NUFFIELD COUNCIL ON BIOETHICS

The care and treatment of children and adolescents in relation to their gender identity: ethical issues

Call for evidence

Introduction

About the Nuffield Council on Bioethics

The Nuffield Council on Bioethics is an independent body that examines and advises on ethical issues arising from developments in bioscience and health. We aim to inform policy and public debate through timely consideration of the ethical questions raised by biological and medical research so that the benefits to society are realised in a way that is consistent with public values.

In late 2019, the Nuffield Council on Bioethics held a series of exploratory meetings with people and representatives of people with experience of gender identity services, medical practitioners, academics, and researchers to understand the ethical challenges in the care and treatment of young people in relation to their gender identity. This exploratory work raised a number of ethical issues about how gender diverse and gender incongruent children and adolescents under the age of 18 should be cared for, which we believe warrant more discussion and consideration.

The aim of this project is to carry out a more in-depth review of some of those issues. Our conclusions will inform practitioners and policy-makers and, ultimately, help improve the well-being of gender diverse and gender incongruent children and adolescents by ensuring they receive ethical, appropriate, and high-quality care. We hope that, as the UK's independent ethics body, we can make a valuable contribution to how these issues are discussed and considered.

About this call for evidence

This call for evidence is an open call for views on some of the issues we want to explore in more detail, including:

- the nature of gender dysphoria and how this affects approaches to care and treatment;
- the social context within which gender dysphoria exists;
- whether there is adequate evidence on the safety and effectiveness of puberty blockers and cross-sex hormones to support treatment;
- current approaches to care and treatment, including the purpose of puberty blockers, the gender affirmative approach, and social transition;
- how to consider the benefits and harms of treatment and non-treatment in decision-making; and
- the ability of children and adolescents to consent to medical interventions for gender dysphoria.

This call for evidence is not concerned with the wider gender identity debate as it relates to questions of self-identification, nor issues about the care and treatment of young adults/adults aged 18 and over. A review of the current provision of gender

identity services for children and young people is the subject of a separate independent review commissioned by NHS England.

Who we want to hear from

We would like to hear from as many people and organisations as possible who have an interest in the care and treatment of children and adolescents in relation to their gender identity, and this call for evidence is open to anyone who wishes to respond. In particular, we would like to hear from anyone with personal experience of using gender identity services or supporting someone to use those services.

The responses to this call for evidence will form an important step in our evidence gathering and play a significant role in influencing this project and its final conclusions. We will also be undertaking a number of other evidence-gathering exercises to ensure we hear from a diverse range of people. Please contact us by emailing gender@nuffieldbioethics.org if you would like to be involved in any further opportunities to contribute, or to alert us to other people or organisations who may be interested in this work.

How to respond

Please complete and return the attached form to gender@nuffieldbioethics.org by **Friday 14 May 2021**. Responses will be handled confidentially, and we will **not** publish your name without express permission.

We have outlined questions grouped under six key themes, alongside a very brief overview of some of the views expressed in the literature. You are welcome to respond to as many, or as few, of the questions as you wish. You will have the opportunity to comment on any other relevant issues you would like to draw to the attention of the Council in the final open-ended section.

A note on terminology: We recognise that the language used in this area is complex, and that not everyone agrees on the 'correct' terminology or how it is used. Throughout this call for evidence we use 'trans' and 'transgender' interchangeably as an umbrella term for anyone whose gender identity does not correspond with their birth sex. We also use the phrase 'gender diverse' to refer to children and adolescents whose gender identity may be different in a variety of ways from their birth sex - this includes people who have been diagnosed with gender dysphoria and gender incongruence. The gender diverse young people we met with through our initial exploratory work told us they preferred this as a collective term.

Your details

Name: Family Education Trust

Organisation (if applicable): Family Education Trust

Email: info@familyeducationtrust.org.uk

*You do not need to provide an email address, but it would be helpful for us to be able to contact you should we have any queries about your response or wish to follow up on any of the points raised. Your email address will **not** be shared or published in the report.*

About your response

Are you responding personally (on your own behalf) or on behalf of an organisation?

☐ Personal ☒ Organisation

May we include your name/your organisation's name in the list of respondents that will be published in the final report?

☒ Yes ☐ No

If you have answered 'yes', please give your name or your organisation's name as it should appear in print:

Family Education Trust

May we quote from your response in the report and make it available on the Council's website when the report is published?

☒ Yes ☐ Yes, anonymously* ☐ No

** If you select this option, please note that your response will be published in full (excluding this form). If you wish to remain anonymous, please make sure that your name and any other identifying information does not appear in the main text of your*

response. The Nuffield Council on Bioethics cannot take responsibility for anonymising responses in which you or your organisation may be identifiable from the content of your response. Please note that obtaining consent to publish a response does not commit the Council to publishing it. We will also not publish any response where it appears to us that to do so might result in detriment to the Council's reputation or render it liable to legal proceedings.

In what capacity are you responding to this call for evidence? Tick all that apply.

