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Witness Statement by John Whitehall

R ex p. Quincy Bell & Mrs A and the Tavistock and Portman NHS Foundation Trust

Biographical information.

1. I am Professor of Paediatrics and Child Health in the School of Medicine in Western Sydney University, Australia. Before taking up this position 10 years ago I was Associate Professor in James Cook University in Townsville, Australia, and Director of the Neonatal Intensive Care Unit in that city which served North Queensland.
2. I have an undergraduate degree in Medicine and Surgery from Sydney University, a Diploma of Child Health from London, qualification as Member of the Royal College of Physicians (UK), and am a Fellow of the Royal Australasian College of Physicians. I have an undergraduate degree in Arts (essentially social and political theory) from Murdoch University, Western Australia, and a Master's Degree in Public Health and Tropical Medicine from James Cook University.
3. In 2015, I was awarded the Howard Williams Medal of the Royal Australasian College of Physicians which '*recognises a member of the Paediatrics & Child Health Division who has made an outstanding contribution to improving the health of children and young people in Australia and/or Aotearoa New Zealand*'.

Expertise.

4. As a paediatrician and a neonatologist I developed a particular interest in the physiology of the developing brain, and in the causes and effects of its disruption. As a general paediatrician, I am interested in the effects of psychological disruption and, societal causation of that disruption. Having studied and lectured in issues of public health and human rights, I am interested in broad issues of public policy and human rights law, particularly with regard to experimentation on children.
5. I have worked in many different countries, including Africa, the Middle East and Asia, and have noted the effect of public policy, including its lack. Currently, I also work in 'outback' Australia where issues of brain development complicated by psychological, psychiatric and family co-morbidities are not uncommon.
6. For many years I have been involved with diagnosis and management of child abuse, including sexual abuse and was Chairman of a major conference on that

theme in Sydney in 1979. The conference lead to the deeper involvement of training and participation by the NSW Police Force.

7. I have published on a broad range of issues relating to children, including law, neonatology, community and general paediatrics, and lecture on various aspects of paediatrics, including the development of the central nervous system.
8. Since 2016 have written and spoken regularly on childhood gender dysphoria. I have found it difficult to secure publication in medical journals of articles that reference international research on side effects of the 'affirmation' process that involves hormonal and surgical intervention on children. For that reason, and to make a broader contribution to the debate, I have published in non-medical journals such as Quadrant Magazine. These referenced articles carry the right of reply, though this has not yet been enacted
9. I contributed with regard to epidemiological, physiological, psychological and medical aspects of childhood gender dysphoria to the book '*Transgender: One Shade of Grey – the legal consequences for man & woman, school, sports, politics, democracy'* (Patrick J Byrne with guest chapters by Professor John Whitehall and Lane Anderson (a pseudonym), Wilkinson Publishing, 2018).
10. In 2019, supported by over by over 200 medical practitioners[1], I was signatory to a referenced request to the Australian Federal Minister for Health for an independent enquiry into the management of childhood gender dysphoria. as delegated by the Federal Minister. As delegated by the Federal Minister, that request has been forwarded to the Ministers of Health of each of the Australian States and Territories.
11. In February 2020, I appeared before the Queensland Parliamentary enquiry into the Health Amendments Bill (2019) which sought to criminalise practice of so-called 'conversion therapy' on minors, and in June, I rendered a submission to the recent consideration of a similar Bill by the government of the Australian Capital Territory.

Opinion on the published management of childhood gender dysphoria by the Tavistock and Portman Gender Identity Disorder Service.

12. The Tavistock and Portman Gender Identity Disorder Service (GIDS) declares one use of the analogue of Gonadotrophin Releasing Hormone (GnRH), which initially stimulates and then exhausts the release of the natural hormone from

[1] Whitehall J. The lack of scientific basis for the medical pathway of treatment of childhood gender dysphoria. Submission to the Australian Federal Minister for Health. 2019. (Attached).

the hypothalamus, is to provide a 'breathing space' in which a gender confused child may have more time to arrive at a greater understanding of their sexual identity. According to a GIDS instructional sheet, 'we can now offer treatment… to give young people time to think about their gender identity' (as well as stopping unwanted physical developments of puberty)[2]. This administration of 'Puberty blockers' is known as Stage 1 therapy in the process of 'affirmation therapy' of a confused child in a direction of gender identity incongruent with chromosomes. The term 'affirmation therapy' is better understood as 'transgender therapy'.

While one effect of the analogue (GnRHa) is to interrupt the vertical stimulation of the gonadal sex hormones and, thus, progression of puberty, it is biologically implausible to claim that doing so facilitates mature acquisition of sexual identity.

Interference with maturation of sexual identity by puberty blockers.

13. Aspects of physical sex and therefore presumably gender identity are programmed before birth under the direction of chromosomal messages. The possession of XX and XY chromosomes, is known to result in sexually dimorphic brain development: to differences in the structure of male and female brains. After a mini-puberty in the post-natal period, the sexually dimorphic brain awaits stimulation in puberty from hormones that continue aspects of brain development during the peripubertal period and activate aspects of function that were programmed prior to birth.
14. This binary genetic differentiation, based on chromosomes but ultimately reproductive function, underlies the biology of males and females. The extent of these biological differences is profound. Weizmann Institute[3] research found in 2017 that of 20,000 human protein-coding genes, around 6,500 genes with activity that was biased toward one sex or the other in at least one tissue".[4] These differentiated male/female characteristics such as body hair, body fat storage, proneness of women to heart disease and osteoporosis in later life. Gene expression in the liver in women regulates drug metabolism, providing

[2] Introductory information. Early intervention young person information sheet. GIDS page 76. Accessed 10/7/20.

