal, thereby making it very difficult for a proper Catholic approach in the psychiatric realm to help these individuals.
Over several months, a committee of our St. Louis Guild met on a regular basis and formulated a very well thought out letter to the Archbishop helping him with the medical aspects, in addition to the moral aspects, that he is very well aware of. With our help, the Archbishop addressed the problems at our local Catholic pediatric hospital, and with SSM healthcare. We also came together as a group and were prepared after several meetings, to meet with the St. Louis Board of Alderman during a public hearing concerning their board bill #295 that would make conversion therapy illegal. This bill was withdrawn at the last minute and the meeting was not necessary, but it is our understanding that we will need to come together again this autumn of 2017 when the bill is reintroduced to the Board of Alderman.

In summary, we have had a very busy year helping Archbishop Carlson, and we look forward to being at his service in the years to come. For the work that was completed by the members of my guild, I request consideration for the St. Louis Guild of the Catholic Medical Association to be considered for the 2017 Outstanding Guild Award.

Thank you for your consideration.

David J. Stansfield, D.O.
President of St. Louis Guild
Catholic Medical Association

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Re: SSM Health system-wide transgender policy

January 25, 2017

Dear Archbishop Carlson,

On behalf of the St. Louis Guild of the Catholic Medical Association, we would like to offer you our assistance in understanding and responding to the SSM Health policy statement condoning and encouraging transgender medical and surgical treatments in SSM facilities.

The policy, attached to this letter, is entitled, “Care of Transgender Patients and Treatment of Gender Dysphoria.” The policy reads, “This policy outlines appropriate and respectful interactions in the care of transgender patients and defines the permissibility of transition-related therapies for adult and minor patients with gender dysphoria. This policy is applicable to all employees of SSM Health, including SSM hospitals, SSM Medical Groups, and operating entities including their employees, agents and medical staff, as well as employed physicians of an SSM Medical Group.” Thus, this policy also grants formal permission for Cardinal Glennon Children’s Medical Center to provide transgender transition services to minors, a service they have already been providing for some time now.
The SSM Health facilities affected by this policy statement are located in four states and multiple dioceses. Also, to the best of our knowledge, SSM Health is the first Catholic hospital system to write a policy condoning transgender transition-related therapies. As such, this is a national issue, not isolated to our diocese. We have contacted the national Catholic Medical Association for assistance in this matter, as well as the episcopal advisor to the national Catholic Medical Association, Most Reverend James Conley.

The St. Louis Guild of the Catholic Medical Association has consulted with multiple medical experts on the issue of providing so-called transgender transition treatment. To date, the medical and scientific argument against the provision of transgender transition services have been unsuccessful in halting the proliferation of clinics providing transition therapies for individuals with gender dysphoria. Although the scientific evidence to support these services is very poor, the societal push for a culture of acceptance of the transgender ideology has led almost every major medical organization to endorse it. As physicians and medical professionals, we can provide you with the solid scientific arguments against transgender treatments, and we hope we can serve you in this way. Nevertheless, we firmly believe that the only way to keep transgender transition services out of our Catholic hospitals is to voice both medical and moral arguments, with the authority of the Catholic Church behind it. The medical arguments alone and the voices of lay physicians are no longer strong enough.

To be clear, the policy allows for not only hormone treatments, but also surgery to remove (normal) ovaries (oophorectomy) and testicles (orchidectomy), and uterus (hysterectomy) for the purpose of gender transition. In fact, the argument has already been made that physicians ought to remove the uterus or ovaries of a woman already on high-dose testosterone in order to protect her from the potential of cancer caused by the hormonal treatment. The only surgery not yet allowed is gender reassignment surgery (vaginoplasty or phalloplasty) since no one in the area can do it yet. However, when available, this would be allowed based on the underlying assumptions on which the policy is based. The policy advocates for and allows medical and surgical treatments that are not scientifically-based, that are permanent with untested longterm repercussions, and that are incompatible with longstanding Church teaching and anthropology.

We are very hopeful that you and your brother bishops will be willing to speak up against the SSM Health policy, and in doing so, can prevent other Catholic hospitals or institutions from following in the footsteps of SSM Health. Because this is likely the first Catholic health institution to write such a system-wide policy a response from the Church would be timely.

