The Hon Greg Hunt MP
Minister for Health
Parliament House
CANBERRA ACT 2600
Via Email: Minister.Hunt@health.gov.au
9/3/2020

Dear Minister Hunt

Re: Inquiry into care and treatment of children and adolescents experiencing gender dysphoria.

I write in response to the reply dated March 5, 2020, you will have received from Associate Professor Mark Lane, representing the Royal Australasian College of Physicians, regarding your request, dated August 16, 2019, for the College's advice on the treatment of gender dysphoria in children. On September 4, 2019, you received a detailed submission entitled 'Request for a parliamentary inquiry into the Social and Medical Transitioning of Children with Gender Dysphoria' which contained 82 references to relevant literature, and was supported by over 200 signatures of concerned medical practitioners. Whether you referred that submission to the College is unknown but by its spirited objection to public inquiry, one presumes the authors of the College reply were aware of its content.

The College was an inappropriate organisation to assess 'affirmation therapy'

I am disappointed in the reply from the College of which I am a member, though such a reply was not unexpected. The College is essentially a fraternity of like-minded doctors committed to achieve and maintain educational standards. It is not known for consideration of ethical or practical behaviours of its members. One of its strengths of this small organisation, but also its weaknesses, is its collegiality: members are reluctant to caste judgement on each other (at least in public) and on the activities of its specialised factions. There is an appropriate humility in the face of the complexity of modern day medicine, with members reluctant to provide opinion on matters beyond their particular experience. Few have the time to become familiar with

the intricacies of other specialities, let alone ideologies that might have influenced their development.

Of relevance to this discussion is the recent ideology of gender fluidity which maintains, without biophysical evidence, that there is no binary division of humanity into males and females according to chromosomes. Gender is fluid, depending on the mind.

This ideology appears to underpin the practice of a minority in the profession committed to the attempt to align the anatomy of a child with mental perception of gender. There is no biological basis for this ideology: given it is based on inner feelings associated with social promotion, fortified by adoption of external characteristics of the opposite sex, it exemplifies a social construct. Traditionally, practitioners have sought to lead the mind in the direction of physical reality. In other words, not to fortify a social construct with medications and surgery.

Apparently the College invited certain of its members to provide opinion on the management of gender dysphoria by a few. Certainly, the College did not seek the opinion of all members. In those approached, I understand there was widespread acceptance of the lack of evidence regarding management of this recent, burgeoning phenomenon and, therefore, deferment to the opinion of the tiny fraction of the College that is involved in its management.

As a result, in its reply, the College of Physicians, whether inadvertently or not, has permitted its imprimatur to be claimed by one side of a highly controversial debate: that of recent hormonal and surgical ‘affirmation’ of matter to mind, rather than that of historic psychotherapeutic affirmation of mind to matter.

The imprecision of the College reply has permitted this outcome. While replete with ‘motherhood’ commitment to ‘expert clinical care that is non-judgemental, supportive, and welcoming’, it lacks content regarding the main issue, merely pointing to ‘Guidelines’ authored by proponents for ‘affirmation’, and the need for their adoption. There was nothing to suggest the authors of the reply had actually read the Guidelines. If they had, by inference at least, the authors lent the unqualified support of all the members of RACP to hormonal and surgical intervention on confused children.

Certainly, supporters for hormonal and surgical intervention took the College's reply as confirmation of their management. The Chief Executive Officer and the Chairman of the Royal Children's Hospital, Melbourne (RCHM) were quick to 'applaud the College's stance in validating the work' of its gender service, which is at the forefront of 'affirmation' therapy in this country, and wrote the Guidelines.

Such imprecision on such a serious matter raises the question as to whether its authors had actually done their 'homework'? Were they unaware of considered and referenced objections to 'affirmative care'? Were they unaware of historical, successful alternatives? Were they forwarded the original submission to the Minister for Health? Either way, after six months' deliberation, their superficial contribution defers to the practice of a small group of its members, confirming the evaluation by the College of this topic of national importance should, at least, not be considered authoritative.

The College appears to support 'unregulated experimentation' on children.

The College acknowledges that 'existing evidence on health and outcomes of clinical care is limited' because of the 'small number of studies, the small sizes of study populations, and the absence of long-term follow up' but concludes reaching the 'gold standard' of research design of the National Health and Medical Council (NHMRC) 'may not be feasible'. Nevertheless, the College calls for the Federal government to fund 'research on the long-term outcomes', essentially, as they come to light under the administration of hormones and the scalpel.

