

Submission to Qld Parliament re pending Health Legislation Amendment Bill 2019

Prof. John Whitehall MB BS, BA, DCH, MPH and TM, MRCP (UK), FRACP.

Professor of Paediatrics and Child Health.

National Chair Christian Medical and Dental Fellowship of Australia

Dear Committee Secretary

Members of the Christian Medical and Dental Fellowship of Australia empathise with the Parliament of Queensland in its concerns for children with gender dysphoria, and with their families. We understand the anguish involved with this problem and sympathise with the sufferers. As doctors and dentists we are committed to reducing suffering in all our patients: gender dysphoria is no different; we are alarmed at its rising incidence and its implications, especially the concept of life long medical dependence and incidence of suicide in adult transgendered folk.

We appreciate the government would want to do all it can to reduce the suffering and that it has sought advice from various sources. But, in the spirit of cooperation we would like to share some 'good news' that may have been overlooked.

The first good news is that all respected sources assure that the great majority of children confused over gender will re-orientate to an identity in accordance their chromosomes, through puberty, with traditional support of individual and family psychotherapy. Please note the very optimistic report by psychiatrist Robert Kosky who was chief paediatric and adolescent psychiatrist of Western Australia, and other optimistic reports contained in the article ... published in Quadrant March 2019, with references supplied.

Sadly, the success of a 'wait and see' policy with psychotherapeutic support appears to have been overlooked in preference to a current vogue of hormonal therapy with the prospect of reproductive surgery.

Worse, such traditional psychotherapy is now derided as 'conversion therapy' and is to be banned in the state of Queensland, and punished as a criminal offence.

Another advantage of psychotherapeutic support is that the commonly associated mental disorders of autism, anxiety, depression and even psychosis may be dealt

with in appropriate ways. We are aware proponents for hormonal and surgical intervention for the mental discordance between gender identity and chromosomes argue that such mental disorders are secondary to the gender dysphoria and or bullying by unsympathetic associates. But the evidence for that claim is weak: often eg with autism, the mental disorder clearly precedes what may be fairly described as the secondary symptom of gender confusion.

In corollary to the usefulness of standard psychotherapy, is its helpfulness in the tragic tendency for children with mental disorder to harm themselves. Proponents for hormonal intervention claim it will reduce such a tendency but sex hormones therapy is not recognised as a therapy for primary autism, anxiety and depression. And there is little scientific evidence that hormonal therapy renders gender confused children more stable. There are no blinded, cross-over trials, and in the single observation of children treated with hormones, there is the confounding effect of inherent psychological support provided by the affirmation and encouragement by the child's authority figures associated with the transgenering process...ranging from doctors, social workers, counsellors, parent, web sites, transgenering peers etc. Such concentrated love and attention might have been all the vulnerably child really needed in the first place.

The real issue of suicide is not with the vulnerable child as much as the vulnerable adult who has not found the process of transgenering as liberating as intended. It is on record that the suicide rate of such sufferers is some 20 times higher than that of the general population, even in the most accepting European countries.

Yet another problem with parliament's insistence on hormonal intervention by its intended banning of psychotherapy is that of the published side effects of the hormones, a reality that appears to be underestimated by proponents for hormonal therapy. Indeed, given the precedence of Whittaker vs Rogers in which the High Court of Australia declared there was an obligation to declare all side-effects, even rarities that might occur but once in several thousand cases.

These side effects, well published internationally relate, first, to the blocking of puberty, and then to the administration of cross sex hormones.

Attached supporting articles will refer more deeply to these effects but, essentially, the hormone blocked by 'puberty blockers' has been revealed to have a widespread role in maintenance of integrity of nerve cells, in and out of the brain.

Within the brain, researchers at Glasgow and Oslo Universities, have demonstrated lasting deleterious effect of puberty blockers on the limbic system which integrates memory, emotion, cognition and reward and leads to a kind of 'internal identity' which is pursued by 'executive function'. On puberty blockers, the limbic systems of sheep are damaged: the functions of many genes are interrupted and, clinically, the sheep loses proficiency in mazes and is more emotionally unstable.

