Submission of Evidence to the Nuffield Council on Bioethics by Our Duty

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

INTRODUCTION

Our Duty is an international support group and advocacy organisation for parents of children who identify as transgender[1].

The first established parent peer support and advocacy group in UK[2], Our Duty is run by parents for parents and now has members in fourteen countries and independent branches in UK, USA and Australia.

We are parents who know, instinctively, that a 'sex change' is not an appropriate treatment pathway for their (or any) child. This point of view is founded on the principle of 'first do no harm'. We are the only UK group representing parents of affected children advocating for the precautionary principle to be applied in the field of gender medicine. These principles inform our responses to this call for evidence.

This submission is informed by the evidence of many parents received by us in support meetings, one-to-one interviews, and responses to our invitation to contribute to this exercise. We operate in a societal environment where it is difficult for parents to be public in their views and their opposition to the medical harm being done to their children. Our opponents are aggressive, intolerant, and very well funded.

Our personal experience of using gender identity services comes as parents of the direct users – our children.

Most of our members have personal experience of supporting direct users of gender services. However, we can report that fewer parents are accepting referrals to these services because of the emerging evidence that they are unsafe.

TERMINOLOGY

This submission will use the term 'Opposite Sex Imitation Medicine' (OSIM) because the phrase 'gender affirming treatment' is a loaded euphemism.

Examples of true gender affirming treatment (meriting social health care) would be mastectomies for males with gynecomastia, or laser hair removal for females with PCOS.

RESPONSE 1 – GENDER DYSPHORIA

the nature of gender dysphoria and how this affects approaches to care and treatment

1. How should gender dysphoria be characterised?

'gender dysphoria' can include both genuine anxiety about one's sexed body alongside the manufactured 'gender dysphoria' with which many of those presenting themselves to gender clinics possess. It is known that many adolescents will, when persuaded that they are 'transgender' present to a gender clinic having rehearsed a script aimed at receiving a diagnosis of gender dysphoria.

More research is required on the epidemiology of gender dysphoria [3], however the condition afflicts patients in clearly identifiable cohorts.

- Pre-pubertal – mostly boys thinking they are girls
- Adolescent – two-thirds girls, one third boys, presenting with no prior history of gender incongruence, often called ROGD [4] and the cohort with which our group is primarily concerned
- Homosexual transsexuals – usually young adult gay men, a few of our members have children in this category.
- Autogynephiles – usually middle aged men

It is our experience that gender dysphoria is founded on a deeply held belief. Just as one might have deeply held religious belief, or a phobia that stems from a deeply held belief (e.g. a dog phobia stems from the belief one will be bitten).

Such deeply held beliefs can come about from excessive rumination or from coercion (also called grooming), and often a combination of both.

It seems clear to us that 'gender dysphoria' is not the correct term to describe the belief these young people hold. However, it is difficult to provide a name, let alone one that might attain widespread acceptance.

Our children are led to believe that they are transgender – this happens in a variety of ways[5]. Abigail Shrier has described the social contagion and the craze-like nature of adolescent gender in her book *Irreversible Damage*[6]. Heather Brunskell-Evans and Michele Moore have collated evidence in their book *Inventing the Transgender Child*[7]. Reports from our parents speak of peer pressure coming from social groups online as well as in real-life. Two disturbing phenomena are that some children at school bully others into believing that they are transgender, and other children seeking support with their emerging sexuality from LGBT Support groups are led to believe that they are not homosexual but instead transgender.

A child becomes transgender because the idea is planted and then is nurtured by others. This process is easier to achieve with vulnerable children, so neurodiverse, homosexual, those in care, are all at greater risk. Society owes a duty of care to these vulnerable and quirky children to protect them from unnecessary harm.

Fundamentally, someone's idea that they are not comfortable with their sexed body is a problem in the mind and not of the body.

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

A young person claiming a transgender identity needs immediate and holistic psychotherapeutic intervention[8]. It is important that they are encouraged to reconnect with reality, with the goal of achieving body/mind reintegration[9], as soon as possible to avoid the damage of harmful OSIM. Social affirmation must not occur. The push for early bodily modification and hormones by some transgender patients is a cause for concern and must be resisted.[10]

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?