This is an extraordinary admission by the College that the aims of 'affirmation' therapy are conjecture, that is to say, wishful thinking. It is relevant that Dr Heneghan, Professor of Evidence-Based Medicine at Oxford, declared the similar practice of 'affirmation' at the UK's Tavistock Gender Clinic, to be 'unregulated experimentation' on children[1].

The extent of deviation of the research design for measuring outcomes of 'affirmation' from the standards of NHMRC should be examined more

closely with reference to the NHMRC text[2]. This is important because the College appears satisfied with its limitations and, at least by default, will mandate its operation.

The basic principle in the NHMRC text is that research should be performed in the 'best interests' of the participant and community. And, pursuit of these 'best interests' should have foundation of substance, not merely 'best wishes'.

There is no reasonable foundation for the assumption 'affirmation therapy' holds 'potential benefit'. The RACP, itself, admits 'gender dysphoria is an emerging area of healthcare' in which 'evidence…is limited'. International concurs that 'long term outcome' is unknown.

Another research principle is that 'the likely benefit…must justify any risks of harm': intervention must be proportionate to need. Given most confused children will orientate without 'affirmation' to a gender congruent to chromosomes, the consequences of intervention (including castration) are disproportionate.

Risks of harm also apply to 'the wider community'. Publicity of validation by RACP of Guidelines for 'affirmation' may increase the prevalence of gender confusion, especially if the RACP condemnation of scientific debate is accepted.

NHMRC declares there should be 'no reason to believe that… participation is contrary to…the child or young persons' best interests. The natural congruence of mind with chromosomes through puberty, the increasing numbers of 'de-transitioners', the established higher risk of suicide in transgendered adults, and the presence of lasting side-effects due to hormones and surgery, are cogent reasons to question whether 'affirmation' constitutes 'best interest'.

NHMRC insists on proper design, but this is not apparent in 'affirmation' research as revealed in the RHCM study protocol, called Trans20[3]. The RHCM programme has no 'control arm' in which children do not receive hormonal and surgical intervention. Outcome is 'un-blinded', permitting a major 'conflict of interest' in which the project is assessed by those responsible for its design and implementation, raising the question of 'observer bias'.

NHMRC insists research be ‘based on a thorough study of current literature, as well as previous studies’ on which would be based ‘research merit and integrity’ and from which would arise a fundamental responsibility to ‘clarify’ risks. Failure of Guidelines for ‘affirmation’ to acknowledge prior success of the alternate form of therapy, psychotherapy, (which could have been set up as an experimental control), and failure to acknowledge side effects publicised in international literature, suggest insufficient preparation.

NHMRC evinces particular concern about the ‘capacity’ of ‘children and young people’ to ‘understand what the research entails’ and, therefore, provide informed consent. It also is concerned about ‘possible coercion by parents, peers, researchers’ and others. The capacity of children to give informed consent, and the possibility of deleterious parental influence will be considered below.

NHMRC insists researchers ‘specify how they will judge’ the capacity for informed consent by children, ‘describe the form of proposed discussions’ and ‘demonstrate’ that such requirements have been met. There is no evidence in the Trans 20 study of RHCM of compliance with these requirements. It would be at least interesting to learn how proponents for ‘affirmation’ separate the symptom of gender dysphoria from the plethora of associated mental co-morbidities, the influence of parents, friends and social media, as well as family upheaval, and judge it worthy of hormonal and surgical attention, including castration.

The College used an inappropriate analogy.

For the sake of this reply, the process of ‘affirmation’ should be recalled. It comprises social affirmation, the administration of puberty blockers, followed by cross sex hormones and, possibly, surgical intervention to mimic the external features of the chosen gender, under a life time of medical supervision. Castration is inherent.

The College defends ‘affirmative’ management by likening it to that of ‘rare cancers’ in which the control arm of ‘no treatment’ is unacceptable and the opinion of ‘experts’ is justified.

The application of this analogy to the ‘affirmative’ management of gender dysphoria is, however, inappropriate. No one is suggesting ‘no treatment’ be offered to gender confused children. These children are

vulnerable and have been shown, in many papers from around the world, to be suffering from a range of mental co-morbidities as well as social disruption that demand help. Indeed, Autism Spectrum Disorder has been reported in as many as 20%. 'Withholding or limiting access to care and treatment' would indeed, as the College declares, be 'unethical' with 'serious impacts'.

The RACP authors appear unaware of the existence of an historic alternative to hormonal and surgical intervention: individual and family psychotherapy that was practiced effectively before the recent employment of puberty blockers and cross sex hormones.