☐ Personal experience of using gender identity services for children and adolescents

☐ Personal experience of supporting a user of gender identity services for children and adolescents

☐ Healthcare professional

☐ Policy maker

☒ Work for a charity or advocacy group

☐ Academic interest

☐ Researcher

☐ Legal/regulatory interest

☐ Other professional interest

☐ Other (please state):

☐ Prefer not to say

We would like to send you a link to the report when it is published and keep you informed about other activities related to this project. If you would like us to do so, please tick here ☒

If you would like to receive our newsletter on all the Council's activities, please tick here ☒

We will use your data to send you the newsletter, project updates, and for our internal reviews of our impact. We will not share your data with any third parties. You

may unsubscribe from our newsletter at any time by clicking the unsubscribe link in any newsletter email or by emailing bioethics@nuffieldbioethics.org. For more information on our principles when dealing with personal data, please see our privacy policy at http://nuffieldbioethics.org/legal.

Section 1: The nature of gender dysphoria

In carrying out our exploratory work, we found that disagreement about what gender dysphoria is underlies many of the disagreements about what the approach to care and treatment of young people should be. Some people think that gender dysphoria is a medical condition, and explain it as a genetic, hormonal, neurodevelopmental or psychiatric condition. Other people reject the idea that gender dysphoria is a medical condition, and understand it as either a social construct or a normal variant of gender expression.

In the absence of clear evidence as to what causes gender dysphoria, it is unlikely that a single agreed view will be reached. That being the case, we want to understand views on whether and how a lack of consensus on what gender dysphoria is, and what causes it, should affect the approach to care and treatment.

1. **How should gender dysphoria be characterised?**

We agree with the continuing characterisation of gender dysphoria as a mental disorder as acknowledged by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). It should be seen as a form of body dysmorphia.

2. **In your view, how should young people with gender dysphoria be treated, cared for, or supported?**

Such young people should be treated with the utmost care and sensitivity. As a form of body dysmorphia, gender dysphoria needs to be carefully treated and certainly not affirmed. Young people who suffer from gender dysphoria need to be helped to accept the body and sex in which they were born. Just as those who suffer from anorexia should be sensitively helped to become more comfortable with their body so should those with gender dysphoria. Those who help those suffering from this condition need to understand that it is often a temporary phase. Gender dysphoric feelings, especially among the young and vulnerable, can often be fleeting. Among young people who experience gender dysphoria only a minority persist with these feelings into adulthood. According to the American Psychiatric Association, in biological males, persistence has ranged from 2.2 to 30 per cent, and in biological females, from 12 to 50 per cent(American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5, 5th edition, 2013, 302.85, Gender Dysphoria in Adolescents and Adults, p.455). NHS England cites research showing that only 12-27 per cent of children who experience gender dysphoric feelings continue with them into adulthood

(NHS England, 'NHS Standard Contract For Gender Identity Development Service For Children And Adolescents', 2015).

It also needs to be acknowledged that a disproportionate number of young people presenting for gender dysphoria are on the autistic spectrum. According to Dr David Bell, formerly of the Tavistock and Portman NHS Foundation Trust 35-40% of children presenting for gender dysphoria at the Tavistock were on the autistic spectrum (Cathy Newman, 'Children have been very seriously damaged' by NHS gender clinic, says former Tavistock staff governor, Channel 4, 23 January 2021).

3. Do you think that treatment and care of gender diverse young people should take into account the deep disagreement about the nature and causes of gender dysphoria? If so, how?

Yes.

There needs to be an acknowledgement among professionals that this area has become deeply affected by ideology and that medical professionals who are experts in this area have been attacked or silenced for not being in agreement with the transgender lobby.

This lobby treats gender dysphoria as something entirely normal and insists that people should be allowed to simply self-identify as the gender they prefer even if this does not match their birth sex. They are willing to attack and smear professionals who disagree with them. For example, Dr Kenneth Zucker of the Child Youth and Family Gender Identity Clinic in Toronto and one the world's leading experts on gender dysphoria was sacked from his job and had his gender identity clinic shut down because of his refusal to embrace 'affirmative therapy' and his emphasis on helping gender dysphoric young people to become comfortable with their birth sex. The trans lobby accused Dr Zucker of engaging in a form of conversion therapy (Jesse Singal, How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired, *The Cut*, 7 February 2016.)

More recently, Dr David Bell, a former psychiatrist at the Tavistock and Portman NHS Foundation Trust has testified that those who expressed concern about the giving of puberty blockers and other hormonal drugs to teenagers faced disciplinary action. Dr Bell himself had been facing such action at the time of his retirement from the clinic. He noted that the Tavistock's chief executive had stated that '*those who raise criticisms against the Trust have an unfortunate attitude to gender*'. Dr Bell said, '*this is like a message to everyone else...I had better not speak out or they will think I am transphobic'* (Cathy Newman, 'Children have been very seriously

damaged' by NHS gender clinic, says former Tavistock staff governor, Channel 4, 23 January 2021).