[3] Moran Gershoni, Shmuel Pietrokovski, "The landscape of sex-differential transcriptome and its consequent selection in human adults", *BMC Biology* (2017) 15:7 DOI 10.1186/s12915-017-0352-z Accessed 14 December 2017.

[4] "6,500 genes expressed differently in men and women," Weizmann Institute of Science, 7 May 2017. https://weizmann.org.au/2017/05/6500-genes-expressed-differently-in-men-and-women/

molecular evidence for the known difference in drug processing between women and men.The study indicates that the biological differences between men and women are far more extensive than previously understood. It also emphasises "the need for a better understanding of the differences between men and women in the genes that cause disease or respond to treatments", the Weizmann Institute concluded.

15.

16. The exact mechanism of the timing and the physiological stimuli of the cascade that culminates in the pubertal increase in the release of GnRH from the hypothalamus are unknown. It is known that the pubertal increase in GnRH causes the release of other hormones that, in turn, induce maturation of the gonads, and their release of the secondary sex hormones, testosterone and oestrogen. It is known that GnRH is not confined to that vertical axis (hypothalamus to pituitary to gonads: HPG axis) but extends 'horizontally' to centres throughout the brain including those associated with cognition, behaviour and emotion. The changing patterns of GnRH release during the peripubertal period, therefore, has the potential to affect many aspects of brain development and function. Indeed, current research suggests that GnRH plays a role in maintaining the integrity of neurons throughout the body. 'Blocking' the role of GnRH is, therefore, greater than just 'blocking' puberty.
17. Mechanistically, it is known that receptors for GnRH exist throughout the brain, from the cortex, to the midbrain and the spinal cord. Furthermore, physical neuronal connections exist from the site of the majority of the GnRH cell bodies i.e. the site of GnRH production to such brain regions as the amygdala in the limbic system[5] which integrates cognition, emotion, memory and reward into what might be described as an inner 'world view' and the 'executive functions' for its pursuit. GnRH is also associated with centres in the mid-brain that influence sexualisation, actions that are complemented in puberty by secondary actions of gonadal sex steroids following GnRH driven activation of the HPG axis. These primary effects of GnRH on mid-brain centres have, in fact, been

[5] Hough D, Robinson JE, Bellingham M et al Peripubertal GnRH and testosterone co-treatment leads to increased familiarity preferences in male sheep. Psychoneuroendocrinology. 2019. 108:70-77

known for several decades[6][7][8][9][10][11]. Thus, GnRH has a central role in the development of puberty and associated gender identity: one that extends 'vertically' to the gonads but also 'horizontally' throughout the brain. Administration of GnRH analogues will block these effects.

18. Research in the University of Glasgow, using one of the only models for the peripubertal effects of GnRH analogues, has revealed that administration of GnRH analogues (puberty blockers) to immature sheep is associated with structural alteration of the amygdala and interference with the expression of many of its component genes.[12][13][14] These structural changes are associated with a sustained reduction in performance in spatial mazes, and greater

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[6]Pfaff DW.Luteinizing hormone-releasing factor potentiates lordosis behaviour in hypophysectomised ovariectomized female rats. Science. 1973. 182(4117):1148-1149.

[7] Pfaff D, Lewis C, Diakow C et al. Neurophysiological analysis of mating behavior responses as hormone sensitive reflexes. Prog Physiol Psychol. 1973;5:253-297

[8] Moss RL MCann SM. Induction of mating behavior in rats by luteinizing hormone releasing factor. Science. 1973;181(4095):177-179. Doi 10.1126/science.181.4095.177

[9] Maney DL, Richardson RD, Wingfield JC. Central administration of chicken gonadotropin-releasing hormone-11 enhances courtship behavior in a female sparrow. Horm Behav. 1997;32(1):11-18. Doi 10.1006/hbeh.1997.1399

[10] Riskind P, Moss RL. Midbrain Central Gray: LHRH infusion enhances lordotic behavior in estrogen-primed ovariectomized Rats. Brain Res Bull. 1979;4(2):203-205. Doi 10.1016/0361-9230(79)90282-X

[11] Bentley GE, Jensen JP, Kaur GJ et al. Rapid inhibition of female sexual behavior by gonadotropin-inhibiting hormone (GnIH). Horm Behav. 2006;49(4):550-555. Doi 10.1016/j.yhbeh.2005.12.005

[12] Nuruddin S, Bruchhage M, Ropstad E et al. Effects of peripubertal gonadotropin-releasing hormone agonist on brain development in sheep...a magnetic resonance imaging study. Psychoneuroendocrinology. 2013;38(10):1994-2002. Doi 10.1016/j.psyneuen.2013.03.009

[13] Nuruddin S, Wojniusz S, Ropstad E et al. Peri-pubertal gonadotropin-releasing hormone analog treatment affects hippocampus gene expression without changing spatial orientation in young sheep. Behav Brain Res. 2013;242(1):9-16. Doi 10.1016/j.bbr.2012.12.027 ·

[14] Nuruddin S, Krogenaes A, Brynildsrud OB et al. Peri-pubertal gonadotropin-releasing hormone agonist treatment affects sex based gene expression of amygdala in sheep. Psychoneuroendocrinology. 2013;38(12).3115-3127. Doi 10.1016/j.psyneuen.2013.09.011

emotional lability.[15][16][17][18] Their evidence has also shown that some of the noted effects are maintained after treatment with the GnRH analogues is terminated, suggestive of long-term potentially permanent change. Similar effects of GnRH analogues on memory and executive function in humans have also be demonstrated.[19][20][21].

