Bioethics:Identity and Gender Dr Deirdre Little

In a ‘true culture of social tenderness’ both Pope Francis and the Bishops of Australia have spoken out on Gender ideology. It is not surprising that the Holy Spirit living in their teaching reveals the same message of truth that emerged from the report on England’s only Gender Identity Development Service. In Pope Francis’ ‘spirit of human fraternity’, the Care Quality Commission’s review was rigorous. Backed up by the subsequent independent interim report of paediatrician Hilary Cass, there was recognition of poor science, of inadequate care and follow-up, and of a fundamental flaw in the self-diagnosing ‘affirmation’ model of management. The resultant outcome has now upended the current treatment model. So.. what has just happened?

Following the necessitated closure of England’s Tavistock Gender Identity Service, the National Institute of Health in the UK has just announced a move away from the ‘affirmative’ model of care and away from giving children puberty-blocking drugs, to now advocating counselling. This is long-awaited news for many health professionals, especially in Australia, where such medical opinions and care have been condemned as conversion therapy. Not just condemned but criminalized; and not just discouraged but threatened with deregistration.

Both Pope Francis’ in Amoris Laetitia,[[1]](#footnote-1) and the Australian Catholic Bishops’ Conference in “Created and Loved” guidance on gender ideology for Catholic Schools,[[2]](#footnote-2) begin from the ‘foundational principle that each person is created in the image and likeness of God and is loved by God.’ Archbishop Comensoli says ‘Created and Loved’ is:

*‘grounded in Christian anthropology which values the worth and dignity of every person, and also sees each person holistically, rather than defining that person by any single characteristic..it is vital that the Catholic vision of the whole person informs our understanding.’*

Without a Christian anthropology, ideologies float adrift – more able to founder. Tavistock’s gender service failed to meet professional review standards, even its own, amid an emerging bundle of negligence claims. Some of the issues hinge around the competency of informed consent, in childhood, to a treatment which can have far-reaching implications and ramifications into their futures. Some patients regretted transitioning as they matured. They claimed contributory, co-existing health problems had not been addressed. A [High Court](https://en.wikipedia.org/wiki/High_Court_of_Justice)  ([Administrative Court](https://en.wikipedia.org/wiki/Administrative_Court_(England_and_Wales))) ruling, which was overturned on appeal, said that it was unlikely that a child under the age of 16 could be ‘*Gillick* competent’[[3]](#footnote-3) to consent to puberty-blocking treatment.

The language of gender identity services and of gender ideology itself is complicated, establishing compartmentalized descriptors of personhood. Its labels - to wear and staple onto each other – tell us who we are. And simplify who we are. They structure a complex ideological development that, in the words of Pope Francis, has ‘colonized’ many countries. Our children and grandchildren are now negotiating these concepts and constructs as they grow up. Those experiencing difficulties deserve the very best of our attention, care and love, drawing on different modalities of health experience and expertise. So it is with great hope and assurance that parents and grandparents can now know that our Catholic Bishops have guided our schools in this changing field, and that they will continue to implement this guidance according to Christian anthropology. We can now expect our Catholic Bishops in their roles and duties as pastors to shepherd the protection of the children in Catholic schools from other anthropologies and from the application of the shifting, outdated or poor science of non-holistic, non-multidisciplinary care.

**Gender Dysphoria Care?**

The recent Tavistock Gender service issues have drawn attention to the quality of health required in this domain. They reveal the problems that can arise without the provision of multidisciplinary, holistic therapy. Deficient evaluation, assessment, diagnosis, management and follow-up, of ‘Gender Dysphoria’ presentations were identified. The “Care Quality Commission” (CQC) inspection of Tavistock and Portman National Health Service (NHS) Foundation Trust’s Gender Identity Service rated it overall as ‘inadequate’. Many concerns were expressed, some quite alarming:

*‘..an audit of capacity, competency and consent was carried out in March 2020. This audit found that assessments of capacity, competency and consent had not been recorded**in accordance with the established procedures in 8 of the eleven 11 records reviewed. The absence of a structured assessment had not been recorded as an ‘Incident’, for any of these records, despite the absence of a formal record of assessment potentially leading to a risk of medicines being administered unlawfully’.*

And, what should strike alarm in any parent or clinician’s heart:

*‘Staff’s assessments of patients were unstructured, inconsistent**and poorly recorded. Staff did not sufficiently record their reasoning in reaching clinical decisions. There were significant variations in the clinical approach of professionals in the team and it was not possible to clearly understand from the records why these decisions had been made’.*

ie: client assessments were poor, and governance didn't notice. And:

*‘Staff did not develop care plans for young people. Many records provided insufficient evidence of staff considering the specific needs of young people, such as autistic spectrum disorders’.*

The NHS announced closure of the service following paediatrician Dr. Hilary Cass’s subsequent independent review and highly critical interim report. Hilary Cass had also observed that one third of children referred to the Tavistock service had autism or another type of neurodiversity.