To assist you, we have put together a draft letter outlining both the medical and moral arguments against transgender transition therapy in Catholic hospitals.

We suggest addressing the letter to senior leadership at SSM Health given their relationship with SSM Health. You might also consider copying the Board of Governors for the Cardinal Glennon Children's Medical Center Foundation, given that you are the president.

Please find attached the draft of our suggested letter to SSM Health.
We are grateful for your commitment to ensuring the best Catholic health care. Please let us know if we can be of further assistance.

Sincerely,

David Stansfield, D.O.
President, St. Louis Guild of the Catholic Medical Association
Response to Board Bill #295

Ethical:

- Evidence for the use of hormones and surgery to tx Gender Dysphoria (GD) has serious limitations (discussed in detail in Hayes Directory May 19, 2014)
- There is a serious ethical problem with allowing irreversible life-changing procedures to be performed on minors
- The ethical requirement of informed consent is fundamental to the practice of medicine (Dept of Health and Human Services)
- Hormonal or surgical sterilization without the full free informed consent is a violation of medical ethics

Medical:

- Hormonal and surgical tx of GD result in sterilization
- The serious limitation of evidence of the benefit of hormonal and surgical tx of minors with GD amounts to experimentation on and the sterilization of minors who are cognitively incapable of providing full, free informed consent for irreversible life-changing procedures
- Puberty is not a disease
- Puberty blocking hormones used to tx GD induce a state of disease in a previously biologically healthy child
- Puberty blockers are dangerous
  - They render the child infertile
  - Arrest bone growth for the duration of therapy
- Cross sex hormones (testosterone and estrogen) are associated with dangerous health risks including, but not limited to:
  - High blood pressure
  - Blood clots
  - Stroke
  - Cancer
- Although cross-sex hormones and sex-reassignment surgery has become “standard of care” for adults with GD, statistical evidence for its benefit is lacking
  - John Hopkins, 1970s studied their patients of the 1960s with sex-reassignment surgery with outcomes of gender dysphoric adults who did not
    - Most surgically treated patients described emotional relief
    - Objective evaluation of their psycho-social adjustment revealed not better than those who did not have the surgery
    - John Hopkins program shut down arguing against amputation of normal body parts to “treat” psychological dysphoria
  - 2011 study at Karolinska Institute in Sweden yielded similar data
    - This was a 30 year longitudinal study which followed 324 people who underwent sex-reassignment surgery
    - After 10 years, they were found to experience increasing psychological distress
    - Most disturbing difference was that their suicide mortality rose almost 20 fold above the comparable non-transgender identified population
Children and adults with GD deserve far better than sterilization, toxic chemicals, surgical mutilations and elevated rates of suicide. The dignity of the human person demands that individuals with GD have the right to compassionate health care providers that demands that mainstream medicine stop treating gender dysphoric persons like second class citizens whose best hope is toxic chemicals, infertility, surgical mutilation and elevated rates of suicide.

Psychiatric:

- Everyone is born with a biological sex, xy or xx
  - These are genetic markers of health, not disease
  - There are exceedingly rare disorders of sex development
- No one is born with a gender
  - Gender awareness and sense of oneself as male or female is a sociological and psychological term
  - Not an objective biological one
- Children (and adults) with GD do not have a disordered body
- FACT: just because I feel and think it does not make it so
  - When an otherwise healthy biological male believes he is female or a healthy biological female believes she is a male,
    - An objectively psychological problem exists
- GD is listed in the Diagnostic and Statistical Manual of Mental Disorders V
  - Which is the authoritative volume that defines and classifies mental disorders
- GD may be described in a similar manner as anorexia nervosa
  - For example, in the case of anorexia nervosa, the assumption that departs from physical reality is the belief by the dangerously thin patient that she is obese
  - Another example is Body Dysmorphic Disorder in which the patient is dysphoric and obsessed with the idea “I am ugly”
  - A third example is Body Integrity Identity Disorder (BIID) in which the person identifies as a disabled person trapped in a fully functional body
    - Individuals with BIID are often so distressed by their fully capable bodies that they seek surgical amputation of healthy limbs or the surgical severing of their spinal cord
- All these disorders, listed in the DSM V have the false beliefs/assumptions that are not merely emotionally distressing for the individuals, but also life threatening
  - What should be obvious is that surgical intervention to relieve the emotional distress and affirm the false assumption that
    - Liposuction for anorexia, cosmetic surgery for BDD and amputation or surgically induced paraplegia for BIID will address the dysphoria
  - These persons genuinely suffer and must be treated with compassion
  - Treating their false assumptions according to their dysphoria place them at risk of death and do not address the underlying psychological distress
- According to DSM V, the “rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary
  - In natal males, persistence ranged from 2.2% to 30%
  - In natal females, persistence ranged from 12% to 50%
  - Simple math allows one to calculate that as many as
    - 97.8% of gender dysphoric boys may come to accept their biological sex
- And as many as 88% of gender dysphoric females may experience similar resolution
  - Although some gender dysphoric children will persist into adulthood,
    - This underscores the importance of further psychological research
    - We must discern how these children and their families differ from those who experience resolution
    - And then use that data to devise therapy that helps them accept reality and achieve emotional health
    - It does not justify euphemizing the chemical castration, sterilization and surgical mutilation of children as healthcare

Children and adults with GD deserve far better than sterilization, toxic chemicals, surgical mutilations and elevated rates of suicide. The dignity of the human person demands that individuals with GD have the right to compassionate health care providers that will help them heal from the deep psychological wounds underlying their false belief.
Objections to the newly established, system-wide, SSM Health policy on the care of transgender patients and treatment of gender dysphoria

As a Catholic health care system, SSM is dedicated to the delivery of exceptional health care services that reveals the healing presence of God. In light of the new SSM policy on the care of transgender patients and treatment of gender dysphoria, representatives of the Archdiocese of St. Louis and several medical organizations are compelled to clearly expound the many ways in which this new policy violates SSM’s founding principle by inflicting irreparable harm to the dignity and health of the very patients it is attempting to treat.

In this letter, we wish to state some of the most serious medical, ethical, and moral objections to this transgender policy. In doing so, we respectfully request that the policy be revised to be in accord with established principles of evidence-based medicine, biomedical ethics and Catholic moral theology which together maintain uncompromised respect for the dignity of the human person, and a proper understanding of the nature of human sexuality. It is essential that any attempt to truly help patients with gender dysphoria follow these basic principles.

The profound distress that some individuals who have incongruence between their sex and gender identity experience has recently gained greater attention by several advocacy groups and medical societies including WPATH and the Endocrine Society. This includes a high incidence of attempted suicide and other psychosocial morbidity. Driven by a sincere desire to alleviate suffering in affected patients, we understand that the new SSM guidelines have been developed to assist affected patients with social transition and alteration of primary and secondary sexual traits. However, it is important to highlight the serious lack of scientific data supporting the efficacy of the proposed treatment paradigm and existing published evidence for persistent long-term morbidity in transgendered patients who have received hormonal and/or surgical intervention.¹

Repeatedly throughout the document, it is stated that there is a requirement that hormonal and/or surgical therapy must be “medically indicated”. The meaning of this term is a critical component of the scientific and medical objection to this policy. The practice of medicine is directed toward curing human disease. The “therapies” allowed by this policy directly and intentionally disrupt normal pubertal processes and alter the innate biological function of normally formed gonads (i.e. testes in biological males and ovaries in biological females). The most immediate result is the induction of sterility.² This effect is widely recognized even by advocates of the WPATH and Endocrine Society guidelines. As sex steroid production during normally timed puberty is critical for optimal bone mineralization, intentional disruption of this process contributes to the development of osteopenia which emerging data suggests

is not fully reversible. Additional known or likely effects of exogenous cross-sex hormonal therapy (androgens exogenously administered to female patients and estrogens to male patients) include hypertension, cardiovascular disease, insulin resistance, thrombosis, and cancer. Thus, the medical procedures being endorsed by SSM induce rather than alleviate disease. This is a clear violation of the ethical principle of nonmaleficence.