19. Perhaps related to interruption of limbic development/maturation/function, is the significant observation that sheep receiving puberty blockers are more likely to prefer familiarity to novelty[22]. Reduction in novelty seeking by male rats on GnRH analogues has also been demonstrated[23].This type of change may reduce the initiative for progress in the maturation of gender identity, as mentioned below.
20. Thus, it is biologically implausible to maintain that the administration of 'puberty blockers' will provide time for maturation of sexual identity, in the

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[15] Evans NP, Robinson JE, Erhard HW et al. Development of psycophysiological motoric reactivity is influenced by peripubertal pharmacological inhibition of GnRH action-results of an ovine model. Psychoneuroendocrinology. 2012;37(11):1876-1884. Doi 10.1016/j.psyneuen.2012.03.020

[16] Hough D, Bellingham M, Haraldsen IRH et al., 2017 Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. Psychoneuroendocrinology. 2017;75(1):173-182. Doi 10.1016/j.psyneuen.2016.10.016

[17] Hough D, Bellingham M, Haraldsen IRH et al. A reduction in long-term spatial memory persists after discontinuation of peripubertal GnRH agonist treatment in sheep. Psychoneuroendocrinology. 2017;77(1):1–8. Doi 10.1016/j.psyneuen.2016.11.029

[18] Wojniusz S, Vogele C, Ropstad E et al. Prepubertal gonadotropin-releasing hormone analog leads to exaggerated behavioral and emotional sex differences in sheep. Hormones and Behaviour. 2011;59(1):22-27. Doi 10.1016/j.yhbeh.2010.09.010

[19] Grigorova M, Sherwin BB, Tulandi T. Effects of treatment with leuprolide acetate depot on working memory and executive functions in young premenopausal women. Psychneuroendocrinology. 2006;31(8):935-947. Doi 10.1016/j.psyneuen.2006.05.004

[20] Craig MC et al. Gonadotropin hormone releasing hormone agonists alter prefrontal function during verbal encoding in young women. Psychoneuroendocrinology. 2007;32(8-10):116-1127. Doi 10.1016/j.psyneuen.2007.09.009

[21] Nelson CJ, Lee JS, Gamboa MC et al Cognitive effects of hormone therapy in men with prostate cancer: a review. Cancer. 2008;113(5):1097-1106. Doi 10.1002/cncr.23658

[22] Hough D, Robinson JE, Bellingham M et al Peripubertal GnRH and testosterone co-treatment leads to increased familiarity prefences in male sheep. Psychoneuroendocrinology. 2019. 108:70-77

[23] Cyrenne DM, Brown G. Effects of suppressing gonadal hormones on response to novel objects in adolescent rats. Hormones and Behavior. 2011;60 (5):625-631.

absence of any additional changes. Furthermore, identity will not mature: it will be held at a neutered level of immature development. Any child treated with puberty blockers will be denied primary sexualisation of mid-brain centres, and the secondary sexualisation by hormones from the gonads. Integration of cognition, emotions, memory and reward will be reduced by the effect of blockers on the amygdala in the limbic system. A preference for the familiar due to a suppressive effect of the blockers on the limbic system is likely to favour continuation of the 'status quo' rather than new concepts of identity that are hallmarks of the pubertal transition. Maintenance of that 'status quo' is likely to be strengthened by the strictures of an adopted sexual/gender identity, including the influence of the child's authority figures who have fortified an identity contrary to chromosomes. The inability of many children to develop a mature concept of the future is also likely to be hindered by the high prevalence of associated mental co-morbidity, including autism, and the high prevalence of family disorder. It should not be forgotten that parental influence has been shown to have been fundamental to the gender confusion of some children[24].

The links between Stages 1 and 2.

21. GIDS maintains that 'Stage 1 (GnRH) and Stage 2 (cross-sex hormones) are 'distinct': the former 'as a matter of design or in practice' does not lead to the latter; the claim they are 'inextricably linked' is 'fundamentally flawed'; any correlation is due to the natural and learned selection of a 'group of young people showing persistent and consistent' gender dysphoria.[25]
22. Though 'inextricable' is too strong a term, almost all children who begin with the administration of puberty blockers (Stage 1) are reported to continue into Stage 2, the administration of cross-sex hormones.
    The linkage is physiologically and psychologically plausible. As described above, the physiological process of pubertal maturation is blocked: the integrating mechanism of the amygdala is reduced; and preference for the familiar is favoured. Psychologically, to the child's confusion (and associated mental co-morbidities), is added the weight of the participation of authority figures in the adoption of a new identity, including pronouns, name, dress, public identity, and special arrangements at school. As well, there is the psychological conflict

[24] Kosky RJ. Gender disordered children: does inpatient treatment help? MJA. 1987;146 (11): MJA.1987:146:565-569.

[25] Tavistock and Portman Trust. Summary Grounds of Resistance on behalf of defendant. At 52, 30,31 and 4(d)

of being neutered by blockers while members of the desired gender undergo the growth and sexualisation of puberty.

This psychological challenge, of keeping up with the developments of the desired gender, is being reduced by the administration of cross-sex hormones at increasingly younger ages, despite the undisputed fact that cross sex hormone treatment is associated with structural change in the recipient's brain. The 'Australian Standards of Care and Treatment Guidelines' promulgated by the Royal Children's Hospital, Melbourne, worryingly, have no age restrictions for the administration of cross sex hormones.