The deep disagreement about the nature and causes of gender dysphoria stems from there being two distinct groups. There are those who favour an evidence-based approach to the diagnosis and treatment of those who have adopted a transgender gender identity, and those who promote such identities as a matter of faith. Those who advocate the faith-based promotion of OSIM fall into three main groups. First, transgender people who wish for society to validate their life choice, and in whose interests it is to have more transgender people and for them to be celebrated. Second, parents of children with transgender identities who have affirmed those identities and encouraged their children to undertake OSIM (it is suggested these parents have Munchausens by Proxy). It is in their interests for their life choices to be validated, too. The third group is the 'allies', the 'useful idiots'[11] with pronouns in their social media biographies and email signatures who think that affirming gender identities is 'the kind thing to do'. Unfortunately, these three groups have amassed considerable power in promoting their faith. We might call this faith 'gender ideology'.

Understanding the nature and motivations of the two opposing groups is a pre-requisite to working out how to deliver an evidence-based approach (preferably incorporating the precautionary principle) while escaping the wrath of the powerful pro-transition lobby.

The treatment and care of gender diverse young people needs to take this terrain into account, particularly since the patients need to fully understand the faith-based nature of those advocating for their medical transition.

RESPONSE 2 – SOCIAL CONTEXT

the social context within which gender dysphoria exists

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

The political power of those who believe in and promote gender ideology is the biggest social factor relevant to gender identity in children and adolescents.

This new religion has been established everywhere from the United Nations[12] all the way through to the general public. The big technology companies such as Twitter[13], Amazon[14] and Facebook all give special treatment to this faith. The BBC and Netflix promote transgenderism as the latest fashion. Academia silences 'gender critical' voices[15]. Even the UK government promotes it with the marketing strategies of the adult gender clinics[16] and a Government Minister reciting the faith's creed from the despatch box. In short, the new religion of gender ideology has become thoroughly entrenched in society. Those of us who are critical of its tenets – who deny that a man can become a woman – who wish to protect our children from harm - who believe that sex is real and it matters – we are the heathens.

For example, a recent employment tribunal held that asserting that sex is real and immutable (i.e. that even if a man imitating a woman has a Gender Recognition Certificate, he cannot honestly describe himself as a woman) is a 'belief is not worthy of respect in a democratic society'.[17] An appeal of this ruling has been heard and is awaiting judgment.

How might these contribute to:

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

This social environment makes it exceedingly difficult for a parent to assert reality when confronted with a child who claims to be transgender. In this environment, rational and loving parents are tarred as bigoted haters.

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

This social environment portrays transgenderism as trendy, positive and normal. While no person should be discriminated against because of their condition, it is likely that persisting transgenderism is an unfortunate condition that could be avoided if it is resolved early enough in its presentation. Much more research is required to demonstrate the veracity of this hypothesis.

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

This environment has resulted in many healthcare practitioners, especially including those working in mental health and gender identity services to align themselves with gender ideology[5]. Some have even taken on the role of activists promoting transgenderism[18]. This makes it almost impossible for parents and patients to gain access to professional help that does not put the young person on a pathway to OSIM. There is a real and pressing demand amongst our members for access to safe treatment (i.e. treatment where OSIM is not an option) for so-called gender dysphoria.

RESPONSE 3 – EVIDENCE FOR TREATING WITH HORMONES

whether there is adequate evidence on the safety and effectiveness of puberty blockers and cross-sex hormones to support treatment

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

No.

There is no good quality evidence that supports medical interventions for gender diverse children and adolescents.

Primarily, we defer to the evidence submitted by experts in support of Keira Bell in her case against The Tavistock and Portman NHS Foundation Trust.

In addition, we refer to the recent evidence reviews published by NICE regarding puberty blockers and cross-sex hormones.

OSIM is experimental treatment of a profoundly harmful nature, it is surprising to many of our members that it ever gained ethical approval.

This experiment has not been conducted as a formal trial. There are inadequate records. Studies published thus far by the gender clinic itself is inconclusive at best.

If this kind of cavalier experimenting on children is not prohibited in law, one must ask why not.

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.

This is an interesting question - 'a different standard' to what? It is our view that if the use of puberty blockers in gender medicine had been commenced adhering to the normal standards one might expect with a medical experiment – i.e. a randomised, controlled trial alongside a longitudinal study of outcomes - then we would know for certain the harmful nature of this particular treatment pathway and it would have ceased long ago.

