**Principles and principalities of childhood gender dysphoria.**

The horrors of ‘medicine’ practiced by doctors under the Nazi regime provoked the development of a code describing the rights of participants and the responsibilities of investigators involved in experimental procedures. Released in 1947, after criminal proceedings against various Nazi experimenters, the list of rights and responsibilities became known as the ‘Nuremburg Code’ and went on to be fundamental to such current documents as ‘The International Ethical Guidelines for Biomedical Research Involving Human Subjects’ by the World Health Organisation.

In fact, the Nuremberg Code had been preceded by ethical Guidelines which had been promulgated in Germany in 1931, before the country succumbed to dictatorial rule. Those Guidelines are informative for at least two reasons. The most important is the demonstration that ethical practice may be over-ruled by the ideology of the state. Another reason is the use of the term ‘innovative therapy’ to describe the kind of medical experimentation that warranted application of the Guidelines. The term permits, if not implies, that despite all the underlying best will in the world there needs to be restriction on the administration of unproven therapy which, therefore, must be defined as experimental.

According to Oxford Dictionaries, synonyms for ‘innovative’ include ‘unprecedented, state of the art, modernistic, trendsetting, and revolutionary’. No-where is the term used for medical therapy based solidly on the scientific method. ‘Innovative therapy’ is thus a good euphemism for the current phenomenon of the medical of management of childhood gender dysphoria: the ‘trend setting’ pathway which progresses through stages of social affirmation, chemical blocking of puberty, administration of cross-sex hormones and possibly to surgical procedures which attempt to remove natural manifestations of gender and construct ersatz features of the opposite sex, under a life time of medical supervision.

Several medical issues need to be emphasised before considering the ethics of the ‘innovative therapy’. The first is that CGD is, itself, a recent phenomenon. Childhood confusion over gender used be rare: in questioning 28 of my colleagues with a combined experience of 931 years, only 12 cases could be recalled. Ten of these had occurred in children with severe associated mental disease, two were associated with sexual abuse. Now, hundreds of children are being presented to special gender clinics each year in Australia.

Proponents argue the problem was denied in the past. My reply is that in over 50 years of paediatrics, I was privy to all kinds of concerns by parents over the sexual behaviour of their children but, no one, ever, declared their child ‘had been born in to the wrong body’. I believe this CGD to be a psychological epidemic fanned by a non-critical media and various school ‘educational programmes’, and given direction by various websites on ubiquitous devices. Proponents have sought extensively for a biological basis but none has been found. The phenomenon is similar to that of anorexia nervosa and its distorted perception of body image, made worse by media propagation of the idea that thinner is better.

Theologically, CGD appears to be a manifestation of the new ideology of gender fluidity which is spreading through the Western World. In this, the mind is superior to a faulted body. But this concept is not new. It is the basis of ancient Gnosticism.

The second is that there is epidemiological evidence that the great majority of dysphoric children will revert to identification with their gender of birth through puberty with heterosexual orientation. Of the remainder, most will revert to revert to natal gender but with homosexual orientation. That life as a homosexual appeared less complicated than that of medicalised transgenderism, was basic to the recent sacking of the director and the closing of the major transgender unit in Toronto. Such is the power of the lobby.

The third is that there remains a huge association of gender dysphoria with co-morbid mental disorder. Some reports reveal three quarters of dysphoric children to have been diagnosed with concurrent mental disease, some so badly they had needed hospitalisation. Proponents of gender fluidity blame societal failure of acceptance but other reports reveal many of the afflicted children ‘had their first contact with psychiatric services due to reasons other than gender identity issues’. Antecedent autism spectrum disorder has been reported in up to 20% of cases.

There is no evidence that the medical pathway of management, per se, makes these children any happier: there is no evidence it reduces the rate of self-harm and suicide. Conversely, there is epidemiological evidence the suicide rate in adults who have undergone transgender surgery is over 20 times higher than in the ordinary population of even the most accepting countries.