The Care Quality Commission's report on the Gender Identity Development Service (GIDS) at the Tavistock confirmed that something of an atmosphere of intimidation existed towards those who questioned the trans agenda. The report stated:

'*Staff did not always feel respected, supported and valued. Some said they felt unable to raise concerns without fear of retribution*.' (Care Quality Commission, Tavistock and Portman NHS Foundation Trust Gender Identity Services Inspection report, 20 January 2021).

To avoid such unacceptable treatment of individuals happening in future we think it essential that the deep disagreements that exist on this issue be considered.

Section 2: The social context

The number of young people being referred to gender identity services has increased significantly over the past ten years, both in the UK and internationally. There has been an increase in the number of referrals from girls (sometimes referred to as natal girls, biological females, or those assigned female at birth).

There are divergent views as to the reasons for this. Some think that gender dysphoria has always been prevalent among young people, but was often unrecognised or repressed. Others think it is a new phenomenon, specific to today's social context. Various social factors and societal changes have been suggested as playing a role in the number of those seeking treatment or contributing to how gender dysphoria is perceived and understood, including:

- shifting social attitudes towards sex and gender;
- intense sexualisation and objectification of women associated with female puberty and womanhood;
- increased visibility of transgender individuals in public life and coverage of trans issues in the media;
- social pressures to conform, or not conform, to gender norms;

- experience of homophobic or other types of abuse and bullying;

- the significant role that social media and the internet play in young people's lives - which, alternatively, upholds and enforces traditional gender norms; offers opportunities for self-expression and the chance to find supportive communities; or contributes to what some have called a 'social contagion' of gender dysphoria.

4. In your view, what social factors are most relevant to the discussion about gender identity in children and adolescents? How might these contribute to:

(a) the onset or expression of gender dysphoria in children and adolescents; and

(b) the way gender dysphoria is understood and perceived in society?

Young people today spend a great deal of time online and are easily impressionable. We are particularly concerned with the role of online influencers on social media and elsewhere. These influencers encourage young people to question their gender and often to experiment with puberty blockers or breast binders. For example, the Youtuber Chase Ross, a female-to-male trans guru with a large following, encourages girls to wear breast binders. Ross will send young girls breast binders at a friend's address if their parents disapprove.

The journalist Abigail Shrier has done substantial research on the role of the influencers and found that influencers diagnose vague symptoms which they claim may be indications of a person being trans. These include '*feeling different, not really fitting in...not feeling feminine or masculine enough...feeling uncomfortable in your body*.' Shrier recounts how one influencer stated:

[Y]ou don't need to be a hundred percent sure you're trans to try hormones.. You can try hormones for three months. After three months there starts to be permanent effects, but until around then you can just try hormones and see how you feel. It's great, it's that easy.

> Shrier concludes of the influencers: *Many of them peddle misinformation, outright medical falsehoods, and just bad advice. They extol the glories of testosterone as if it were a protein shake, not a Schedule III controlled substance. They enthuse over double mastectomies as if they were of no more significance than a haircut.*

(Abigail Shrier, *Irreversible Damage: Teenage Girls and the Transgender Craze*, Swift Press, 2020).

The transgender lobby has an immense influence in society through groups like Stonewall who have considerable influence over schools. Many schools are pressured to become Stonewall Ambassador Schools. A false impression is frequently given that 'gender identity' is protected under the Equality Act and that therefore, schools, medical professionals and others have a duty to affirm a transgender identity.

5. How might the social factors you have identified affect whether, what, and how care and treatment is provided to children and adolescents?

We believe that these factors have a great impact on the care given. The case of Keira Bell is a good example. Here, the claims of a vulnerable young person that she was in the wrong body were taken at face value first by her local child and adolescent mental health service (CAMHS) who referred her to the Tavistock gender clinic and subsequently by the Tavistock itself who put her on hormone blockers that permanently altered her body.

That these factors were at work at the Tavistock can be seen from the CQC's report on that clinic's gender identity service. This report revealed that a desire to affirm a transgender identity appears to have trumped children's safety, competency to consent to treatment and staff reservations about the procedures. For example, the report stated:

•*'Staff did not always assess and manage risk well. Many of the young people waiting for or receiving a service were vulnerable and at risk of self-harm.'*

•*'Staff had not consistently recorded the competency, capacity and consent of patients referred for medical treatment before January 2020.'*

•*'Staff did not always feel respected, supported and valued. Some said they felt unable to raise concerns without fear of retribution.'* (Care Quality

Commission, Tavistock and Portman NHS Foundation Trust Gender Identity Services Inspection report, 20 January 2021).

Section 3: Research evidence

There are differences of opinion as to what the existing evidence base on the use of puberty blockers (gonadotropin-releasing hormone agonists (GnRHas)) and cross-sex hormones means for clinical practice. Some believe that the existing evidence and clinical experience provides an ethical justification for the use of puberty blockers and cross-sex hormones in care, pointing to the literature which shows the potential risks of not providing that treatment (i.e. increased psychiatric morbidity, self-harming behaviours and suicide). They reject the claim that the use of these treatments is 'experimental', or argue that it is similar to other areas of paediatric practice where there are no licensed treatment options.