The uniformity of the few reports from gender clinics confirming that the large majority of children progress from Stage 1 to Stage 2 also suggests pathophysiological linkage. GIDS may well have an excellent process of selection, but gender units which may lack such prowess still report that most children progress to Stage 2.

Stage 1 therapy is 'generally considered to be physically reversible'[26].

23. While this therapy may be considered reversible by its proponents, sheep studies have revealed sustained effects on the amygdala as reported above. There is a lack of data on the minimum treatment time or age specificity for GnRH agonists to result in sustained damage on a sheep or a human child, but interruption on normal development of white matter has been demonstrated to have continued for 28 months in a natal male on blockers since almost 12 years of age. This structural change was associated with 'a decrease in their overall intellectual performance after the onset of pubertal block, pointing to immaturity in their cognitive development' and a 'slightly lower' global performance on intellectual testing 'predominantly due to the reduction in operational memory[27].

'The effects of GnRH are properly explained…to children and young persons'[28]: 'documents provided clearly set out all the risks of treatment'[29]

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[26] Ibid 34.

[27] Schneider M, Spritzer P, Soll B et al. Brain Maturation, Cognition and Voice Pattern in a Gender Dysphoria Case under Pubertal Suppression. Front. Hum. Neurosci. 2017. 11:528. doi: 10.3389/fnhum.2017.00528.

[28] Ibid in 54

[29] Ibid in 34

24. Certainly some well-known risks are enumerated in GIDS literature, including interruption to physical manifestations of puberty, and reduction bone density. And, to its credit, GIDS does mention that 'Hormone blockers could affect your memory, your concentration or the way you feel about your gender' However, there is no evidence of exploration of these latter factors and the potential long-term nature of any such effects is not intimated or explored in its printed material. Therefore, there is no way of knowing how deeply these matters are pursued or how they are made plain to an early adolescent mind, and the minds of parents and carers.
25. GIDS maintains it discusses 'how likely you are to change your mind about your gender identity' with confused children but provides no details of the sharing of relevant statistics as those contained in the Diagnostic and Scientific Manual of Mental Health which confirm that the majority of confused children develop an identity congruent with chromosomes through puberty.
26. No-where is it apparent that GIDS shares literature that would warn of significant and lasting effects of 'blockers'. As mentioned above, there are reported effects on cognition, emotion and behaviour associated with the blocking of cerebral inter-connections in growing brains but recent, international literature reveals other concerns that do not feature in explanatory literature. For example, in adult females administered 'blockers' as therapy for endometriosis, a dramatic reduction in the number of myenteric plexus neurons has been found, associated with gastro-intestinal symptomatology[30]. These, and laboratory studies suggest an overall modulatory role for GnRH on the integrity of neurons throughout the body[31][32].
27. It is quite true, as declared by GIDS, 'there could be other long-term effects of hormone blockers in early puberty that we don't yet know about that'. Indeed, many authors report the lack of data associated with so-called 'affirmation

[30] Ohlsson B. Gonadotrophin_releasing hormone and its physiological and pathophysiological roles in relation ot the structure and function of the gastro-intestinal tract. European Surgical Research. 2016:57:22-33.

[31] Prange-Kiel J, Jarry H, Schoen M et al. Gonadotropin releasing hormone regulates spine density via its regulatory role in hippocampal oestrogen synthesis. J Cell Biol. 2008;180(2):417-426. Doi 10.1083/jcb.200707043

[32] Quintanar JL, Calderón-Vallejo D, Hernández-Jasso I. Effects of GnRH on Neurite Outgrowth, Neurofilament and Spinophilin Proteins Expression in Cultured Spinal Cord Neurons of Rat Embryos. Neurochem Res. 2016;41(10):2693-2698. Doi 10.1007/s11064-016-1983-0

therapy'[33][34][35][36]. These admissions proclaim the experimental nature of its administration.

The side effects of cross sex hormones.

28. GIDS declares 'many progress' to Stage 2[37] but, as with the cerebral effects of blockers, there is little evidence of discussion of the effects of cross sex hormones on the brain, particularly the growing brain of adolescence. There is no mention, for example, of the work of Pol et al which reports the adult male brain shrinks at a rate 10 times faster than ageing after only 4 months administration of the female hormone, oestrogen. This shrinkage is presumed due to cell death[38]. On testosterone, the adult female brain has been shown to hypertrophy, presumably by stimulation of microcellular components. Nor are other studies mentioned which reveal structural effects on the brain.[39][40]

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[33] Chew D, Anderson J, Williams K et al. Hormonal Treatment in Young people with Gender Dysphoria: a systematic review. Pediatrics 2018;141(4). Doi 10.1542/peds.2017-3742

[34] Costa R, Dunsford M, Skagerburg E et al. Psychological support, puberty suppression, and psychosocial functioning in Adolescents with Gender Dysphoria. J Sex Med. 2015;12(11):2206-2214 Doi 10.1111/jsm.13034

[35] de Vries AL, McGuire JK, Steensma TD et al. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014;134(4):696-704.Doi 10.1542/peds.2013-2958

[36] Schwartz D. Listening to children imagining gender: observing the inflation of an idea. J Homosexuality. 2012;59(3):460-479. Doi 10.1080/00918369.2012.653314

[37] Ibid in 31.