RESPONSE 4 – CURRENT TREATMENT APPROACHES

current approaches to care and treatment, including the purpose of puberty blockers, the gender affirmative approach, and social transition

WPATH and NHS

The current approach to care and treatment in the UK is based on the World Professional Association for Transgender Health (WPATH) guidelines. These guidelines are flawed, written as they are by a pro-transition lobby group[19]. Moreover, their interpretation and application in the UK eschews any psychological and psychosocial support to patients and families and instead concentrates on a 'patient led' pathway that has become known as the 'gender affirming model of treatment' (GAMT).

The purpose of puberty blockers

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

Puberty blockers are gonadotropin-releasing hormone (GnRH) agonists. They are used for a variety of indications including in fertility medicine and to lower sex hormone levels in the treatment of hormone-sensitive cancers such as prostate cancer and breast cancer, certain gynaecological disorders like heavy periods and endometriosis, high testosterone levels in women, and early puberty in children.

When used in gender medicine they almost invariably lead onto OSIM. [see Bell v Tavistock][20] Moreover, they do not even improve the short-term wellbeing of those receiving them.[21]

Furthermore, Sweden has ended the practice of prescribing puberty blockers and cross-sex hormones for children under the age of 16. Hormonal intervention may now only occur within research trials approved by Sweden's ethical review board.[22]

Side-effects include reduced bone density[23]; and adolescent maturation, neurological, physical, and social, is disrupted.

Their use in gender medicine is unethical and should cease.

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 is the way that causes the least harm – the long-term prospects should be considered as more important than the short-term desire to alleviate any distress resulting from gender dysphoria.

Social transition

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

The 'Gender Affirmation' approach, which means automatically accepting the child's new gender identity, is being challenged in some quarters. Guidance issued by the Department for Education (DfE) in September 2020 warned schools not to use external providers who suggest that non-conformity to gender stereotypes is synonymous with having a different gender identity.[24]

The 'Gender Affirmation' approach could include using the Gender Dysphoric Child's new name and pronouns and allowing female pupils to use breast binders. But affirming the new identity is the first part of a journey that could lead to a pupil taking puberty blockers, and then to irreversible cross-sex

hormones. As the judges in Bell case noted, once a child is on the first stage of the clinical pathway, it is "extremely rare for a child to get off it." Schools are, therefore, advised to consider adopting a "watch and wait" approach, which neither affirms the child as the opposite sex, nor attempts to force them to conform to sex stereotypes. They could allow a boy to wear a skirt, for example, but not to use the girls' changing-rooms.[25]

Social transition is a gateway to medical transition. It amplifies the problem. It validates an unsustainable and inappropriate belief. If gender dysphoria is to be 'nipped in the bud' then social transition must cease to be an acceptable practice. Society needs to do its part in rejecting 'pronoun culture' and the concept of 'Self-ID'. A boy claiming to be a girl is still a boy, and it is profoundly damaging to that boy's mental wellbeing, and particularly to his chances of avoiding being medicalised by the gender ideology industry, if his claim to be a girl is humoured with any seriousness.

RESPONSE 5 – CONSIDERING BENEFITS AND HARMS

how to consider the benefits and harms of treatment and non-treatment in decision-making

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

The current GAMT pathway is a short-term palliative treatment which seeks to alleviate current discomfort. Its benefits are primarily cosmetic and frequently short-lived.

Any ethical treatment pathway for gender dysphoria should aim to be curative and to take a long-term view of a patient's healthcare needs.

We suggest that permanent disfigurement and a lifelong medication requirement are so detrimental in the long-term as to outweigh any short-term amelioration of the condition. On this basis we consider OSIM to be both harmful and unethical. It is incumbent on the medical professionals working in gender identity services to seek and find treatments which require no long-term medication and which maintain the bodily integrity of the patient.

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?

Each 'persister' that reaches 'a point of no return' with their Opposite Sex Imitation Medicine has been let down – let down by society, let down by the psychotherapeutic professions, and profoundly let down by the medical profession. It should be the objective of any advanced civilization presented with this problem to TARGET 100% DESISTANCE, and as early as possible.

In any case, we are presented with many young people who have suffered iatrogenic harm, much of it irreversible and life-limiting. Of course, it is necessary that persisters, desisters and detransitioners command the best health care that we can provide. There is a duty of care, not least from those who are responsible for this scandal, to provide the best remedy possible. Medical research should dedicate itself to finding the best solutions to the irreversible harm that has been done to the victims of gender ideology. More resources, money and expertise should be directed at making good this problem than should be spent on perpetuating it.