Others believe that the current state of research evidence provides an insufficient basis for treatment, and that puberty blockers should be considered experimental treatment and prescribed only in the context of a research study. This was the conclusion of the High Court in the recent *Bell v Tavistock and Portman NHS Foundation Trust* case, on the basis of the uncertainty over the short- and long-term clinical and life-course outcomes and ambiguity over their purpose.

6. **In your view, does the available evidence support medical interventions in gender diverse children and adolescents? Please expand on your comments.**

No.

A study by two of the world's most respected academics in this area, Dr Lawrence Mayer and Dr Paul McHugh of Johns Hopkins University School of Medicine, concluded that:

The hypothesis that gender identity is an innate, fixed property of human beings that is independent of biological sex— that a person might be 'a man trapped in a woman's body' or 'a woman trapped in a man's body'—is not supported by scientific evidence (Lawrence S. Mayer and Paul R. McHugh, Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences, *New Atlantis,* Number 50, Fall 2016).

The evidence shows us that gender dysphoric feelings, especially in the young, are often fleeting and among young people who experience gender dysphoria only a minority persist with these feelings through into adulthood. For example, according to the American Psychiatric Association, in biological males, persistence has ranged from 2.2 to 30 per cent, and in biological females, from 12 to 50 per cent (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5, 5th edition, 2013, 302.85, Gender Dysphoria in Adolescents and Adults, p.455). NHS England cites research showing that only 12-27 per cent of children who experience gender dysphoric feelings continue with them into adulthood (NHS England, 'NHS Standard Contract For Gender Identity Development Service For Children And Adolescents', 2015). In addition, there is little evidence that transition and the use of puberty blockers alleviates distress in the long term (Puberty blockers do not alleviate negative thoughts in children with gender dysphoria, finds study, *BMJ* 2021; 372: n356).

7. Does the use of puberty blockers in this context warrant a different standard of evidence to support decisions about treatment compared to other paediatric interventions? Please expand on your comments.

Yes.

The use of puberty blockers cannot be treated like other paediatric interventions due to permanent alterations they make to a person's body.

Additionally, there is little evidence that the use of puberty blockers alleviates distress in the long term (Puberty blockers do not alleviate negative thoughts in children with gender dysphoria, finds study, *BMJ* 2021; 372: n356). On the contrary, considerable evidence exists that puberty blockers cause harm. For example, in letter published in the *Archives of Disease in Childhood*, three paediatricians and child health specialists highlighted the dangers of puberty blockers, stating that:

…their use leaves a young person in developmental limbo without the benefit of pubertal hormones or secondary sexual characteristics, which would tend to consolidate gender identity… over 90% of young people attending endocrinology clinics for puberty-blocking intervention proceed to cross-sex hormone therapy. In contrast, 73%–88% of prepubertal GD clinic attenders, who receive no intervention, eventually lose their desire to identify with the non-birth sex… the use of puberty blockers may prevent

some young people with GD from finally becoming comfortable with the birth sex.

These specialists further stated that the use of puberty blockers is 'likely to threaten the maturation of the adolescent mind'. They referred to studies suggesting that pubertal hormones promote cognitive maturity and that puberty has a significant part to play in structural brain development. 'To halt the natural process of puberty is an intervention of momentous proportions with lifelong medical, psychological and emotional implications' they concluded (Christopher Richards, Julie Maxwell, Noel McCune, 'Use of puberty blockers for gender dysphoria: a momentous step in the dark', *Archives of Disease in Childhood*, published online 17 January 2019, doi:10.1136/archdischild-2018-315881)

The Astrid Lindgren Children's Hospital in Sweden recently decided against the use of hormonal treatments for those under 16 stating that *These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis (*Astrid Lindgren Children's Hospital, Policy Change Regarding Hormonal Treatment of Minors with Gender Dysphoria, April 2021).

The recent Keira Bell case further illustrates the permanent damage that such medication can do to a young woman's body. As Ms Bell said, illustrating the highly experimental, leap in the dark nature of such treatment: *I don't know if I will ever really look like a woman again...I feel I was a guinea pig at the Tavistock, and I don't think anyone knows what will happen to my body in the future.'*

Section 4: Approaches to care and treatment

The current approach to care and treatment in the UK is based on the World Professional Association for Transgender Health (WPATH) guidelines. It focuses on providing psychological and psychosocial support to patients and families and, if there are persistent signs of gender dysphoria upon reaching puberty, making a referral to a paediatric endocrine clinic for puberty suppression with the option of receiving cross-sex hormones to masculinise or feminise the body from the age of 16.

<u>The purpose of puberty blockers</u>

One of the current dilemmas in treatment decisions relates to the *purpose* of puberty blockers: whether it is to give young people time for reflection and exploration before proceeding with further, irreversible treatment, or whether it is intended as the first

step towards other treatment and designed to facilitate more straightforward transition with cross-sex hormones and later surgical interventions.

There is also a broader question about whether the provision of puberty blockers at a young age opens up or closes down future choices, for example, whether it leaves room for gender identity to fluctuate or evolve over time, or whether it determines or fixes a particular identity which excludes exploration of other options. Evidence on the number of children and adolescents with profound and longstanding gender dysphoria who persist in their gender identities, and on those who desist and do not become transgender adults, illustrates the complexity of the situation.