It is also highly problematic that there lacks rigorous scientific understanding of the effects of the currently proposed treatment paradigm on patients with gender dysphoria, with a lack of adequate longterm data on the repercussions of the treatments proposed. To date, there have been no properly controlled long-term trials designed to test the hypothesis that hormonal and/or surgical manipulation of primary and secondary sexual traits truly leads to long-term resolution of psychological morbidity in affected patients. Indeed, the few published studies available show persistently elevated rates of depression, suicide and substance abuse in treated adults. Data suggesting short term alleviation of dysphoria in transgendered children receiving cross-hormone administration are not properly controlled or of sufficient duration to draw definitive conclusions. Thus, even apart from the moral objections discussed below, the SSM transgender policy represents an adoption of uncontrolled, untested medical experimentation that has a high likelihood of inducing harm rather than benefit to affected patients. This is a clear violation of the principle of beneficence.

The claim that pubertal blockade is efficacious in that it allows children more time to explore their sexuality and potentially revert to a gender concordant with their sex is an arguably flawed hypothesis that is unsupported by scientific evidence. Consideration of normal neurocognitive and social development of adolescent children leads to a much more plausible hypothesis that such medical and social interventions will perpetuate transgender identity. There is evidence demonstrating that most children with gender discordance will revert back to a gender identity corresponding to their sex. Already, there is evidence that the number of children and adolescents presenting for care is increasing at a rate that exceeds the background prevalence of transgender persisting individuals. Thus, it is likely that implementation of the SSM policy will drive many children or adolescents who would otherwise naturally desist a transgender identity, to persist in one.

Recognition of the normal process of development of sexual identity throughout childhood and the

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difficulty that adolescents have in integrating this with emerging reproductive capacity makes it nearly impossible for minors to “demonstrate thorough understanding of transition-related therapies, its permanence, and expected outcomes”. This vulnerability is in no way eliminated by the participation of parents in making such a decision, for which they themselves are not provided with reliable information regarding likely long-term outcomes. Thus, the SSM transgender policy cannot be interpreted to be a proper application even of the ethical principle of autonomy.

Objections to the SSM policy on the care of transgender patients and treatment of gender dysphoria are not only scientific, but moral as well. The policy is based on principles and assumptions that are in clear violation of respect for the inherent dignity of the human person, created in the image of God as male and female. As the Catechism of the Catholic Church teaches, "the human body shares in the dignity of 'the image of God': it is a human body precisely because it is animated by a spiritual soul [...] Man, though made of body and soul, is a unity" (n. 364). The body is fundamental to personal identity, and not simply a material possession to be used or exploited. In sexuality, we see human bodiliness formed in two complementary ways, male and female, whose biological structures shape one's physicality down to the chromosomal level. Consequently, sexual identity, as revealed in one's biological constitution, is a dimension of the human being that characterizes his or her whole person—body and soul—as made in God's image. The Catechism confirms that "[s]exuality affects all aspects of the human person in the unity of his body and soul" (n. 2332).

As a result, "Everyone, man and woman, should acknowledge and accept his sexual identity" (n. 2333). This demand is not primarily a restriction but a call to see and live out the meaningfulness of human sexuality, which "especially concerns affectivity, the capacity to love and to procreate, and in a more general way the aptitude for forming bonds of communion with others" (n. 2332). In other words, the Church's teaching expresses a fundamental dimension of the human person: that he or she, precisely in being male or female, is thereby capable of acting in the image and likeness of God, through life-giving love in a communion of persons.7 These teachings are not meant to deny or downplay the experiences of gender dysphoria (or disorders of sex development), but they do reject any view of man and woman that separates biological sexuality from gender identity. Such separation would deny the human body/soul unity and the meaning of man and woman as complementary ways of imaging God, in and through procreative activity and love.8

We should emphasize that one particular way in which the SSM transgender policy violates the dignity of the human person is in its allowance for the induction of sterility as a result of permitted therapies. Compassionate medical care must always be rooted in the truth of who we are and intended to treat disease. Misdiagnosis and incorrect medication or procedures can be gravely harmful to the patient even when inspired by the best of intentions. The purpose of medical interventions is to restore the body to wholeness: to heal. So, for instance, it would be correct to surgically remove a cancerous