**What is Gender Dysphoria ?**

**See Australian Catholic Bishops discussion of terms** [**https://bit.ly/CreatedandLoved**](https://bit.ly/CreatedandLoved)

The sex of a child is now described medically (by the American Psychiatric Association, the Mayo clinic and the Melbourne Children’s Hospital etc) as ‘assigned at birth’. However, we obstetricians do not assign sex. We observe it.[[4]](#footnote-4) The term Gender Dysphoria refers to a level of distress that impairs functioning when there is an incongruence experienced between the observed sex and gender identity. However, some current concepts of gender identity have been more recently developed, with stereotypes, variances, norms and delineating behaviours contributing towards categorization of persons. The irony here is that gender identity itself can become ‘assigned’ by modern theories. What it is to be male or female has a natural breadth and depth of human variation and personality, but can now be filed and sub-filed, defining and delineating an individual. Children today are growing up in an era of emphasis on their categorization in both social media culture and educational contexts.

The Australian Catholic Bishops guidance has commented on this phenomenon:

***‘Rigid cultural stereotypes of masculinity and femininity are unfortunate and undesirable..[creating] unreasonable pressure on children to present..in particular ways’***

The current ‘affirmation method’ of management, used in many gender clinics, endorses the child’s perceptions. The Care Quality Commission review criticized this ‘predominantly affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that had developed..’. Staff interviewed said they felt under pressure to adopt an unquestioning, affirmative approach, an approach at odds with the approach they were trained to adopt in other clinical contexts. The distressed child, exposed to internet and peer pressure, tends to become the diagnoser. Dr. Hilary Cass’ report asserted ‘many authors view gender expression as a result of a complex interaction between biological, cultural, social and psychological factors.’ She observed the over-representation of children in care, and queried the early hormone intervention:

***“We have no way of knowing whether, rather than buying time to make a decision, puberty blockers may disrupt that decision-making process”***

Despite world-wide movements tending away from using puberty blockers in minors, Australian states are mandating the ‘affirmation’ approach. While Finland guidelines advocate counselling rather than puberty-blocking hormones, and Sweden advises against puberty blocking hormones for young children, Victoria, Queensland and the ACT may fine, imprison and de-register health professionals who do not respond to self-identification by endorsing use of these hormone interventions. Such counselling, though in step with approaches in more progressive Scandinavian countries and now the UK, is still deemed a form of ’conversion therapy’ by leaders here who follow their own guidelines.

When new Queensland legislation comes into effect, the 2.3% of Australian children aged 16 and 17 self-diagnosed as transgender or gender diverse will now have less access to counselling. The new legislation passed in October 2022, will immediately name and shame doctors who question the ‘affirmation’ method, or other consensus-regimented responses - such as to abortion, euthanasia etc, prior to any further investigation being carried out around the issue at hand.

**‘Created and Loved’**

 Our Australian Bishops have reminded us that research data suggests the vast majority of children and teens experiencing gender incongruence will pass ‘safely and naturally’ through this with supportive psychological care. 80 to 90% of prepubescent children will not remain gender incongruent into their future. (Kaltiala Hano 2018). They also remind us that many popular rhetorical perceptions of sex and gender are incompatible with ‘the generosity of the Christian vision’. Specifically, we are reminded that gender is not entirely separate from biological sex, nor is it arbitrarily assigned at birth, but rather is an aspect of the gift of life. Pope Francis refers to an attack on creation, and has taught on gender ideology on several occasions, and in Amoris Laetitia (n 56.):

*\* ‘Yet another challenge is posed by the various forms of an ideology of gender that* ***denies the difference and reciprocity in nature of a man and a woman and envisages a society without sexual differences,*** *thereby eliminating the anthropological basis of the family..It is a source of concern that ..ideologies of this sort ..manage to assert themselves as absolute and unquestionable, even dictating how children should be raised..*

*\* ‘It needs to be emphasized that biological sex and the socio-cultural role of sex (gender) can be distinguished but not separated. It is one thing to be understanding of human weakness and the complexities of life and another to accept ideologies that attempt to sunder what are inseparable aspects of reality’.*

*\* ‘Let us not fall into the sin of trying to replace the Creator..Creation is prior to us and must be received as a gift. At the same time, we are called to protect our humanity, and this means, in the first place, accepting it and respecting it as it was created.’*

We thank our Catholic leadership for its leadership - of our youth, of our teachers, of our Catholic schools - for its light and wisdom to the parents, grandparents and health providers of Australia and for its injection of prudence and moral courage into our drifting social and cultural norms.

1. Amoris Laetitia (n 56). [↑](#footnote-ref-1)
2. <https://bit.ly/CreatedandLoved> [↑](#footnote-ref-2)
3. ‘If a child passes the Gillick test, he or she is considered ‘Gillick competent’ to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions. Therefore, each individual decision requires assessment of Gillick competence.’

   https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-8-gillick-competency-fraser-guidelines [↑](#footnote-ref-3)
4. ‘Intersex’ refers to a very rare medical condition that may or may not be apparent at birth. The term properly applies to those conditions in which chromosomal sex is inconsistent with the observable characteristics of an individual, ie phenotypic sex, or in which the observable characteristics are not classifiable as either male or female. Applying this definition, the true prevalence of Intersex is about 0.018%. https://pubmed.ncbi.nlm.nih.gov/12476264/ [↑](#footnote-ref-4)