8. **What should be the purpose of puberty blockers? Does this match up with how they are used in practice?**

Puberty blockers should never be given to vulnerable children or young people. Children prior to and during puberty and adolescence are far too young and vulnerable to consent to and understand the consequences of such treatment. Just as the law sees fit to protect the young from premature exposure to sex, alcohol and cigarettes, so much more should the young be protected from taking body-altering medication which they may regret in later life.

We concur with the ruling of the High Court in *Bell v. Tavistock*:

A child under 16 may only consent to the use of medication intended to suppress puberty where he or she is competent to understand the nature of the treatment. That includes an understanding of the immediate and long-term consequences of the treatment, the limited evidence available as to its efficacy or purpose, the fact that the vast majority of patients proceed to the use of cross-sex hormones, and its potential life changing consequences for a child. There will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication. It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers. It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blockers (Bell v. Tavistock judgment, [2020] EWHC 3274).

However, we would go further and say that it is entirely inappropriate to give puberty blockers to any child under 16. Given that changing gender is going to be probably the most significant event in a person's life, we believe that this is a decision that can only be made by mature adults under the safeguards contained in the 2004 Gender Recognition Act.

The gender affirmative approach

One current approach to care and treatment of children and young people is often referred to as the 'gender affirmative' approach. It seeks to affirm the gender identity expressed by young people without questioning it. This approach complements the idea that gender is innate, sometimes expressed as the view that gender diverse and gender incongruent young people are 'born this way'. According to the gender affirmative approach, refusing to acknowledge and affirm gender identity, or attempting to 'cure' gender dysphoria, would be an attack on the identity and dignity of children and young people.

Others note evidence that a number of young people will desist from questioning their gender identity and will not become transgender adults. They also note evidence that suggests the majority of gender-questioning young people later identify as homosexual or bisexual adults, and worry that it is not always easy for children or clinicians to distinguish early questions and feelings about gender identity from early questions and feelings about sexuality. On this basis, they question whether the presence of gender non-conforming feelings and behaviour provides sufficient basis to endorse, unquestioningly, a child's view of their gender.

Those who view gender dysphoria as a symptom of broader mental health or social problems may advocate psychological and therapeutic approaches which adopt a more enquiring approach to a young person's expressed gender identity. Finally, the high rates of autism spectrum disorders (ASD) and mental health conditions in gender diverse and gender incongruent children and adolescents, and whether they are interrelated or simply co-existing, may also influence views on the most appropriate approach.

9. What is the best way to respond to a child or adolescent who expresses unhappiness or discomfort with their gender identity?

The best way to respond is to provide careful and sensitive counselling. It needs to be remembered that the principal individuals responsible for caring for children and adolescents are their parents. Parents must be consulted and respected and decisions should not be taken without their consent. Due to the often very temporary nature of gender dysphoria in young people, as far as is possible, attempts should be made to help the child or young person become more comfortable with the sex in which they were born. Clinicians also need to be aware of any physical or mental issues that the child or young person may have that may have an influence on the experience of gender dysphoria.

Social transition

Another approach to gender dysphoria is to support young people to live in accordance with their chosen gender identity, through choice of dress, changing names or pronouns - known as social transition. Some encourage early social transition as a way of exploring and expressing gender without the need for medical intervention, and note that it can help to reduce signs of distress and dysphoria. Recent trends in referrals indicate that a growing number of young people presenting to specialist gender clinics do so having already made a social transition.

Others have argued that social transition makes it difficult for young people to change their minds, and in fact increases the likelihood of later medical transition. Some raise concerns about external pressure to socially transition, perhaps from parents, mentors, or peers. They question whether social transition opens up or closes down future options. Some note that young people who later desist from identifying as trans may find this difficult it they have socially transitioned.

10. Should children and adolescents with gender dysphoria be encouraged or supported to transition socially? When should this occur?

No.

Since gender dysphoria in the young is frequently a fleeting occurrence encouraging social transition is premature and harmful.

A study by the thinktank Civitas found that:

The further a child proceeds along the path of social transition, the more difficult it becomes for them to revert to living as their original sex. To do so would involve not only personal acknowledgement that they have made a mistake but a public declaration that they are not deserving of the praise that has often been lauded upon them.

Social transition paves the way for medical interventions which, for children, can begin with hormones to stop the onset of puberty but may, for older teenagers, also include cross-sex hormones (Joanna Williams, *The Corrosive Impact of Transgender Ideology*, Civitas, 2020).

Encouraging young people to adopt an identity with which they may not persist would be deeply irresponsible.

Section 5: Understanding benefit and harm

As with other medical interventions, decisions about treatment can be seen through the lens of benefit and harm: what is most likely, given the available information, to

prevent the greatest harm and yield the greatest overall benefit for a child? There are differences in opinion as to what those benefits and harms are, and the extent to which the available evidence can be used to draw conclusions. Some believe that the existing evidence base provides a definitive answer as to whether medical interventions are beneficial or harmful, while others believe that the long-term risks and benefits have not yet been fully established.