Hormonal and surgical 'affirmation' for childhood gender is entirely new: not a continuum of prior experience. Therein, resides another objection to the analogy of 'rare cancers' whose management is based on lengthy experience with other cancers, scientific evaluations of various chemotherapies and their side effects, and the outcomes of surgical intervention.

Finally, spontaneous recovery is unexpected in cancers, but predicted in children confused over gender. International literature assures that, through puberty, the large majority of gender confused children will orientate to an identity congruent with their chromosomes. All that may be needed can be summarised as 'watchful, supportive, waiting' with appropriate treatment of co-morbid mental disorder in the child and or the parents, and practical help with family disruption, as detailed in my letter to you on September 4, 2020.

The College appears unaware of relevant literature.

The RACP reply gives the impression its authors have not been informed of the literature supporting psychotherapy, leading them to the presumption that hormonal therapy is the only option.

The authors can hardly be blamed for ignorance of psychotherapy if they had relied for information on various Guidelines and from other social proponents for hormones. Indeed, psychotherapy has become the subject of parliamentary campaigns for its legislative banning. It is condemned as 'Conversion Therapy', according to the claim it is unethical to 'convert' a child from a new, assumed gender identity back to one congruent with its natal sex.

As introduction, the College authors should examine the report in the Medical Journal of Australia in 1985 by the then Chief Child and Adolescent Psychiatrist of Western Australia, Dr Robert Kosky. The report is important because it recounts experience with 8 children who presented to the children's hospital in Perth over the 5 years from 1975 to 1979 and, therefore, is instructional for at least two reasons.

First, the gender confusion in the children was not found to represent discord between their feelings and chromosomes, but a psychological disturbance in their mothers that inspired a symbiotic relationship of pathology with their children. Psychotherapy was found successful. No-one received hormones.

Second, the report reveals the scarcity of gender dysphoria in those days, compared to the current epidemic. The children's hospital in Perth now receives 2-3 consultations every week and the children's gender service in Victoria is reported to be deal with 200 new patients every year. We are not dealing with 'rare cancers'.

The College appears unaware of limitations of explanations otherwise necessary for informed consent.

The College declares (and NHMRC insists) on the need for 'informed discussions about the limitations of available evidence…in a way each child or adolescent can understand'. Leaving aside the question if any child is old enough to make a mature decision regarding such massive intervention (including castration), the authors seem unaware that information extended by various gender clinics is incomplete, if not misleading. Some of these deficiencies need to be emphasised lest the Ministry, itself, be misled.

- The administration of puberty blockers is consistently avowed to be 'safe and reversible', when veterinary and human research would disavow such claims.
- Though proponents of 'affirmation' therapy discuss metabolic complications of cross sex hormones, no mention appears of their effect on the brain. One study has reported a rate of brain shrinkage in transgendering natal males on oestrogen to be ten times faster than ageing, after only 4 weeks of administration. The shrinkage is presumed due to cell death. The Minister should be

reminded that cross sex hormones may be administered during the period of great adolescent brain growth, and then continued for life. The final effect on the brain is unknown.

- As well as the sex hormones, puberty blockers have also been revealed to incur structural change in the developing brain with associated cognitive change. And, veterinary research has revealed structural change and molecular dysfunction in the limbic system of sheep.
- Proponents for surgical affirmation declare mastectomies to be 'reversible' as if the human breast can be reduced to cosmetic appendages replaceable with silicon sacs.
- There is little evidence that full information is presented to a young person regarding the outcome of genital surgery, because the responsible clinics and their associated surgeons have publicised no list that includes, for example, incontinence and reduced sexual function and sensation. Castration is euphemised by the term 'reduced reproductive capacity' though acknowledged by the practice of preserving biopsies of gonadal tissue. There appears to be no realistic explanation of the difficulties of IVF therapy, nor of the risk of abnormalities in its offspring.
- While the proponents for 'affirmation' therapy claim it will prevent self harm and suicide, they do not inform that there is no evidence that gender dysphoria, *per se*, is associated with an increased risk of suicide. Nor is mentioned the increased emotional lability of sheep on puberty blockers, the provocation of psychiatric symptoms in women on blockers for endometriosis, the increased rate of suicide attempts and subsequent hospital admissions of young people on blockers, and the twenty times risk of successful suicide in transgendered adults.

The College appears unaware of biological implausibility.

