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Observations in a Gender Diversity Clinic

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Recently, I was a physician-observer in a clinic for children and adolescents who are struggling with gender identity. Since the clinic opened several years ago, the number of patients seen annually has grown to well over six hundred. The staff includes an adolescent-medicine physician, a pediatric endocrinologist, a nurse, and a social worker. I spent twenty-four hours over three clinic days observing the interactions of staff and listening to intake synopses of patients and discussions of treatment plans. My aim was to better understand the working diagnosis of gender dysphoria, the protocols used in treatment, and the ethical concerns. These objectives were not achieved in the way I expected.

Although I am a medical professional in the field of pediatrics, it was a challenge to gain access to the clinic. When I first inquired, leaving a detailed phone message with the coordinator, I received no response. I was able to speak to someone at the clinic only after talking to a colleague who happened to be a pediatric endocrinologist at the children's hospital associated with the clinic. Even then, I was accepted only as an observer in the conference room of the clinic, nowhere else. This was unlike any other medical education opportunity I have had. I was a doctor who was not permitted to interact with patients!

The conversations I thought I would have did not occur. Efforts to discuss the ethical issues associated with "treatment" were met with resistance, and the way patients were talked about was unsettling, with the confusing use of pronouns and references to patients' organs that made them seem disembodied: for example, *the* uterus, not *her* uterus.

A New Normal?

In the past decade, the number of transgender clinics associated with children's hospitals has grown across the nation, accompanying the surge in diagnoses of gender dysphoria in young children and adolescents. In the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), published in 2013 by the American Psychiatric Association, gender dysphoria replaced the previous diagnosis of gender identity disorder, which had been categorized with sexual dysfunctions and paraphilias and emphasized cross-gender identification. Gender dysphoria, on the other hand, is described as conflict experienced between a person's natal sex and the gender with which he or she identifies, accompanied by distress and difficulty functioning.[1] It emphasizes "gender incongruence," a term intended to reduce the stigma associated with the diagnosis. A child's sex at birth is described as the "assigned gender," as if it were determined by society and not biology.[2]

Jack Drescher, MD, a psychiatrist who helped write the *DSM-5* criteria for gender dysphoria, explains that removing the diagnosis from the category of sexual dysfunctions and changing "disorder" to "dysphoria" was also meant to lessen the pathologizing association,[3] a step toward viewing transgender identification as a normal variation of sexual identification. Similarly, a 2013 article by David Levine and the Committee on Adolescence of the American Academy of Pediatrics refers to LGBT youth as a "sexual minority" and states clearly that "being a member of this group of teens is not, in itself, a risk behavior, nor should sexual minority youth be considered abnormal."[4]

According to the World Professional Association for Transgender Health, the psychological distress associated with transgenderism is socially induced and is not inherent in the condition.[5] In other words, it is the result not of patients' psychological difficulties but their lack of social acceptance. If gender dysphoria results from the incongruence of biological and experienced gender, then the associated psychosocial stresses reportedly resolve with medical therapy and social acceptance from the surrounding community.[6] Indeed, the diagnosis remains in the *DSM-5* not to identify a mental disorder but to maintain access to mental and physical health services for those who receive the diagnosis.[7]

Lack of Ethical Understanding

On my first morning at the clinic, before patients were seen, we discussed the current and successive stages of therapy for children and adolescents with gender dysphoria. Treatment usually begins with puberty blockers and proceeds to cross-sex hormone therapy and eventually, for some, sex reassignment surgery. When I asked the lead physician for his thoughts on comparing those with gender dysphoria who desire sex reassignment surgery to those

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with body integrity identity disorder who desire amputations, he paused and responded that he had never thought about it. The pediatric endocrinologist in the room hastily interjected that she could not imagine how anyone could want to be an amputee.

In thinking more about the comparison, my question has become, How are the two conditions really different? Why is it wrong for a physician to fulfill one person's desire to become an amputee but acceptable to fulfill someone else's desire to change sex? Under the principle of totality and integrity, removing a part of the body or impairing the body's integrity is justifiable only if it leads to the well-being of the body as a whole. Amputation of a gangrenous limb may thus be necessary to protect someone's life, but removing the secondary sex characteristics and healthy reproductive organs of a transgender person is not. It is the distress, anxiety, and depression that should be treated.

According to the *Ethical and Religious Directives for Catholic Health Care Services*, "The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient."[8] Manipulating, mutilating, and sterilizing transgender individuals violates their dignity and does not address the actual causes of their suffering.

