April 5, 2016

The Most Reverend Bishop James D. Conley
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Your Excellency,

My name is Dr. Michelle Cretella. I am President of the American College of Pediatricians, a national organization of pediatricians and other pediatric healthcare providers which drafts position statements and social policy recommendations rooted in science and natural law. I am joined in this letter by Dr. Paul McHugh and the leaders of three other national medical organizations; the Catholic Medical Association, the Christian Medical & Dental Associations, and the Association of American Physicians & Surgeons. All of these organizations dedicated to promoting ethical evidence-based medicine. Together our organizations represent over 30,000 physicians, healthcare professionals and constituents concerned with the grave harm perpetrated against children via so called transgender medicine. Catholic healthcare institutions are a haven for both families who desire the certain knowledge that their child’s human dignity will be respected in medical decision-making and also for healthcare providers who cherish the right to practice in accordance with their moral conscience. Therefore, we ask that the USCCB use the information in this letter to produce a statement that will encourage Catholic hospitals and all healthcare providers of good will to oppose the use of puberty-blocking drugs, cross-sex hormones and sex reassignment surgery as treatment for gender dysphoria (GD) in children and adolescents.

The May 19, 2014 issue of the highly respected Hayes Directory reports that the practice of using hormones and surgery to treat GD is based on "very low quality of evidence" and goes on to discuss the "serious limitations to the evidence" in great detail.1 Of greater concern, however, is the fact that these interventions result in sterility.1 Hence, the treatment of GD in childhood and adolescence with hormones effectively amounts to mass experimentation on, and sterilization of, youth who are cognitively incapable of providing informed consent. There is a serious ethical problem with allowing irreversible, life-changing procedures to be performed on minors who are too young to give valid consent themselves. This ethical requirement of informed consent is fundamental to the practice of medicine, as emphasized on the U.S. Department of Health & Human Services website: "The voluntary consent of the human subject is absolutely essential."2 Moreover, when an individual is sterilized, even as a secondary outcome of therapy, without full, free and informed consent, it is a violation of international law.3 The United States Council of Catholic Bishops, of course, already condemns procedures that induce sterility even secondarily except under rare circumstances, and similarly acknowledges the right to and need for informed consent for all medical care. We could rest our case on this egregious violation of medical ethics alone, but have included further medical and psychological considerations for the sake of completeness.

Human sexuality is an objective biological binary trait: “XY” and “XX” are genetic markers of health – not genetic markers of a disorder. The norm for human design is to be conceived either male or female. Human sexuality is binary by design with the obvious purpose being the reproduction and flourishing of our species. This principle is self-evident. The exceedingly rare disorders of sex development (DSDs), including but not limited to
testicular feminization and congenital adrenal hyperplasia, are all medically identifiable deviations from the sexual binary norm, and are rightly recognized as disorders of human design. Individuals with DSDs do not constitute a third sex.\(^4\)

No one is born with a gender. Everyone is born with a biological sex. Gender (an awareness and sense of oneself as male or female) is a sociological term and psychological concept; not an objective biological one. No one is born with an awareness of themselves as male or female; this awareness is learned and develops over time. Like all developmental processes, the formation of a person's gender identity may be derailed by a child’s subjective perceptions, relationships, and adverse experiences from infancy forward. People who identify as “feeling like the opposite sex” or “somewhere in between” do not comprise a third sex. They remain biological men or biological women.\(^5,6\)

Children with GD do not have a disordered body though they feel as though they do. Similarly, many men with GD express the unscientific belief that they are a "feminine essence" trapped in a male body.\(^6\) The fact is, however, that just because "I feel it and think it" does not make it so. A person's belief that he or she is something they are not is, at best, a sign of confused thinking. When an otherwise healthy biological male believes he is female, or an otherwise healthy biological female believes she is male, an objective psychological problem exists known as Gender Dysphoria (GD).\(^7\) The psychodynamic and social learning theories of GD alluded to in the previous paragraph have never been disproved.\(^6,7,8\)

Gender Dysphoria may be described as a disorder of assumption akin to anorexia nervosa. In the case of anorexia, the assumption that departs from physical reality is the belief by the dangerously thin patient that she is obese. Body dysmorphic disorder (BDD) is a second example in which the person is consumed by the false assumption that "I am ugly." The final example we will cite is body integrity identity disorder (BIID). In this case, the individual identifies as a disabled person trapped in a fully functional body. Individuals with BIID are often so distressed by their fully capable bodies that they seek surgical amputation of healthy limbs or the surgical severing of their spinal cord.\(^9\) All of the aforementioned false beliefs are not merely emotionally distressing for the individuals but also life-threatening. What should be equally obvious, however, is that surgical intervention to relieve emotional distress and "affirm" the false assumption (liposuction for anorexia; cosmetic surgery for BDD; amputation or surgically induced paraplegia for BIID) does not address the patient's underlying psychological trauma and may also result in the patient's death.