[38] Hulshoff Pol HE, Cohen-Kettenis PT, Van Haren NE, et al. Changing your sex changes your brain: Influences of testosterone and estrogen on adult human brain structure. Eur J Endocrinol. 2006;155(1):S107–S111. Doi 10.1530/eje.1.02248

[39] Zubiaurre-Elorza L, Junque C, Gomez-Gil E, & Guillamon A. (2014). Effects of cross-sex hormone treatment on cortical thickness in transsexual individuals. J Sex Med, 2014;11(5):1248–1261. Doi https://doi.org/10.1111/jsm.12491

[40] Rametti G, Carrillo, B, Gomez-Gil E, Junque C, Zubiaurre-Elorza L, Segovia S., Gomez A, Karadi K, Guillamon, A. Effects of androgenisation on the white matter microstructure of female-to-male transsexuals. A diffusion tensor imaging study. Psychoneuroendocrinology, 2012;37, 1261–1269. Doi 10.1016/j.psyneuen.2011.12.019

29. In association, there is no evidence of any discussion with adolescents or their parents of the higher rate of suicide in adults who have transgendered[41][42][43]. While proponents for transgender therapy would argue such rates reflect societal lack of acceptance, associated mental disease, disappointment with the results of transgendering, and the iatrogenic effect of structural change on the brain cannot be discounted.
30. In all, GIDS literature does not appear to share with confused children and their carers the statistical assurance that almost all confused children will revert to an identity congruent with chromosomes through puberty, that 'puberty blockers' and cross sex hormones have structural effects on the brain, and the warning that the rate of suicide in adults is significantly higher after transgendering. The literature does not warn the process of hormonal and surgical 'affirmation' is experimental.

Aspects of Australian law: Summary, from a medical perspective, of how the Family Court of Australia abdicated its responsibility for impartial appraisal of the hormonal and surgical process of gender identity known as 'affirmation therapy' but more correctly called transitioning or transgender therapy

31. From the perspective of a paediatrician, I perceive a dramatic retreat from judicial responsibility for the management of dysphoric children in recent years. As the numbers of confused children presenting to the Family Court for authorisation for hormonal and surgical intervention increased, lengths of judicial deliberations decreased, certitude replaced doubt, abetted by a sustained absence of contrary opinion. Finally, the Court declared its role to be

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[41] Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A et al. Hormonal therapy and sex reassignment: a systematic review and meta-analysisof quality of life and psychosocial outcomes. Clin Endocrinol (Oxf) 2010;72(10): 214–231. Doi 10.1111/j.1365-2265.2009.03625.

[42] De Cuypere, Elaut E, Heylens G, et al. Long term follow up: psychosexual outcome of Belgian transsexuals after sex reassignment surgery. Sexologies. 2006;15:126-133.

[43] Dhejene C, Lichtenstein P, Boman M etal. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PLOS 1. 2011;6(2):e16885. Doi 10.1371/journal.pone.0016885

obstructive, appeared to have been recruited to the highly contested idea of gender fluidity, and relinquished accountability for massive hormonal and surgical interventions to small groups of medical and allied health proponents for 'affirmation' in specialised clinics.

In at least temporal association with the rapid growth of the phenomenon of childhood gender dysphoria, legislation has been tabled in certain Australian states in the effort to enforce compliance with transgendering, even to criminalise its avoidance, and the Australian Health Regulation Agency (AHPRA) has distributed for discussion a new 'Code of Conduct' whose effect would be to dissuade as 'unprofessional' public 'broadcasts' contrary to the perceived wisdom of medical authorities, which would undermine 'public trust'.

32. In *re Alex* (2004)[44] the Family Court of Australia (FCA) authorised consent for suppression of menstruation in a 13 year old natal female who identified as a male. The case was complicated by Gillick incompetence and such severe family disruption that Alex had been taken into care. Alex suffered from depression and 'perceptual disturbances' in which he 'could hear his own voice or the voice of his (dead) father' and felt that 'somebody can read my mind and the thoughts in my mind.' Nevertheless, it was decided by proponent medical therapists that Alex was of sufficient mental ability to benefit from hormonal suppression of menses, prior to initiation of 'irreversible' hormonal therapy to approximate the external appearance of a gender incongruent with chromosomes when aged 16. As much as possible, external features would be aligned with psychological feelings. The judge did 'wonder' if gender dysphoria was a 'disease or malfunction' or a variant of normal sexuality. In 2009, the FCA[45] permitted authorisation by the State (which was caring for Alex) for bilateral mastectomies, though Alex was only 16 years of age. The court minimised international advice against irreversible surgical procedures by arguing that should he change his mind 'the disadvantages would be minimal as Alex could have reconstructive breast surgery and use means other than breastfeeding to feed a baby'. Thus the functions of the human breast were reduced to cosmetic appendages.

[44] Re Alex [2004] FamCA 297

[45] Re: Alex [2009] FamCA 1292 (6 May 2009)

33. *Re Brodie* (2008)[46], concerned a 13 year old natal female adamant she was a boy. Brodie existed in such a 'tremendous state of turmoil and anger' at betrayal by an abandoning father her mother was 'nearly ready to ask the State to take responsibility'. Therapists argued puberty blockers would reduce the 'hostility and anxiety' and assured the courts their effects were 'completely reversible'. The judge congratulated Brodie for being fortunate in having therapists who 'continue to keep up with research'.
34. In *re Bernadette*[47], concerning a 17 year old natal male, the 'Dutch Protocol' appeared in Australian courts, declaring gender identity was determined by the mind not the 'genitalia or other aspects of …physical appearance or presentation'. It formalised the description of management into three stages: Stage 1 would comprise the administration of 'puberty blockers'; Stage 2, the administration of cross-sex hormones; and Stage 3, the performance of irreversible surgery to approximate the physical features of the desired gender. Social affirmation, with new names, manner of dressing etc would, most likely, accompany or precede Stage 1. The effects of Stages 2 and 3 were deemed irreversible.
35. Three features stand out in *re Bernadette.* First, the judge was not convinced transsexualism was a 'normally occurring factor of human development' and, therefore 'it was in the best interests of every child' for the court to retain authorising power. Second, for the first and last time in Family Court deliberations, concerns of 'potential damage to the brain' by puberty blockers were raised. Ironically, the judge declared he was 'satisfied' Stage I therapy was reversible despite 'the British view…that brain development continues throughout adolescence' and blockage may incur 'potential damage'. The judge was comforted by the views of Dutch professors who 'comment on the need for a study on the brains of adolescent transsexuals to endeavour to detect functional effect and difficulties.' Thus, the judge appeared satisfied that an absence of brain damage in the present would be confirmed by research to be pursued in the future. Third, the judge declared 'so far as Stage 2 is concerned I am satisfied that it would be possible to reverse that treatment'. The judge appears to have been aided in his medical optimism by the absence of any significant opinion to the contrary.

