

Dear Doctor,

In Australia, we have a clear template of the standard referral pathway. General practitioners refer to specialists, who refer to sub-specialists. Whenever we feel we need a more specialised opinion than our own we refer the patient to a colleague along this pathway. We can often choose to whom we refer; we may value a particular practitioner's expertise on a particular matter, or we may know that someone may suit the patient best. This is most evident in the private system. There are also times when we don't get a choice, a patient has to be referred to a general service in the public system. While this may have issues, there are often benefits, and there are many times when referring a patient to the local public hospital service is in their best interests.

This is often true for children. Our tertiary children's hospitals, situated in the state capital cities around Australia, offer not just specialised services that may not be able to be accessed elsewhere, but a multitude of services that can serve a child's whole needs. It is recognised that for many diseases and conditions, a holistic or specialised service offered at a child's local children's hospital serves their best interests. The simplest example is cancer; all children who are diagnosed with cancer are treated by a team of specialists whose concentrated knowledge and expertise, in a multi-disciplinary team, provides the best care. No one would ever dream of treating a child with chemotherapy without this team's knowledge and input.

But there exists a service at my local children's hospital, and at other hospitals around the country, to which I will never refer a child. I believe this service is not appropriate for children, and is actively doing harm, and this open letter is my way of reaching out to you to urge you to consider your role in this referral pathway.

I am talking about the paediatric gender service at my local children's hospital.

What I mean specifically are the paediatric endocrinologists that are part of the paediatric gender service, but seeing as it seems you can't refer to the paediatric gender service without a paediatric endocrinologist getting involved at some stage, the whole service needs to be included.

In Australia, as a country and a medical profession, we are completely behind on this. Many of you reading this will have little knowledge of what role paediatric endocrinologists have in treating children in this clinic. It may be that the first time it has come to your attention is during this election campaign, when old tweets by the Liberal candidate for Warringah, Katherine Deves came to light. In one she tweeted about "vulnerable children surgically mutilated and sterilised". The uproar and backlash in the media was furious.

There is a simple reason why Ms. Deves tweeted about children being surgically mutilated and sterilised.

It's because children are being surgically mutilated and sterilised.

The backlash against this tweet focused on the fact that in Australia, patients have to reach the age of 18 before any surgery on genitals can take place. For the time being, let's ignore the fact that having to



reach the age of 18 before a patient's underdeveloped genitals are surgically mutilated is not the stone cold "gotcha" Ms. Deves's critics think it is. Let's focus on the facts.

Around the world, there are girls as young as 13 who have had a bilateral mastectomy because of the dysphoria about their bodies. This has been done in gender clinics, and also by unscrupulous private surgeons, who as a marketing tool, might describe this surgery as "yeeting the teets". Ms. Deves probably knows this. There was nothing in her tweet that was specific to genital surgery in Australia. That's something her critics inferred. Ms. Deves thinks girls this age having completely healthy breast tissue removed because of their mental health struggles is mutilation. So do I.

And the backlash that focused on the "surgically mutilated" part, conveniently failed to address the part about children being sterilised. This is where paediatric endocrinologists come in.

The medical affirmative pathway for gender diverse children is known as the Dutch Protocol, due to its beginnings in the Netherlands. It consists of three steps:

Gonadotropin-releasing hormone (GnRH) agonists, commonly known as puberty blockers, to suppress the levels of LH and FSH, and thus suppress puberty

"Gender affirming" or "cross sex" hormones, usually started at 16, to "affirm" a child's body with the appearance of the sex they wish they were; males get oestrogen, females get testosterone

Surgery, in a variety of forms ranging from simple cosmetic procedures to major surgery like mastectomy and genital surgery.

The problem is the puberty blockers and the problem is this:

Paediatric endocrinologists in gender clinics in Australia and around the world are taking a cohort of physically healthy children and they are suppressing the puberty of these children at its earliest active stage, Tanner Stage 2. Puberty for these children is never allowed to progress. The bodies of these children are frozen forever at this stage, even though they are growing chronologically older. Contrary to the popular belief, puberty blockers are not a "pause". We now know that at least 98% of children who commence puberty blockers continue along the affirmative pathway onto cross sex hormones.

When gender clinics say puberty blockers are reversible they are telling a truth, but they are being disingenuous. When they say puberty blockers are a "pause" to give children time to think, they are certainly being economical with the truth. They know that those children are now set along this pathway. There is no pause. There is no reversal

The paediatric endocrinologist then takes that body, frozen at the physical state of early puberty, and masculinises or feminises that body, depending on the child's sex.

They are creating a cohort of adults with children's bodies, just adulterated by testosterone or oestrogen.

If a child has their body arrested at Tanner stage 2, how does that child develop fertility? The simple answer is, they can't. We all need the later stages of puberty to fully develop sperm and eggs. They have been sterilised by medical means. They have been sterilised by doctors at our children's hospitals.

If a child has their body arrested at Tanner stage 2, how does a child develop sexual function? The simple answer is, they can't. They have been rendered sexually dysfunctional adults by medical means, by doctors at our children's hospitals.

If a child has their body arrested at Tanner stage 2, then is subjected to abnormal levels of exogenously administered hormones for which that body is not equipped, how do they escape harm? The simple answer is, they can't. They have been committed to a lifetime of hormone-induced iatrogenic disease by doctors at our children's hospitals.

And here lies my first problem with paediatric gender endocrinologists. They do the exact opposite of

all other endocrinologists. The whole point of endocrinology is to treat disease caused by hormone levels being pathologically elevated or depressed. The whole point of endocrinology is to put hormone levels back into the normal range. This is true of every endocrine disease - diabetes, thyroid disease, adrenal insufficiency and so on.