Regarding children with GD, recall first and foremost that puberty is not a disease; therefore, it should not be treated as one. Rather, it is puberty-blocking hormones that induce a state of disease—the absence of puberty—in a previously biologically healthy child. Puberty blockers are dangerous: they render the child infertile and arrest bone growth for the duration of therapy.\(^1,9\) It must also be recognized that endogenous sex hormones during puberty not only induce secondary sex traits, but also contribute to normal brain development. The brains of children on puberty blockers are deprived of this healthful process. Additionally, a recent study confirms that children placed on puberty blockers to impersonate the opposite sex inevitably go on to embrace a transgender identity and request cross-sex hormones.\(^9\) Besides causing permanent infertility, cross-sex hormones (testosterone and estrogen) are associated with dangerous health risks including but not limited to high blood pressure, blood clots, stroke, and cancer.\(^9,10,11,12,13\)

The use of hormones for the treatment of children with GD is all the more unacceptable when one considers the condition's high rate of resolution. According to the DSM-V, "Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%." Simple math allows one to calculate that as many as 97.8% of gender-confused boys may come to accept their biological sex, and that for gender-confused girls as many as 88% may experience similar resolution.\(^7\) Although some gender-confused children will persist into adulthood with GD, this only underscores the importance of further psychological research. We must discern how these children and their families differ from those who experience resolution and then use that data to devise
therapy that helps them accept reality and achieve emotional health. It does not justify euphemizing the chemical castration, sterilization and surgical mutilation of children as healthcare.

Finally, although cross-sex hormones and sex-reassignment surgery has become "standard of care" for adults with GD, it is recognized as woefully inadequate. In the 1960s Johns Hopkins University became the first medical center to offer sex-reassignment surgery in the United States. During the 1970s a study was launched to compare the outcomes of adults with GD who had surgery with the outcomes of gender dysphoric adults who did not. Most of the surgically treated patients described themselves as "satisfied" with the results; they experienced emotional relief. Yet, when objectively evaluated, their subsequent psycho-social adjustments were no better than those who did not have the surgery. These results argued against the amputation of normal body parts to "treat" a psychological disorder and the program was shut down. A 2011 study at the Karolinska Institute in Sweden yielded similar data. This thirty-year longitudinal study followed 324 people who underwent sex-reassignment surgery. After 10 years they were found to experience increasing psychological distress. The most disturbing difference was that their suicide mortality rose almost 20-fold above the comparable non-transgender identified population.

Children and adults with GD deserve far better than sterilization, toxic chemicals, surgical mutilation and persistent elevated rates of suicide. The dignity of the human person demands that individuals with GD have a right to compassionate physicians of conscience who will help them heal from the deep psychological wounds underlying their false belief. Please stand with us as we demand mainstream medicine stop treating gender dysphoric persons like second class citizens whose best hope is toxic chemicals, infertility, surgical mutilation and persistently elevated rates of suicide.

Sincerely,

[Signature]

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[Signature]

Paul McHugh, M.D.
University Distinguished Service Professor of Psychiatry at Johns Hopkins Medical School and the former psychiatrist in chief at Johns Hopkins Hospital

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David Stevens, MD, M.A. (Ethics)
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Jane Orient, MD, Executive Director
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Andrew L. Schlafly
AAPS General Counsel
References:


Addendum:


This Catholic policy prohibits the assortment of sterility-inducing treatments being used for Gender Dysphoria (GD), which is usually temporary in duration. These objectionable treatments are neither necessary nor justified by "a present and serious pathology," as required by the Bishops' Directives.

Free and informed consent by minors for these irreversible, life-changing treatments is clearly lacking. As the Bishops require in their Directives:

27. Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

Concerning the life-changing treatments for GD, the "risks, side-effects, consequences and ... alternatives" are not fully disclosed, and thus consent is inadequate. Moreover, in Catholic hospitals a surrogate's consent is only "to be followed so long as it does not contradict Catholic principles." *Id.* ¶ 28. These treatments, because of their inducement of sterility, violate Catholic principles and thus should not be allowed in Catholic hospitals regardless of whether a surrogate or guardian requests it for a minor.