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[46] Re Brodie [2008] FamCA 334

[47] ***Re Bernadette (2010) Fam CA 94.***

36. *Re Jamie* (2011)[48] was the saga of a natal boy that continued into the Full Court. Though deemed Gillick competent to receive puberty blockers, (even at an age less than recommended internationally) 'it was difficult to ensure' *Jamie* understood 'the full and extensive ramifications of such decisions, especially in the long term'. The court declared, nevertheless, that blockers were 'safe and entirely reversible' and there was no need for its protective role.
    To the contrary, the court decided the 'nature…of Stage 2' therapy was such that its authorisation would continue to be needed for parental consent to the child's treatment unless the child demonstrated Gillick competence, in which case the court could authorise the child to consent. If incompetent, the court would decide what was in the child's 'best interests'.
    Four years later, approaching 15 years of age, Jamie was reported to be suffering because she had the appearance of a 'pre-pubescent girl…(who) does not resemble her female peers, particularly in terms of development of the breasts'. The court acquiesced to the early administration of oestrogen, contrary to international advice.
37. *Re Sam and Terry* (2013)[49] concerned a natal boy identifying as a girl, and a girl as a boy, both of whom were deemed Gillick incompetent. Sam was essentially housebound with mental disorder. Terry had Asperger's Syndrome. Stage 2 therapies were approved. A psychiatrist declared gender dysphoria does not require psychiatric treatment: 'what it requires is gender transition which is a medical and surgical process'.
    The court, however, reaffirmed its need to be the 'decision maker' with regard to advanced therapy for gender dysphoria, citing *re Jane* and the need to prevent the removal of a 'girl's clitoris for religious or quasi-cultural reasons, and of the sterilisation of a perfectly healthy girl for misguided, albeit sincere reasons'. The court appeared to have accepted the idea that surgical interventions on the reproductive systems of gender confused adolescents were 'guided'. Certainly, there was no medical opinion that suggested irrevocable surgery on genitalia to reduce psychological disturbance was 'misguided', given historical successes with individual and family psychotherapy, and the role of psychiatry.
38. In *re Cameron* (2015)[50], the judge evinced pleasure that gender identity incongruent with chromosomes was 'not now generally considered a mental

[48] Re Jamie [2015] FamCA 455

[49] Re Sam and Terry [2008] FamCA 334

[50] Re Cameron 2015] FamCA 1113

illness' (at least by proponents in the Court) and though the natal girl 'did not have full understanding' authorised Stage 2 therapy.

39. By 2016, certitude in the positive effects of hormonal therapy had become utopian. In *re Celeste*[51], concerning a natal male transitioning to female it was declared Stage 2 therapy 'would maintain…self-esteem, retain…congruence of self as a young woman and facilitate her normative psychological, social and sexual development'. Judicial credulity in such prophecies was not challenged by the prior history of Asperger's Syndrome, attention deficit/hyperactivity syndrome, language disorder which had reduced Celeste's capacity for education, and the admission, in the Court, that she 'does not understand everything that is said to her'.
40. In *Re Gabrielle*[52], concerning another natal male child identifying as female, the court found oestrogens to be necessary for the child to 'continue living happily', and that their denial 'would result in a loss of recognition and validity of her sense of self…depression and anxiety (will) increase and (she) will be at greater risk of self harm and death from suicide'. Paradoxically, it was asserted that should *Gabrielle* change her mind and wish to re-align identity with chromosomes at some future stage, despite all her previous mental co-morbidities, (and the irretrievable consequences of transgendering therapy), 'she has the thoughtfulness and creativity to be able to manage…de-transition comfortably'. The Court was deprived of any contrary opinion that would maintain that gender dysphoria, *per se*, is not associated with a higher rate of suicide, while transgendering is associated with a much higher rate of suicide than in the general population.
41. In 2016, approval for mastectomies continued. *Re Lincoln*[53] concerned a natal female who had been on blockers for 2 years and cross sex-hormones for 6 months. A medical doctor supported the procedures though declaring Lincoln to be 'not very knowledgeable about… side effects and complications', but assuring this 'did not strike me as being out of keeping with his stage of development'. The judge concluded Lincoln was competent to consent but equivocated by adding 'if I am wrong…I accept the submission of all parties that the proposed treatment is in the best interests of Lincoln'.

    Re Lincoln smoothed the pathway for surgical transgendering in children'. The judge could not understand how a child could consent for Stage 2 therapy and

[51] Re Celeste 2016] FamCA 503

[52] Re Gabriell [2016] FamCA 470

[53] Re Lincoln [2016] FamCA 267

not Stage 3, because both were 'irreversible'. And, it paved the way for earlier administration of cross sex hormones: one therapist declared 'lagging behind their peers in pubertal development' creates its own 'psychological stress' and, therefore, Stage 2 should start at a lower age than recommended internationally when the 'diagnosis is clear cut'.