Adult humans, on blockers for various medical reasons, have also demonstrated reduction in 'executive function' but, of course, there are other effects on their brains, from drug therapy for cancer to ageing, that confound analysis. Nevertheless, the primary effect of puberty blockers on the brain cannot be excluded.

Recently, a young natal male administered blockers for gender confusion was found, on MRI examination, to have not undergone the expected growth in cerebral white matter, complicated by a reduction in cognitive ability.

Even nerve cells in the bowel appear to be affected by administration of puberty blockers: adult women receiving them for endometriosis demonstrated an unexpected increase in gastro-intestinal symptoms, associated, as revealed on biopsy by a marked reduction in enteric neurons.

Thus, it has been strongly hypothesised that the blocked hormone has a widespread role in maintenance of nerve cell integrity.

These demonstrated side effects should be acknowledged by proponents of hormonal therapy, instead of the repeated assertion that the effects of blockers are 'safe and entirely' reversible. That blockers may be administered to children as young as 10, when they are about to undergo the great cerebral development in adolescence, is of grave concern.

Blockers are given for several reasons, according to proponents. One reason is to afford the child more time to consider its gender identity and procreative future. But, if the sexualising effects of blocked hormones are denied to the brain, and if the limbic system is damaged, how is it biological plausible that blockers permit rational consideration of gender identity?

Cross sex hormones also have effects on the brain that appear not to be acknowledged by their proponents. For example, one study has revealed a male brain on oestrogens shrinks at a rate 10 times faster than ageing, after only four

months. Yet the transgendering child and adolescent will be receiving them for life!

Which raises the question of why transgendering adults are more likely to commit suicide? Proponents of hormones argue they do so because of ostracism by society, even though the high rates were recorded in the most accepting of countries. Unasked is the question of whether, ultimately, expected happiness did not eventuate after all that medical treatment. The psychological vulnerability of these folk is widely recognised.

Also unasked, but valid, is the question of whether the effect of the hormones on a brain organised before birth to anticipate and respond to hormones directed by chromosomes (and not gender clinics) might have so deranged neuronal connectivity that reality became distorted?

Many questions remain to be answered. Indeed, proponents of hormonal and surgical intervention are at the forefront of confessions of lack of evidence. Some programmes are now in place to 'see what happens', without any control 'arm' to the intervention which would, of course, involve not giving hormones, relying on psychotherapy.

Such is the depth and breadth of knowledge regarding any possible advantage of hormonal intervention, and such is the integrity of research revealing complications that the whole process can be fairly described as experimental.

Therefore, it is only fair to refer to the documents of human rights and experimentation that were hammered out at the end of WW2 in response to human experimentation. Given all that is known (of side effects, including later suicide) and all that is not known of positive effects, it surprises that Queensland Government should identify with one arm of the experiment, and even threaten criminal sanctions against anyone utilising the, once standard and often effective, other arm of psychotherapy.

Why get involved in this medical matter? Why force a crisis of conscience on therapists aware of grave side effects and unconvinced of advantages of hormonal and surgical intervention in confused and vulnerable children, most of whom are known to revert to an identity in accordance with chromosomes with traditional support. Why ban psychotherapy? Why deride it as 'conversion therapy?' Does child and adolescent psychiatry have no role in allaying confusion and orientating the mind of vulnerable young people to physical realities?

Given the excuse that 'the government made me do it' was renounced at the Nuremburg trials, why cause crises of conscience by forcing therapists to wonder wherein lies their greater duty of care? To obey the rulers and entrain the children to gender clinics that are prone to administer hormones and surgery? Or to disobey the government, rely on psychotherapy, and accept the consequences. Surely the Government of Queensland would prefer therapists who acted on traditional ethics?

Prof. John Whitehall MB BS, BA, DCH, MPH and TM, MRCP (UK), FRACP.

Professor of Paediatrics and Child Health.

National Chair Christian Medical and Dental Fellowship of Australia