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?

The existence of a great many detransitioners is indicative that the GAMT is widely ineffective. The risk of OSIM failing to cure dysphoria combined with the very real risk of regret at the profound, life limiting effects of the treatment, means that the GAMT is patently unethical.

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

There has been no randomised controlled trial of OSIM and therefore we have no way of knowing whether those patients who have received it would have been happier had they not received it.

It is better for no person to receive Opposite Sex Imitation Medicine than for one person to receive it in error. This is the same logic behind why the UK does not have the death penalty, it is held that the price of one mistake is too high. Given the severe life-limiting nature of OSIM this principle is relevant.

Any treatment should be psychotherapeutic in nature – the problem is in the mind not in the body.

RESPONSE 6 - CONSENT

the ability of children and adolescents to consent to medical interventions for gender dysphoria

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.

First, we need consider the concept of informed consent. Informed consent requires both all the information[26] and the capacity to consent.

Interpretations of Gillick competency accept that the more severe the implications of any medicine, the more mature in mind the patient needs to be.[27]

The administration of puberty blockers and cross-sex hormones in response to gender identity issues is at the extreme end of questionable medical practice. There is no evidence of any long-term good, and plenty of evidence of long-term harm. Patients are vulnerable and not yet mature enough to properly know themselves and are being taken advantage of.

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)?

In an ideal environment where OSIM is not available at all to young people (under the age of 25) or anyone via socially funded healthcare (i.e. the NHS in UK), then parents should have responsibility up to the age of majority and the young person can have responsibility thereafter.

In an unsafe and dangerous environment where OSIM is available freely (as is the case in the UK at present), then such extreme and unnecessary medicalisation must be sanctioned by a court of law.

What is required is for there to be legislation, or policy decision if that is all that is required, halting the provision of OSIM entirely on the NHS and only permitting it for those over 25 years of age who are prepared to fund it themselves and who have passed a psychiatric evaluation.

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?

Puberty suppressants and cross-sex hormones should not be available, at all, for the purposes of treating gender identity issues in minors. The chances of such issues resolving themselves in the normal course of adolescent turmoil means that a likely transient nature of the issue, when weighed against the risk of permanent long-term harm, makes OSIM for minors profoundly unethical.

RESPONSE 7 - OTHER

General points on the ethics of Opposite Sex Imitation Medicine and the debate surrounding it

18. 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?

The so-called 'gender affirming model of treatment' is profoundly unethical and must be halted.

That the debate seems to concentrate on those under 18 is cause for concern on two counts:

First, the reality of waiting times forcing 50% of young people with gender identity issues into adult services, where there is far less scrutiny, is a genuine danger.

Second, it is widely acknowledged that adolescents do not mature in terms of long-term or doubly abstract thinking capacity until approximately 25 years of age. This means that the capacity to give consent to such profound and life-altering medical treatments as OSIM is not fully developed. Consequently, we consider unethical to treat patients contemplating OSIM as adults until they are over 25 years of age.

OSIM is demonstrably harmful and is unethical regardless of the age of the patient. For a person to give truly informed consent to such radical, life-limiting and identity altering medicine, one would have to be of sufficient soundness of mind to acknowledge that what, in fact, they were embarking upon is radical and extreme cosmetic body modification with no clinical justification. In which case, such patients should finance it themselves. Moreover, practitioners would need to be aware that they were at risk of prosecution for Grievous Bodily Harm.

We propose that transgenderism could be very similar to a deep seated fear of growing up into one's adult sexed body. That fear is a normal attribute of puberty and adolescence, however it can be amplified by external influences and rumination. We note that adolescents claiming a transgender identity frequently have generalised social anxiety which could well be the intermediate step between normal apprehension and full-blown phobia of one's own natural development. We call upon interested academics to research this theory.

Adolescence is not an illness – don't treat it like one

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

Many of our members feel that they must remain anonymous online when outside of the safe networks we provide. Where parents work in professions or organisations which have been entirely 'captured' by gender ideology, then they are obliged to adopt multiple personalities to cope at home, at work, socially, and when discussing gender identity issues with sympathetic others. The climate is changing. When Our Duty was established 2018, 90% of members felt unable to talk about these issues openly. Now the figure is nearer 50%. Nevertheless, society has a long way to travel before the desire to tell the truth about human sex and to champion the bodily integrity of our children is the mainstream consensus it should be.

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