It should be noted that the Australian Standards of Care and Treatment Guidelines promulgated in 2018 by the Royal Children's Hospital, Melbourne, have no strictures on age.

42. *re Darryl (2016)*[54], established another precedent. Almost uniquely in the history of deliberations of childhood gender dysphoria in the Family Court, an expert witness declared the natal female child who was prone to depression and self-harming did not possess 'the competency to consent to irreversible treatment' and 'given the grave consequences, I am not persuaded that most minors would be in the position to fully understand the implications of irreversible hormone treatment over the entire lifespan'.

    The judge, however, had a different point of view, declaring 'there can be no doubt' about Darryl's competence, adding he did 'not accept the words 'understand fully' require a child to have achieved the maximum understanding which later years may give them when their brain and personality are fully developed'. The judge appeared convinced that full development would not bring recognition that a grave error had been made in Darryl's disturbed adolescence, from which 'de-transitioning' would be very difficult.
43. 2016 ended with a call, in *re Lucas*[55], for abolition of the role of the court in gender dysphoria. Regarding a 17 year old natal girl seeking authority for testosterone, the judge declared 'an urgent need for statutory intervention…to undo the consequences of *re Jamie'*, leaving the administration of both Stage 1 and Stage 2 to the medical proponents for transgendering.
44. In November 2017, in *re Kelvin*[56], the Full Court abrogated the Family Court's gatekeeping role for Stage 2 therapy. In an earlier Court that year[57], authorisation had been extended to the then 16 year old natal female who identified as male to receive Stage 2, cross sex hormone therapy. Consideration of the need for such authorisation for all Gillick competent minors, absent controversy, was referred to the Full Court.

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[54] Re Darryl 2016] FamCA 720

[55] Re Lucas [2018] FamCA 161

[56] Re Kelvin 2017] FamCAFC258

[57] Re Kelvin (2017) FamCA 78

In the lower Court it had been reported that Kelvin had come from a broken home and was estranged from his mother. When 9, he had 'discovered the concept of transgender in a book and immediately identified with it'. Social transgendering had emerged by 13 years, complicated with 'anxiety and depression' and interruption with 'schooling'. A psychiatrist opined Stage 2 therapy would 'further align (his) physical gender characteristics with his inner gender identity' promoting 'a healthy and integrated identity, positive self-concept', which would evolve into a 'healthy and well adjusted adult'. That more than twelve months of psychotherapy had resulted in a 'noticeable difference' in his temperament in which 'despite brief moments of dysphoria (his) underlying attitude and confidence has improved', were attributed to his transgendering identification rather than any general maturation. Administration of testosterone was encouraged.

The Full Court considered the precedent of Marion's case in which, in 1992[58], parents had appealed to the High Court for authority to provide consent for sterilisation of their 14 year old mentally retarded daughter in order to relieve stresses associated with menstruation and unwanted pregnancy. The Court ruled authorisation would not be provided for medical intervention upon children which was non-therapeutic, irreversible, invasive, associated with a significant risk of the wrong decision being made and where the consequences of such a decision were grave.

'Non-therapeutic' treatment was defined as 'inappropriate or disproportionate having regard to cosmetic deformity, pathological condition or psychological disorder for which the treatment is administered and of treatment which is administered chiefly for other purposes'.

The Full Court accepted the premise that gender dysphoria was, indeed, a disease for which Stage 2 therapy was 'therapeutic' and, therefore, there was no need for its authorisation by the Family Court as decided in 2013 in Re Jamie The Court claimed it was 'readily apparent the judicial understanding of Gender Dysphoria and its treatment have fallen behind the advances in medical science'.

An example of such new 'medical science' was proffered to the Court from 'the experience of the gender service of the Royal Children's Hospital, (Melbourne 2003-2017)…that 96% of patients continue…to identify as transgender into late adolescence and so one sees some evidence there about persistence of gender dysphoria'.

[58] re Marion (No 2) [1992] FamCA 87

The Court's acceptance of such 'science' was unopposed. Despite there being 5 intervening parties, none addressed the accumulation of evidence in those same years of the physiological role of GnRH and the side effects of its blocking, of cerebral effects of cross-sex hormones, of the continued absence of evidence that gender dysphoria *per se* was associated with suicide, of the growing numbers of transgendered adults who did suicide, of the growing evidence for association of gender dysphoria with co-morbid individual and family stresses, and the growing physical and legal phenomenon of de-transitioning.

With regard to the 'science', no one emphasised the need for therapeutic controls, independent evaluation, blinded administration, biological plausibility, and absence of contrary effects in animal models. No one mentioned psychological obstacles to leaving 'The Protocol', including the pressures of authority and custom, and loss of celebrity. Sheep studies would provide biological understanding of resistance to change.

The Full Court declared 'in no case has contradictory evidence been forthcoming…to challenge the desirability of the relevant treatment', apparently without wondering how such contradiction might appear without invitation.

45. In March 2018, in *re Mathew*[59], concerning a 16 year old natal female seeking approval for bilateral mastectomy, the judge made a declaration that 'where the subject child has been diagnosed as suffering from Gender Dysphoria, where treating practitioners have agreed that the subject child is Gillick competent, where it is agreed that the proposed treatment is therapeutic and where there is no controversy, no application to the Family Court is necessary before Stage 3 treatment for Gender Dysphoria can proceed'. The judge defined such Stage 3 treatment to include, but not be limited to, chest reconstructive surgery, phalloplasty, hysterectomy, salpingectomy, creation of a neo-vagina and vaginoplasty.