Fourthly, there is no evidence that the ‘modernistic’ blocking of the effect of Gonadotropin Releasing Hormone (GnRH) on the pituitary gland (so called puberty blocking) is ‘safe and entirely reversible’ as proclaimed by proponents. To the contrary, sustained damage to the limbic system of sheep has been demonstrated in scientific studies, leaving the animal with reduced memory and increased emotional lability. In adult humans, reduced cognitive function has been found but, admittedly, the effect has been difficult to differentiate from confounding effects of other drugs and the causative illness. Moreover, women receiving GnRH agonists to reduce the stimulating effect of oestrogen in endometriosis have been reported to suffer from an increased rate of gastro-intestinal disease, associated with a 50% reduction in neurons in the myenteric plexus. This clinical and other laboratory studies raise the concept that GnRH has a widespread role in neuronal modulation and integrity.

GnRH appears to have a particular role in the process of sexualisation. Its producing neurons began their foetal life in the developing nasal placode from where they migrated to reside in an arc from the hypothalamus to beyond the limbic system. There are not many of them but their dendrites are festooned with spines denoting widespread connectivity with neurons throughout the brain, far from the specific connection from the hypothalamus to the pituitary. Indeed, there are receptors for GnRH throughout the brain, suggesting a fundamental role in general socio-sexual development, activation of sexual identity and facilitation of sexual function, enmeshed with cortical, emotional, memory and executive function. This general effect is over and above the specific effect of stimulating gonadotrophins to stimulate the maturation of the testes or ovaries with their associated production of sex hormones. All of these sexualising functions can be expected to be reduced by the administration of blockers.

Thus, it is illogical for proponents to claim that puberty blockers should be administered from the onset of the early manifestations of puberty in children confused over their gender in order to provide more time for cogitation of future identity and reproduction. According to Family Court records, one child began blockers at 10 ½ years of age. Even if a child of that age could approach such issues with any sense of maturity, how can a valid conclusion be reached once the orientating effects of all the hormones are neutered with blockers? Meanwhile, the confused child is exposed to the re-orientating pressure of all its authority figures from parents (usually only one), school teachers, psychologists, social workers, gender paediatricians and, perhaps most powerful of all, to the transgender websites. It is no accident that no children have yet been reported to have begun blocker ‘therapy’ and not progressed to the next stage, the receipt of cross sex hormones.

Fifthly, whereas proponents list metabolic side effects of cross sex hormones, there are but few references to scientific reports that reveal these hormones affect the brain. After only four months on oestrogen, the brains of adult men have been found to shrink at a rate 10 times that of ageing. Apoptosis of grey matter is considered the cause. Conversely, parts of the brains of natal females hypertrophy on testosterone.

One long term effect of the administration of cross sex hormones is euphemistically called ‘reduced reproductive capacity’ which is, in fact, chemical castration. ‘Futuristically’, fertility may by assured by deep freezing of sperm or ova from biopsied organs.

Sixth, whereas international recommendations would reserve the use of cross sex hormones until the age of 16, and irreversible surgery until 18, recent Australian Guidelines mention no ages, permitting the medical pathway to increasingly younger children. For proponents, this is logical; if puberty is blocked in a child from its earliest stages, peers will be growing taller and developing secondary sexual characteristics. Therefore, if the child and its authorities are committed to gender change, it is surely kinder to ‘get on with it’.

Under the sophistry that the results of bilateral mastectomy are not irreversible, as if breast feeding is irrelevant and all that matters is size, in Australia, mastectomies have been approved by the Family Court and performed on two girls aged 15, one 16 and two 17. Since the Court abrogated its responsibility in November 2017, the numbers of natal girls undergoing the ‘reversible procedure’ of ‘top surgery’ are unlikely to be made public. There is no data regarding ‘bottom surgery’ in Australia.

There are many declarations in main stream, peer reviewed medical journals regarding the lack of evidence to support the massive intervention into the mind and body of children that comprises the medical pathway of management of childhood gender dysphoria. There is abundant evidence that ‘watchful, compassionate waiting’ will be rewarded by orientation to natal gender through puberty.

Therefore, the medical pathway must be defined as experimental, which brings us back to the Nuremberg Code and consideration of its principles.

The first principle of the Code is ‘informed consent’. How can a child be truly informed when its authority figures continue to ‘affirm’ another gender? How can its brain by affirmed of sexual identity when its natural pathways are blocked?