Some of the suggested benefits associated with medical interventions in relation to gender identity include:

- in the case of puberty blockers, the prevention of irreversible development of secondary sex characteristics, making any further surgical intervention easier or unnecessary;
- in the case of cross-sex hormones, the development of physical features which complement one's gender identity;
- the alleviation of distress associated with gender dysphoria;
- greater social acceptance and improved relationships;
- improved psychological functioning; and
- reduction of risks of suicidality and self-harming behaviours.

These need to be weighed against a number of suggested harms, which include:

- unknown or uncertain long-term adverse effects of puberty blockers;
- in the case of puberty blockers, the risk of decreased bone density and increased risk of osteoporosis;
- adverse effects on brain function by blocking puberty's normal role in cognitive development;
- loss of fertility;
- the negative consequences of disrupting physiological puberty, given the role it might play in the formation and development of a consistent gender identity;
- adverse impacts on social and emotional function - for example, the feeling of being 'left behind' or 'out of sync' with peers who will be going through puberty;

- inhibition of age-appropriate sexual and romantic development and exploration;

- later regret and distress at an earlier decision; and

- for some individuals, a decision to desist or detransition if gender identity subsequently changes - with no reliable way of distinguishing between those individuals who will persist in their gender identities and benefit from treatment and those who will not.

11. How should the possible benefits and harms of treatment and non-treatment be weighed?

Children and young people suffering from gender dysphoria need careful and sensitive counselling, but we are doubtful about the benefits of treatment at such a young age.

A NICE evidence review of gender-affirming hormones for children and adolescents with gender dysphoria found that the evidence of clinical effectiveness and safety of gender-affirming hormones was of "very low" quality. The review stated:

*Any potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria (*NICE, Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria, October 2020*)*.

Considerable evidence exists of the harm done by such treatment, especially that aimed at suppressing puberty. In letter published in the *Archives of Disease in Childhood*, three paediatricians and child health specialists highlighted the dangers of puberty blockers, stating that:

…their use leaves a young person in developmental limbo without the benefit of pubertal hormones or secondary sexual characteristics, which would tend to consolidate gender identity… over 90% of young people attending endocrinology clinics for puberty-blocking intervention proceed to cross-sex hormone therapy. In contrast, 73%–88% of prepubertal GD clinic attenders, who receive no intervention, eventually lose their desire to identify with the non-birth sex… the use of puberty blockers may prevent some young people with GD from finally becoming comfortable with the birth sex.

These specialists further stated that the use of puberty blockers is '*likely to threaten the maturation of the adolescent mind'*. They referred to studies suggesting that pubertal hormones promote cognitive maturity and that puberty has a significant part to play in structural brain development. '*To halt the natural process of puberty is an intervention of momentous proportions with lifelong medical, psychological and emotional implications'* they concluded (Christopher Richards, Julie Maxwell, Noel McCune, 'Use of puberty blockers for gender dysphoria: a momentous step in the dark', *Archives of Disease in Childhood*, published online 17 January 2019, doi:10.1136/archdischild-2018-315881)

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The recent Keira Bell case further illustrates the permanent damage that such medication can do to a young woman's body. As Ms Bell said illustrating the highly experimental, leap in the dark nature of such treatment: *I don't know if I will ever really look like a woman again...I feel I was a guinea pig at the Tavistock, and I don't think anyone knows what will happen to my body in the future'* (Quoted in Amie Gordon, C Campaigners say 'common sense has prevailed' as High Court rules children under 16 are unlikely to be able to give 'informed consent' to take puberty blockers, *Daily Mail*, 1 December 2020).

12. How should we balance the needs of young people who will become trans adults ('persisters') with those who will not ('desisters') if we cannot reliably distinguish between the two?

It is difficult to know how these needs could be balanced since we simply cannot predict whether a gender dysphoric young person will persist or desist as they reach adulthood. However, based on the evidence that exists most young people who experience gender dysphoria do in fact desist.

We restate again what we have said earlier in our responses to questions 2 and 6. Gender dysphoric feelings, especially among the young and vulnerable, can often be fleeting. Among young people who experience gender dysphoria only a minority persist with these feelings into adulthood.

According to the American Psychiatric Association, in biological males, persistence has ranged from 2.2 to 30 per cent, and in biological females, from 12 to 50 per cent (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5, 5th edition, 2013, 302.85, Gender Dysphoria in Adolescents and Adults, p.455). NHS England cites research showing that only 12-27 per cent of children who experience gender dysphoric feelings continue with them into adulthood (NHS England, 'NHS Standard Contract For Gender Identity Development Service For Children And Adolescents', 2015).

Based on this evidence, while not neglecting the needs of a minority, we believe that there should be a greater emphasis put on desistance and a focus on helping gender dysphoric young people to accept the sex in which they were born.

13. How should the evidence on desistence and detransitioning be factored into decisions on whether and when children and adolescents should be permitted to embark on different stages of treatment?