Though International guidelines suggest irreversible surgery be delayed until the adolescent reaches 18 years of age, mastectomies are approved and past history of the Family Court is characterised by a flexible interpretation of Guidelines.

45. In May, 2020, *re Imogen* concerned an allegedly Gillick competent 16 year old natal male identifying as a female who wished 'to move to stage 2 gender affirming hormonal therapy with the support of her doctors and her father' but in opposition to the wishes of her mother who sought and received permission

[59] Re Mathew [2018] FamCA 161

to engage further medical advice regarding her daughter. A third group, supported by 'a number of women's organisations in Australia' sought permission to intervene in the proceedings: to raise 'concerns in relation to the current orthodox medical treatment of children' with gender dysphoria. These concerns would include 'the impact of aggressive transactivism on organisations established to protect human rights', the 'many developments that raise questions about the merits of gender affirming in all cases', the capacity of a minor to consent to 'medical and surgical interventions such as puberty blockers, cross-sex hormones and sex re-assignment surgeries', and the need to 'revisit the notion of the "mature minor" as promulgated 35 years ago' in the Gillick case[60].

The group questioned the decision of the Full Court regarding Kelvin, declaring it 'was a stated case and not a defended case and therefore the court should not be guided entirely by that case which was based on limited and largely untested medical evidence'.

The judge rejected the application of the third group to appear in court but, in the Introduction to his summary did state 'questions in this case...may be whether a court order is necessary for Imogen to have gender affirming therapy. This potentially could involve a reconsideration of whether or not Stage 2 treatment (and possibly Stage 1 treatment) is non-therapeutic'.

Discussion.

46. In only 16 years, the Family Court of Australia moved from rejection of authorisation for surgical sterilisation of a mentally impaired girl because of stresses of menses and wanted pregnancy, to abrogation of responsibility for even greater hormonal and surgical intervention for gender dysphoria. Accordingly, the Family Court overlooked past successes with individual and family psychotherapy, accepted assurances of safety without reference to contrary international research, and was persuaded by claims of 'science' that were not founded on usual standards. In this way, the Family Court relinquished medical practice to experimentation.

How can this have occurred? The answer must lie in the lack of contrary opinion brought before the court. How the courts could have permitted such lack is unknown. Even when contrary written opinion[61] was brought before the court,

[60] Gillick v West Norfolk and Wisbech Area Health Authority [1985] UKHL 7; [1986] AC 112

[61] Whitehall J. 'The Family Court must protect gender-dysphoric children'Quadrant, November 2017.

as in *re Rae* (2017)[62] , proponents for transgendering dismissed the arguments: they were not contained in a 'peer reviewed' journal, represented mere 'personal opinion' (though comprised of references to international research published in 'peer reviewed' journals), gave unwarranted prominence to animal studies, and wrongly ascribed as 'side effect' the impact of cross-sex hormones on the human brain which is 'an expected part of the physical, psychological and emotional changes'. Rapid shrinkage of the adult male brain on oestrogen, revealed by Pol et al, was a 'not surprising' documentation of 'subtle brain changes'. Though similar contrary information[63] was admitted, a week later, into the Full Court in *Re Kelvin*, its contents were not acknowledged.

47. Medico-legally, in Australia, the High Court decision in *Rogers vs Whitaker*[64] conveys the obligation of a practitioner to warn a patient of 'real and foreseeable risks', even those with as little as one in fourteen thousand chance of occurrence, if such disclosure might deter the administration of that therapy. There is no indication that gender clinics in Australia or the UK share all the reported information of side effects of transgendering therapy even though contained in 'peer reviewed literature'. The propensity for medico-legal challenge is, therefore, high.
48. Such medico-legal challenges have occurred in Australia. In 2004, *re Finch vs Southern Health* concerned a young man who had undergone sex change surgery in the Monash Medical Centre when 21 years old. Subsequently, he became filled with regret and alleged an underlying psychological condition had not been diagnosed by that hospital and that he had been inappropriately treated[65]. The Melbourne Age reported 'Australia's only sex-change clinic has been temporarily shut down and its controversial director forced to quit amid growing claims that patients with psychiatric problems have been wrongly diagnosed as transsexuals and encouraged to have radical gender reassignment surgery. The *Sunday Age* reported at least eight former patients of the Gender Dysphoria Clinic at Melbourne's Monash Medical Centre believe they may have been misdiagnosed: 'Some have tried to commit suicide while struggling to live as the opposite sex after the irreversible operations'. At least three similar challenges by de-transitioners are believed current in Australia, but details are not public.

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[62] Re Rae [2017] FamCA 958

[63] Whitehall J. 'Childhood Gender Dysphoria and the Law' Quadrant. May 2017.

[64] Re Rogers v. Whitaker [1992] HCA 58; (1992) 175 CLR 479

[65] Re Finch v Southern Health & Ors [2004] VCC 44 (12 November 2004)

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Finally, despite the short march of hormonal and surgical treatment of children with gender dysphoria through the Family Court of Australia, the most recent judgement in Re Imogen raises hopes that reconsideration of the non-therapeutic role of Stages 1 and 2 might be revisited. Surely, developments in understanding of physiology, epidemiology and medico-legal inevitability will prevail and the massive interventions of hormones and surgery will retire into history as did eugenics and frontal lobotomies, to be replaced by compassionate individual and family therapy, with full support of mental and family co-morbidities.

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