The second principle maintains results are ‘unprocurable’ by other means. Why institute the massive intrusion when most will revert to natal gender without it? What is wrong with compassionate ‘watchful waiting’, while treating the mental disorders with established protocols?

The third is that the experimentation should be based on prior animal research and only after all relevant data have been analysed. Why does the medical pathway ignore the warnings of bench and veterinary science? Why ignore the MRI measurements of human brain size affected by cross sex hormones?

The fourth and seventh is that the experiment should be conducted so as to avoid all unnecessary mental and physical suffering. Given the suicide rate in adults after transgender surgery, it would appear that the most effective way to reduce suffering would be to avoid the medical pathway.

The fifth declares no experiment should be conducted when there is a priori belief that death or disabling injury may occur. Though this provision may seem redundant after the fourth, it is, at least emphatic. There is evidence from sheep studies that irreversible damage to the limbic system may result from the use of ‘blockers’. ‘Top surgery’ is disabling, and suicide is also final.

The sixth declares the humanitarian benefit should exceed the risk. But there is no scientific evidence on which to evaluate the possibility of any lasting benefit to children who have progressed through the pathway.

The eighth declares the experiment should only be conducted by scientifically qualified persons but that implies dispassionate appraisal of results gathered over time. Proponents of the medical pathway do not convince of dispassionate appraisal: a number of parents have related to me their concern over superficial evaluation followed by determination for medicalisation. As the phenomenon is recent, no-one knows what will happen to the children, now cosseted by all kinds of support, when they have entered the unsupported, lonely life of an adult.

The ninth declares the subject should have the right to bring the experiment to an end when he or she has reached a physical or mental state that would preclude continuation. Whether a child will be able to decide to leave the experiment is one thing, given the pressure of authorities and the cerebral effects of drugs, but another very relevant question is whether anyone caught up with the experiment will be able to leave when conscience would preclude continuation? More relevantly, given the gathering force for legal obligation, will a medical practitioner be able not to enter a confused child on the pathway of intervention? Will a paediatric trainee be able to avoid rotation in a gender unit?

This is a very serious consideration and progresses to the final principle of the Code that the experimenter ‘must be prepared to terminate the experiment at any stage’ if continuation is deemed ‘likely to result in injury, disability or death’ of the subject.

Again, there is a similarity in these last two principles that both emphasises their importance and the need for the right of a medical practitioner not to enter a patient into a medical process for which there is evidence of undue suffering. Given the strength of the ideology of gender dysphoria and the commitment of its proponents, it could be predicted that the ideology will present a major challenge to members of the medical profession in the future. In ‘revolutionary’ manner, there may be a lot of tears, if not blood, on the floor.

The Federal Australian Labor Party has already declared it will render ‘conversion’ therapy illegal should it win power at the next election. Shadow Minister for Health, Catherine King, has vowed to make it her personal calling to forbid and therefore criminalise any therapy that seeks to orientate (or convert) a gender identity back towards one consistent with its sexual anatomy (and thus chromosomal complement) at birth. A therapist may, therefore, (and probably with Medicare support) direct the identity of a patient as frequently and in any direction requested except backwards to the identity at birth. Sins of omission will rank equally with those of commission. There will be no ‘sitting on the fence’. A child presented with gender dysphoria will have to be directed to a gender dysphoria clinic.

Should the hormones of puberty seek to re-orientate the child to the gender of birth, who will be game to help that child? Under the law, such help may be forbidden.

As well as criminal offence, mere ‘sitting on the fence’ is likely to offend a new ‘Code of Conduct’ of the Australian Health Practitioners’ Regulation Authority (AHPRA). Under consideration of Professionalism, a doctor may be declared wanting on the basis of any public statements that differ from the proclaimed wisdom of the profession and thereby reduce community trust. Furthermore, the words of a medical practitioner may be considered unprofessional if they cause a member of the public to feel culturally unsafe. Opposition by a doctor to entering a child on the medical pathway to gender transition has the possibility of being very costly...which is what it is all about! We are struggling with principalities and powers, not merely ethical principles.