Some people have argued that the principle of double effect can be used to justify the use of cross-sex hormones in transgender patients: the proposed good effect is relief of suffering; the unintended bad effect is sterilization.[9] Others have argued that administration of cross-sex hormones does not satisfy the four criteria of the principle.[10] For the principle of double effect to apply, however, the act itself must be morally good or at least morally indifferent or neutral. For a child experiencing precocious puberty, the act of administering pubertal blockers may be morally good, as may the act of administering corrective hormones to someone with abnormal hormone secretion. In someone with gender dysphoria, however, the administration of the same hormones cannot be morally good or neutral, because it interferes with natural, healthy developmental processes. In these cases, the principle of double effect cannot be validly applied.

No High-Quality Evidence for Recommendations

When I asked about the protocols used at the clinic, I learned they are not standardized, because not enough conclusive studies have been done. The Endocrine Society published their clinical practice guideline for gender dysphoria in 2017, which consists of twenty-eight recommendations.[11] Each recommendation is graded by the strength (strong or weak) and the quality (very low, low, moderate, or high) of the evidence for it. Twenty-one percent of the recommendations are "ungraded good practice statements." Of the graded recommendations, 45 percent have strong evidence and 55 percent have weak. In terms of the quality of evidence, 23 percent of have very low quality evidence, 63 percent have low quality, and 14 percent have moderate. None of the recommendations is supported by high-quality evidence. The society states clearly that "in the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols."[12] In other words, there are no current standardized treatment protocols for gender dysphoria.

The recommendations supported by moderate-quality evidence include providing information and counseling for fertility preservation in adolescents before initiating puberty suppression and before treating with cross-sex hormones; confirming clinically that the patient meets gender dysphoria criteria and confirming the endocrine component of gender transition before treatment is begun; and evaluating patients for medical conditions that could be worsened by hormone depletion and cross-sex hormonal therapy. Recommendations for beginning therapy were supported by evidence of only very low or low quality.[13]

Prospective follow-up studies have shown that for approximately 85 percent of children diagnosed with gender identity disorder, the condition does not persist through adolescence.[14] So if the evidence for over half of the graded recommendations is weak and most of the evidence is of very low or low quality, and if gender dysphoria does not persist in a significant percentage of children, what is the benefit of administering puberty blockers and cross-sex hormones to children who have received the diagnosis?

Puberty blockers are used to allow children time to explore their gender identity, reduce behavioral and emotional problems, and make it easier for them to "pass" as the assumed gender.[15] When I inquired about the percentage of those who began a program of pubertal blockers and then decided not to continue them, the answer was close to none. A 2011 study conducted by Annelou De Vries and colleagues reported similar findings. It assessed gender dysphoria and psychological function before and after puberty suppression in seventy young people between the ages of twelve and sixteen. Of the seventy, none withdrew from puberty suppression and all went on to begin cross-sex hormone treatment.[16]

This finding is grossly disparate with the natural course of gender dysphoria, which in most children does not persist. Here, all the children who underwent puberty suppression went on to receive cross-sex hormones, marking the beginning of gender reassignment. This suggests that use of the pubertal blockers is not allowing the children "time to decide," as is claimed. The decision has effectively been made when use of the puberty blockers commences. This leads the children to almost inevitably identify as transgender and consigns them to lifelong use of synthetic cross-sex hormones, which render them infertile. These effects are neither benign nor fully reversible.[17]

The Catholic Medical Association notes that puberty blockers "arrest bone growth, decrease bone density, prevent the normal pubertal organization and maturation of the

adolescent brain, and prevent the development of sperm in boys and eggs in girls."[18] The use of puberty blockers (specifically GnRH analogues) in gender dysphoria is off-label and has not been approved by the US Food and Drug Administration.[19] The long-term effects of the drugs are unknown. According to Paul Hruz and colleagues, "The evidence for the safety and efficacy of puberty suppression is thin, based more on the subjective judgments of clinicians than on rigorous empirical evidence. It is, in this sense, still experimental—yet it is an experiment being conducted in an uncontrolled and unsystematic manner."[20]

Not a Psychiatric Diagnosis?