Despite pointing favourably to 'affirmative' Guidelines, the College seems unaware of the biological implausibility of claims that administration of puberty blockers provide more time for a young person to attain mature understanding of gender identity and procreative future. The College authors appear unaware of the role of

the blocked hormone, Gonadotropin Releasing Hormone (GnRH), in the stimulation of midbrain centres that facilitate development of sexualisation. Also, they appear unaware of the strongly suggested role of GnRH in maturation and maintenance of neuronal integrity throughout the body, and its proven role in the limbic system which integrates cognition, memory, emotion, reward etc into an inner 'world view' of identity. Furthermore, the authors appear to minimise the orientating effect of natural sex hormones released to activate, during puberty, neuronal organisation laid down in the first weeks of foetal life to instil sexualisation.

Without the orientating effects of natural hormones and a functioning limbic system, how can a child be expected to arrive at a mature conclusion of gender identity and reproductive future? And, how much harder is orientation for the vulnerable child under the sustained pressure of authority figures fortifying an identity incongruent with chromosomes?

The College appears unaware of the value of open scientific discussion.

The College advises against a parliamentary enquiry into 'affirmation therapy' declaring it 'would not increase the scientific evidence'. But the issue is not about increasing that evidence, it is about making extant evidence known, and subjecting it to disinterested scientific appraisal.

The College argues, reasonably, that public discussion may 'further harm vulnerable patients and their families through increased media and public discussion'. That patients may become upset upon realisation that inflicted therapy has been experimental is the basis of resentment by the growing number of 'de-transitioners', two of whom are in the process of litigation against the Tavistock Centre in England, and one of whom has already pursued litigation in 2004 in the County Court Victoria against the gender dysphoric clinic at Melbourne's Monash Medical Centre. At very least, the Federal government should be interested in the possibility of widespread litigation by 'de-transitioners'.

The risk of resentment, however, does not validate suppression of sensitive scientific review of earlier management. Would it have been wrong to have continued with frontal lobotomies because earlier recipients were resentful, or to have suppressed debate over thalidomide?

As professed by the College, a primary responsibility is avoidance of harm. The College should consider the hundreds of children being brought, annually, to 'affirmative' gender clinics. They and their families will not be helped by silencing debate about known side effects in an unknown future. Perhaps parliamentary debate might add balance to the current promotion of 'affirmation' and foster 'informed consent'.

Secondarily, discussion may permit some children to withdraw from 'affirmative' therapy before irreparable damage is incurred. The phenomenon of 'plasticity' in which the brain may repair damage should encourage. And gonads do not surrender easily.

The College will collude in the reduction of free speech, and the mandatory referral of all gender confused children to centres that practice 'affirmation'.

One further consequence of the reply from the RACP is that it will complement the current political attempt by governments of various Australian states to outlaw so-called 'conversion therapy'. That the College declares 'withholding care' is 'unethical', and that it appears to equate psychotherapy with 'no treatment', will lead to the conclusion that the College only validates the 'affirmative' treatment outlined in Guidelines: in other words, that 'affirmation' represents the 'majority opinion'.

To be held to represent 'majority opinion' has serious consequences. It should be recalled that, last year, the Australian Health Practitioners' Agency invited discussion on a revised Code of Conduct for its members, and that one of its main points declared a practitioner to be 'unprofessional' if practicing contrary to 'majority opinion' and, thereby, bringing 'the profession into disrepute by undermining community trust'.

'Public broadcasts' 'contrary to 'majority opinion' that caused a member of the public to feel 'culturally unsafe' would also be deemed 'unprofessional', invoking the concept of de-registration.

Thus dissent may be silenced, and dissenters punished, by collusion between governments, AHPRA and RACP. Only 'affirmation' will be free.

Conclusion: the Minister for Health should disregard this advice by RACP and pursue an independent inquiry into the management of childhood gender dysphoria.

The reply from the College is both disappointing and dangerous. It disappoints by its rejection of scientific evidence and debate. It is dangerous because its 'majority opinion' may help mandate intrusive, unnecessary hormonal and surgical therapy, while silencing scientific discussion with the intimidation of de-registration. The Minister is requested to proceed with independent, disinterested inquiry into the scientific basis for 'affirmative' therapy. This inquiry should be rational, not emotional: based on mathematical, anatomical, physiological and pathological principles rather than wishful thinking.

[1]Heneghan C. as quoted Daily Mail Australia . April 8. 2019.

[2] Australian Government, the National Health and Medical Research Council, and the Australian Research Council 'The National Statement on Ethical Conduct in Human Research 2018', https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018. Accessed 11/3/2020.

[3] Tollit MA, Pace CC, Telfer M et al. What are the health outcomes of trans and gender diverse young people in Australia" Study protocol for the Trans20 longitudinal cohort study. BMJ Open. 2019;9:e032151 doi:10.1136/bmjopen-2019-032151.