But not when it comes to treating gender diverse children. When a child enters the clinic of a paediatric gender endocrinologist for their first injection of a puberty blocker, they have zero endocrine disease. That child's hormone levels are all exactly where they should be. Their gonadotropins are normal, their sex hormones are normal for the stage of puberty. They have no disease.

Yet when they leave, the paediatric gender endocrinologist has induced abnormal hormone levels. In that child, a doctor has deliberately suppressed normal hormone levels to treat, not endocrine disease, but that child's mental distress.

When that child turns 16, that iatrogenic hormone suppression has continued. The paediatric gender endocrinologist then goes one step further, and deliberately introduces exogenous sex hormones. They deliberately raise a female's testosterone to levels that can only be described as pathological. They deliberately raise a male's oestrogen levels too. They continue to suppress that child's own natural sex hormone levels.

They are inducing iatrogenic disease. On purpose. Not as a side effect, but deliberately.

In what other circumstance would this be considered acceptable? Within endocrinology, can you imagine another similar circumstance? If any endocrinologist was to deliberately elevate or suppress a patient's thyroxine level outside the normal range, they would be subjected to disciplinary action. But it has been deemed acceptable for paediatric gender endocrinologists to do this with gonadotropins and sex hormones. Why?

In what other speciality would this be considered acceptable? A physically healthy child never enters a paediatric gastroenterologist's clinic and leaves with gastrointestinal disease that wasn't there before. Why are physically healthy children seeing specialists who treat disease the child doesn't have?

Everything paediatric gender endocrinologists do is antithetical to both paediatrics and endocrinology.

The aim of paediatrics is to ensure children reach adulthood as healthy as possible. Paediatric gender endocrinologists take physically healthy children and commit them to a lifetime of medicalisation.

If a child has significantly delayed puberty at the age of 16, a paediatric endocrinologist will help initiate it, because we all recognise that puberty is an essential component of human development that gives us all that we need to be healthy adults. Paediatric gender endocrinologists have decided puberty is now optional for some children, and those essentials aren't required.

The evidence for this pathway is low. Its aim, to improve mental health outcomes, remains weakly supported. And everyone else knows it. Everyone else is talking about it. The UK's National Institute for Health and Care Excellence (NICE) appraised the evidence for both puberty blockers and cross sex hormones and found the evidence "very low". This pathway has been subject to a judicial review. The NHS asked Dr Hilary Cass, past President of the Royal College of Paediatrics and Child Health, to review the treatment of gender diverse children. She wrote in her Interim report that

"At this stage the Review is not able to provide advice on the use of hormone treatments due to gaps in the evidence base."

The Karolinska Institutet, the seat of the Nobel prize for medicine, has recommended immediate cessation of this pathway for all children under the age of 18. Even one of the original Dutch clinicians has expressed concern about the rest of the world adopting this pathway blindly.



The world has started to take notice of the problems this pathway brings and is undertaking a review.

Which brings me to the second and most important reason as to why you should never refer to your local paediatric gender clinic here in Australia. They know all this. They know the implications of this pathway. They know it has problems like infertility. They know the evidence is weak. They know there is scrutiny elsewhere. They know. But they carry on anyway. There is little acknowledgment, except for the clinicians at Westmead, that there is anything to see here. According to most gender clinics in Australia, everything is fine and dandy. I took part in an online education series in November and December last year, run by my local gender clinic. I was genuinely interested in what they had to say. There have been so many developments over the preceding year or two I was sure they would discuss the difficulties and the controversies.

But there was nothing. Not a single mention of any of the concerns. They told an online audience across the state that everything was fine. It was a demonstration of ideology, not medicine.

No child should be treated in a clinic, run by a tertiary children's hospital, that places ideology above self-reflection and evidence. No child should be treated in a clinic that doesn't have the courage in its convictions to come out and publicly acknowledge that they are in fact sterilising children. No child should be treated in a clinic that does not disclose its treatments, its numbers, or any statistics. If you refer a child to my local children's hospital paediatric gender clinic, what is the likelihood that child will be given puberty blockers? What is the likelihood they won't stop them? I asked my local clinic, and they wouldn't tell me.

We are in the midst of a medical scandal. This is happening under our noses. We are all somewhat complicit; we have failed to support our colleagues who have raised concerns before, we have blindly assumed that a children's hospital must be doing the right thing simply because it's the children's hospital. We haven't asked questions. Or we've been too afraid to. It may be that the people doing this are colleagues we work alongside and know are good people and it seems wrong to criticise them. But the only way to bring this to the fore is if, as a profession, we stand up and push for that scrutiny. We need openness from the clinics. We need honesty. We need acknowledgement of the truth. We need to discuss all of the issues with which I have barely scratched the surface here - the huge explosion of girls presenting, the high rates of autism and trauma, the concern over brain maturation, children being treated on this pathway while in the care of protective services, the influence of social media, the stories of those who detransition long after the paediatric gender services are done with them, and above all, consent. Can a child at the age of 11 or 12, when puberty is just starting, consent to this pathway and all of its outcomes both known and unknown? This is the most important question of all.

It's likely I will attract criticism about "politicising children", given the election. But when are we going to have this conversation in Australia? When are we going to confront and acknowledge the reality of what we are doing to children, even if you're convinced it's the right path? If not now, when? When a critical number of those children look back on the life they've been given and ask why did it happen? It will be too late. It is already too late for some. Right now, in Australia, there are children, teenagers and adults among us who have been committed to this lifetime of medicalisation. I want to make sure there aren't any more.

Primum non nocere.

Dr Dylan Wilson