We have already provided evidence of the frequently fleeting nature of gender dysphoric feelings. We feel that given this evidence, desistance should be encouraged and treated as the norm. The overwhelming focus should be to help young people to feel more comfortable in the body they were born with. The Keira Bell case shows us how administering treatment can be terribly premature. Keira Bell now has to live with the permanent damage done to her by the treatment she received. In her own words:

I don't know if I will ever really look like a woman again...I feel I was a guinea pig at the Tavistock, and I don't think anyone knows what will happen to my body in the future' (Quoted in Amie Gordon, C Campaigners say 'common sense has prevailed' as High Court rules children under 16 are unlikely to be able to give 'informed consent' to take puberty blockers, *Daily Mail*, 1 December 2020).

These words should act as a warning against premature treatment for a condition that has a very high chance of desisting.

14. What are the ethical implications of providing treatment that children and adolescents might later regret or reconsider?

One of the chief ethical implications of treatment is that we are essentially involved in conducting a dangerous experiment on children and young people. This is particularly the case in regard to the use of puberty blockers and cross-sex hormones. As was stated by three paediatricians and child health specialists in a letter published in *Archives of Disease in Childhood*. We are taking 'a momentous step in the dark'. In the words of those three specialists: '*To halt the natural process of puberty is an intervention of momentous proportions with lifelong medical, psychological and emotional implications* (Christopher Richards, Julie Maxwell, Noel McCune, 'Use of puberty blockers for gender dysphoria: a momentous step in the dark', *Archives of Disease in Childhood*, published online 17 January 2019, doi:10.1136/archdischild-2018-315881).

That many later regret or reconsider can be seen most prominently in the Keira Bell case but in numerous other cases of detransition (for example, see here https://post-trans.com/Detransition-English).

Section 6: Consent and capacity

There are differences of opinion as to the capacity of children and adolescents to consent to medical interventions in relation to gender identity. Some believe that decisions about capacity should be made on an individual basis, and that with appropriate consultation, discussion, and the provision of detailed and age-appropriate information, many young people reach the standard of competence to make such decisions. They may hold that there is no reason for treating this decision differently from other types of medical treatment to which - if found to have capacity - young people can consent themselves.

Others express doubts about whether children and adolescents have reached an appropriate state of cognitive development and emotional maturity to be able to make this sort of decision. They emphasise the uncertainties surrounding the long-term effects of medical treatment for gender identity; the (in)ability of young people to properly understand how treatment will affect future decisions and desires; and the uniqueness of treatment for gender identity as lifelong and life-changing in a way that few other treatments are.

There are differences of opinion too as to whether the consent of a young person alone should be sufficient, or whether there is a role for those with parental responsibility in addition to, or instead of, that young person's consent. In the UK, a young person is deemed to have capacity if they are able to weigh the information required and arrive at a decision; understand the nature and purpose of the

proposed intervention; understand the risks of any proposed intervention as well as any alternatives; and are free from undue pressure or influence. This is often referred to as the standard of 'Gillick competence'. If the young person is not deemed to have capacity, the normal position would be that someone with parental responsibility must consent to medical treatment on their behalf. In the context of medical interventions in relation to gender identity the policy of the Gender Identity Development Service (GIDS) in England and Wales has always been that it would be inappropriate to administer puberty blockers to any patient without their consent and on the basis of parental consent alone.

A recent High Court judgement in the UK held that there will be 'enormous difficulties' in a child under 16 understanding and weighing the necessary information and being able to give consent to puberty blockers or cross-sex hormones. The Court concluded that it was 'highly unlikely' that anyone aged 13 or under could be deemed competent to give consent and 'doubtful' that anyone aged 14 or 15 could do so. Furthermore, in respect of young people aged 16 and over, clinicians 'may well regard these' as cases requiring consideration by the court. This decision is currently on appeal.

15. Do you think that children and adolescents under the age of 16 have the capacity to consent to puberty blockers and cross-sex hormones? Please expand on your answer.

No.

The decision to change one's gender is surely one of the most, if not the most, significant, and life-changing decisions that any human being can make in their life. Children under the age of 16 cannot drive a car, they cannot engage in sexual intercourse, they cannot smoke cigarettes or drink alcohol. That they are not allowed to do these things is for their own protection. Taking puberty blockers and cross-sex hormones is likely to a be far more drastic and life-changing than any of the aforementioned activities as it is treatment from which their bodies may never recover.

We concur with the ruling of the High Court in the *Bell v. Tavistock* judgment which after noting the pitfalls of taking puberty blockers noted:

There will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication (Bell v. Tavistock judgment, [2020] EWHC 3274).

16. **Who should have the authority to consent to and make decisions about medical intervention in relation to gender identity? (E.g. a competent young person alone; a competent young person *and* those with parental responsibility; those with parental responsibility should be able to consent on behalf a young person who lacks capacity; a court)?**

We do not believe that there should medical intervention in relation to gender identity with regards to any person who is not a mature adult. If such intervention does take place, parental consent would be essential.