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7 Pope Francis, "Address to the Bishops of Puerto Rico" (June 8, 2015).
8 Compendium of the Social Doctrine of the Church, n. 224
portion of the body as an attempt to heal the whole. This surgery would come under the principle of double effect. Yet the interventions permitted by the SSM policy, while well intentioned, do not accomplish the end of medical care and thus the principle of double effect could not apply to them. Instead they risk permanent damage and the possibility of rendering the patient vulnerable to additional medical problems. Furthermore, by causing sterility, such procedures may prevent the person from an intimate partnership of life and love wherein a child springs from the heart of spousal giving. (CCC, n. 2364-2366)

In light of the Church's teachings, we observe that the proposed therapies do not actually transition a person from woman to man or man to woman. They merely minimize recognizable traits of one sex so that the person can imitate the other sex. Language such as “transitioning” masks this reality. Genuine loving care must always operate in the truth of God’s design. Those who consider “gender transitioning” as a possible healing path for some persons assume an anthropology that is fundamentally at odds with what the Catholic Church has taught repeatedly regarding the human person. The SSM policy seems to be informed with an anthropology and gender ideology that holds that persons can choose their own sex. Popes Francis, Benedict and St. John Paul have all warned against such ideology as being contrary to the church’s understanding of the created and given nature of the human person made in the image of God. Recently, Pope Francis in his remarks to Polish bishops at World Youth Day especially denounced the imposition of gender ideology on children and adolescents. Yet the SSM policy affirms such gender ideology by helping minors to choose their own sex by way of hormonal and surgical therapies. Gender reassignment surgeries aside, removal of ovaries or testicles, or of uterus in order to further a transition (and to protect a patient from the effects of potentially high-dose carcinogenic hormonal therapies) are already allowed by the policy and have the potential to pose problems for physician who wish to conscientiously object to such procedures.

There is also the issue of scandal. As the policy stands now, it is likely to mislead people into thinking that human sexuality is an area for self-creation and manipulation. It is likely to create confusion among doctors, healthcare personnel and patients about what the Church teaches about the human person, who has a nature created by God that must be respected and that cannot be manipulated at will.9

The policy states that it is applicable to all employees of SSM Health across the system. This raises the problem of Catholic employees being required to uphold a policy that is contrary to the Church’s teaching as it has been reaffirmed by the last three popes. Catholic employees of SSM who wish to follow the church's teaching would be put into a difficult situation. All of these things harm a Catholic Healthcare System in its mission to provide healthcare according to the healing ministry of Jesus, which is inseparable from the full truth He revealed about the human person.

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It is our understanding this this SSM policy on the care of transgender patients and treatment of gender dysphoria is the first of its kind for a Catholic health system, and yet advocates for and allows medical and surgical treatments that are not scientifically-based, that are permanent with untested long-term repercussions, and that are incompatible with longstanding Church teaching and anthropology.

In light of the medical, ethical, and moral problems with the SSM transgender care policy, we vigorously assert an imperative for the development of alternative approaches that truly reveal the healing presence of God. Importantly, rejection of hormonal and surgical interventions does not mean rejection of all assistance. Efforts to eliminate any form of disrespect, bullying, physical or verbal abuse, or other form of mistreatment in patients experiencing gender discordance, with or without dysphoria, are clearly warranted. Investigation of strategies to better integrate gender identity with daily life experiences and to alleviate feelings of isolation, mistrust, and despair are similarly laudable. Ongoing education of health care workers, family members, and society regarding the fundamental nature and purpose of human sexuality is yet another way that SSM can contribute to preservation of mutual understanding, respect, and sense of self-worth in people with gender incongruence.

While efforts continue to better understand the etiologies of gender discordance and develop appropriate psychological approaches to alleviating suffering in affected patients, SSM in the meantime is well served by remaining mindful of the fundamental medical precept of Hippocrates: "Primum non nocere", first do no harm.

Respectfully yours,

Most Reverend Robert J. Carlson, Archbishop of St. Louis
Chairman of the Board of Governors, SSM Health Cardinal Glennon Children’s Foundation

David J. Stansfield, DO
President, St. Louis Guild of the Catholic Medical Association

National Catholic Medical Association
Christian Medical and Dental Association

American College of Pediatrics