There is strong resistance to psychotherapy and a heavy push for hormonal treatment in the transgender community, with a rejection of the way gender dysphoria is "pathologized." Some activists want to do away with a mental health evaluation altogether. If the mental health evaluation is rejected, however, then the hormones and surgeries are there only to alter the physical features. If a reduction in distress and suicidal risk are the desired outcomes, then a mental health evaluation is appropriate, but why would there be a psychiatric diagnosis without a psychiatric therapy? We do not treat distress associated with anorexia, bulimia, or apotemnophilia (the desire for an amputation) by affirming the delusions and altering body parts.

Ironically, despite attempts to "depathologize" the condition, the WPATH standards of care emphasize the importance of mental health professionals' competence in evaluating children and adolescents with gender dysphoria and providing guidelines for acceptable psychological and social interventions. They are to assess and treat coexisting mental health disorders and aim psychotherapy primarily at reducing the distress the youth may be experiencing in relation to gender dysphoria. Treatment focused on helping the children or adolescents identify with their biological sex is considered unethical, and a binary view of gender is discouraged. The World Professional Association for Transgender Health recommends that adolescents be referred for puberty-suppressing hormones to alleviate gender dysphoria.[21]

How can it be unethical to affirm a binary view of gender when the natural course of gender expression for 85 percent or more children is to align with their biological sex? Why is there such a push to enable children to affirm the gender expression of the opposite sex? As stated so clearly by Dr. Mayer, "Nearly all children ultimately identify with their biological sex. The notion that a two-year-old, having expressed thoughts or behaviors identified with the opposite sex, can be labeled for life as transgender has absolutely no support in science. Indeed, it is iniquitous to believe that all children who have gender-atypical thoughts or behavior at some point in their development, particularly before puberty, should be encouraged to become transgender."[22] Ignoring this wise advice, WPATH holds that therapists must be "trained" in the area of gender dysphoria. This ensures that ideological blinders remain in place.

At the clinic I visited, the intake revealed that a high percentage of children with gender dysphoria also had psychiatric comorbidities, including depression with and without suicidal ideations, anxiety, bipolar disorder, ADHD, and autism spectrum disorders. Many children were on psychotropic medications and were being seen by therapists. According to WPATH, it is recommended that the children and adolescents be seen by a mental health professional so that they can be assessed and receive counseling. Yet many of the gender dysphoria clinics associated with children's hospitals do not have a mental health professional on staff.

The largest survey to date of gender-nonconforming and transgender adults, with over six thousand respondents, was conducted by the National Gay and Lesbian Task Force and the National Center for Transgender Equality. Forty-one percent of respondents had attempted suicide. This is a horrifying number, which greatly exceeds the 4.6 percent suicide attempt rate reported for the overall US population.[23] A population-based matched cohort study conducted in Sweden, spanning thirty years, looked at 324 sex-reassigned individuals with the objective of estimating mortality, morbidity, and criminal rates after reassignment surgery. Although gender dysphoria may have been alleviated, morbidity and mortality were substantially higher among transsexual subjects than in the control population. These included higher rates of psychiatric hospitalizations, attempted and successful suicides, and death from cardiovascular disease.[24]

For those with gender dysphoria, eliminating the mental health component contributes further to a false security, based in political and cultural ideas that sound scientific but lack evidence, which are actually turning the children into hormone- and surgery-dependent experimentees. And at what point does the autonomy of individual patients become the deciding factor for performing medically unnecessary and unjustifiable procedures, so that physicians are no longer advocates for their patients but merely technicians performing procedures the patients want?

Moral Decline in the Profession of Medicine

No matter how closely one identifies with the opposite sex, it is not possible to change oneself into that sex. Sex is a biological reality. Hormones and surgery cannot change it. Transgender ideology is falsely convincing people otherwise, with severe consequences for children, their families, society, and medicine as a profession. The protection of conscience rights is important for those who practice evidence-based medicine grounded in the ethical principle of doing no harm. We cannot provide children and adolescents with puberty blockers, cross-sex hormones, and sex reassignment surgery that are not supported by strong scientific evidence. When medical education is influenced by social agendas, vulnerable populations ultimately pay the price.

Jennifer Bilek, an environmental activist, looked into the funding of the transgender movement after she was removed from a speaking venue by transgender rights

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activists. Following the money, she discovered that several wealthy elites are investing in foundations and "philanthropic" work to further the transgender agenda. She connects the money to pharmaceuticals and technology, both of which are necessary for transgender individuals who transition—and who thus become what she calls medical patients for life.[25] It is past the time for physicians to stand up for their profession and join forces against this experimental abuse of our children.

Notes

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