17. **Is there anything distinctive about the use of puberty suppressants and cross-sex hormones such that they warrant a different standard of consent compared to other paediatric medical decisions?**

Since such medication permanently alters a person's body and that we are dealing with vulnerable children and young people, we believe that there needs to be a higher standard of consent.

Section 7: Other

Please use this section to share any other thoughts and comments which you have not been able to make in response to earlier questions.

Finally, we are also interested in understanding people's views and experiences of how this topic is debated and discussed more broadly. Many people have highlighted how polarised and hostile the debate around issues of gender identity and trans rights has become, and noted that this may inhibit open discussion about some of the clinical, legal and ethical complexities of this issue.

15. **Are there any other ethical issues which arise in the context of the care and treatment of children and young people in relation to their gender identity that you would like to draw to our attention?**

Here we would simply like to summarise what we have stated earlier. We consider gender dysphoria to be a form of body dysmorphia that needs to be carefully treated but certainly not affirmed. Young people who suffer from gender dysphoria need to be helped to accept the body and sex in which they were born. Just as those who suffer from anorexia should be sensitively helped to become more comfortable with their body so should those with gender dysphoria.

A study by two of the world's most respected academics in this area, Dr Lawrence Mayer and Dr Paul McHugh of Johns Hopkins University School of Medicine, concluded that:

The hypothesis that gender identity is an innate, fixed property of human beings that is independent of biological sex— that a person might be 'a man trapped in a woman's body' or 'a woman trapped in a man's body'—is not supported by scientific evidence (Lawrence S. Mayer and Paul R. McHugh, Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences, *New Atlantis,* Number 50, Fall 2016).

Those who help those suffering from this condition need to understand that it is often a temporary phase. Gender dysphoric feelings, especially among the young and vulnerable, can often be fleeting. Among young people who experience gender dysphoria only a minority persist with these feelings into adulthood. According to the American Psychiatric Association, in biological males, persistence has ranged from 2.2 to 30 per cent, and in biological females, from 12 to 50 per cent (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5, 5th edition, 2013, 302.85, Gender Dysphoria in Adolescents and Adults, p.455). NHS England cites research showing that only 12-27 per cent of children who experience gender dysphoric feelings continue with them into adulthood (NHS England, 'NHS Standard Contract For Gender Identity Development Service For Children And Adolescents', 2015).

We believe that the administering of puberty blockers and cross-sex hormones to vulnerable children and young people to be a thoroughly unethical experiment.

There is little evidence that transition and the use of puberty blockers alleviates distress in the long term (Puberty blockers do not alleviate negative thoughts in children with gender dysphoria, finds study, *BMJ* 2021; 372: n356).

A NICE evidence review of gender-affirming hormones for children and adolescents with gender dysphoria found that the evidence of clinical effectiveness and safety of gender-affirming hormones was of "very low" quality. The review stated:

*Any potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria (*NICE, Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria, October 2020*)*.

Considerable evidence exists of the harm done by such treatment, especially that aimed at suppressing puberty. In letter published in the *Archives of Disease in Childhood*, three paediatricians and child health specialists highlighted the dangers of puberty blockers, stating that:

…their use leaves a young person in developmental limbo without the benefit of pubertal hormones or secondary sexual characteristics, which would tend to consolidate gender identity… over 90% of young people attending endocrinology clinics for puberty-blocking intervention proceed to cross-sex hormone therapy. In contrast, 73%–88% of prepubertal GD clinic attenders, who receive no intervention, eventually lose their desire to identify with the non-birth sex… the use of puberty blockers may prevent some young people with GD from finally becoming comfortable with the birth sex.

These specialists further stated that the use of puberty blockers is 'likely to threaten the maturation of the adolescent mind'. They referred to studies suggesting that pubertal hormones promote cognitive maturity and that puberty has a significant part to play in structural brain development. 'To halt the natural process of puberty is an intervention of momentous proportions with lifelong medical, psychological and emotional implications' they concluded (Christopher Richards, Julie Maxwell, Noel McCune, 'Use of puberty blockers for gender dysphoria: a momentous step in the dark', *Archives of Disease in Childhood*, published online 17 January 2019, doi:10.1136/archdischild-2018-315881).

The Astrid Lindgren Children's Hospital in Sweden recently decided against the use of hormonal treatments for those under 16 stating that *These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis. (*Astrid Lindgren Children's Hospital, Policy Change Regarding Hormonal Treatment of Minors with Gender Dysphoria, April 2021).

The recent Keira Bell case further illustrates the permanent damage that such medication can do to a young woman's body. As Ms Bell said illustrating the highly experimental, leap in the dark nature of such treatment: *I don't know if I will ever really look like a woman again...I feel I was a guinea pig at the Tavistock, and I don't think anyone knows what will happen to my body in the future'* (Quoted in Amie Gordon, C Campaigners say 'common sense has prevailed' as High Court rules children under 16 are unlikely to be able to give 'informed consent' to take puberty blockers, *Daily Mail*, 1 December 2020).

The experimentation on children and young people with such dangerous medication needs to stop.

16. **More generally, have you felt able to engage in talking about these issues openly in your personal or professional life?**