THE COUNTESS

Mr. Roderic O'Gorman TD
Minister for Children, Equality, Disability, Integration and Youth
cc An Taoiseach, Micheál Martin. 6, July 2021

Dear Minister O'Gorman,

The Countess is a grassroots human rights and advocacy group that provides data-driven and evidenced-based resources to Irish citizens to inform them of the Gender Recognition Act, Gender Theory, and their impact on Irish society, in particular, women and girls. www.thecountess.ie

We represent a constituency of parents and citizens who are committed to the welfare of vulnerable children. We are writing to you in relation to the Government's National Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI+) Inclusion Strategy.

We believe our democracy must work for all of us, not just a tiny minority and their allies. Our position is that trans rights are human rights. Trans-identified people must have every possible human and civil right, but not at a cost to women and children.

We are particularly concerned with the provisions contained in the "Prohibition of Conversion Therapies Bill 2018" and the "Gender Recognition (Amendment) Bill 2017". These Bills, unless amended from their original drafts, could have profound and devastating adverse effects on children, particularly young girls. In this regard, we have prepared the attached Memorandum, which seeks to outline and explain our concerns and is submitted herewith for your attention and consideration.

Against the background of these radical proposals for our society, and as stakeholders, we would like to request a meeting with you to provide an opportunity for discussions on these issues. As the recent Maya Forstater Appeal in the UK held, "gender critical" views are compatible with Articles 9 & 10 of the European Court of Human Rights and that they are not excluded from protection by virtue of Article 17 of the ECHR. As such, the perspective of the constituency we represent is no less valid, and should be heard alongside the transgender activists referred to by Colm Keena[1] in his recent article for the Irish Times.

It is time to examine these template laws in the round and not simply from one perspective.

We very much look forward to hearing back from you at your earliest convenience.

With kind regards,

le meas,

Laoise Ui Aodha de Brun,

[1] https://www.irishtimes.com/life-and-style/health-family/gender-distress-treatment-in-young-people-a-highly-charged-debate-1.4602455.

Founder, The Countess

Memorandum on the "Prohibition of Conversion Therapies Bill", and, the "Gender Recognition (Amendment) Bill 2017."

The Government's National Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI+) Inclusion Strategy provides a number of very welcome and positive measures designed to "create an Ireland that cherishes its LGBT+ people equally." For this purpose, it includes 108 actions to achieve concrete and tangible results.

However, the Strategy also has a number of negative and adverse implications for children, particularly for teenage girls, and it is to these, we wish to bring the Minister's attention.

The specific legislative amendments that are of particular concern to us are outlined below under **(1) The Prohibition of Conversion Therapies Bill, and (2) Gender Recognition (Amendment) Bill 2017).** The effects of both these Bills are linked and intertwined.

Our overriding concern is that, as currently drafted, both of these Bills put vulnerable children as risk.

The affirmative/informed consent model is explained as follows by Dr. Sarah L. Schulz, a Professor of Psychology at Point Park University in the USA who is also Faculty Advisor for the LGBTQ community:

> *The Informed consent model allows for clients who are dysphoric about their gender to access hormone treatments and surgical interventions without undergoing mental health evaluation or referral from a mental health specialist. Clinicians are encouraged to "affirm" a person's belief that they are transgender. Many children under the age of 18 are giving informed consent to irreversible medical treatments including underage mastectomies, sometimes without parental consent.*

(1) Prohibition of Conversion Therapies Bill

> *"In the first instance, it is our position that there is no convincing medical evidence to show that gender dysphoria has a biological cause, and to deny a distressed person access to a competent psychotherapist to relieve that distress is unethical." Dr Will Malone, Endocrinologist, Society for Evidence Based Gender Medicine.*

We understand that the aim of the Bill is to de-pathologise gender dysphoria (no longer treat it as a mental illness)[2] and to prohibit conversion therapy for LGBTQ+ people, including transgender people.

[2] The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults.

Historically, Conversion Therapy sought to change a person's sexual orientation by psychological or physical interventions. People who were gay were told that being gay was a pathology (it was in the psychiatric manual as a pathology) and that the outcome of the "treatment" was to convert the gay person from same sex attraction to heterosexual.

This often involved electric shock treatment and chemical castration as well as being forced to watch porn, and suffering humiliation and trauma.

The Irish Government would appear to believe that by including "gender identity and gender expression" in the Bill, this will normalise gender dysphoria and that this is similar to the way homosexuality was normalised several decades ago. However, the proposed legislation departs fundamentally from that methodology (the medicalisation of gay people ceased many years ago), by effectively facilitating the medicalisation of children and young girls and boys.

It also opens the door to the World Professional Association for Transgender Health (WPATH)[3] "informed consent model" of care, whereby gender dysphoric children (a desire to be of another gender) and young people are "affirmed" in their perceived gender. In effect then, this process provides for the most extreme life-altering medical procedures on the bodies of young people without an evidence base.[4]

In this model, the so-called "informed consent model", or "affirmative care model", the focus is on obtaining consent of the child only, as the threshold for the initiation of hormone therapy. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription. There have always been a number of people, whose biological sexed bodies caused them distress. For a tiny handful (0.01% of the population) medical transition was a way to alleviate their distress but we are witnessing a social phenomenon with a reversal of natal sex, from traditionally male to female, presenting as transgender and an increase of 4,400% of girls wishing to transition. This diagnostic craze cannot be explained by a greater tolerance in society toward trans people or we would be observing many middle-aged women transitioning. There are none.

By seeking to criminalise parents and/or professionals working in both the medical and therapeutic fields who question the "affirmative care model", the Bill is also eliminating/denying legitimate non-intervention care, such as psychological exploration, that would greatly benefit the treatment of young people who may be experiencing gender dysphoria. This is unethical.

Permitting or agreeing to therapy by a professional does not remove the option later on for medical treatment, if required. Those with gender dysphoria do not fit a 'one size model' and need to have access to a range of therapeutic options. Criminalising such

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[3] See Appendix 1 for a fuller outline of this organisation's approach to the treatment of gender dysphoria.

[4] Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria, Paul W Hruz, MD, PhD.)

therapy removes this choice and this will result and lead on to normalizing, and rushing through, medical transition for young people. As an example, some anorexics improve with cognitive and family therapy and some are so severe they require hospitalisation and a stomach tube to feed them: there are a range of treatment options to suit the severity of the condition.

In short, the 2018 Bill provides that any attempt by a professional to provide therapy or medical care outside of the "affirmation model" will be regarded as "conversion therapy" and deemed to be unlawful. It will also be unlawful for a person, including a parent, to take a child out of the country for what is deemed "conversion therapy".

The sanctions set out in the Bill include imprisonment and/or a substantial fine. Furthermore, a professional, if found guilty, will be reported to their governing body. These measures will criminalise parents and therapists who seek to unpick the root cause of the adolescent child's mental distress. These sanctions are disproportionate and will be open to scrutiny down the line when/if the child detransitions and asks why their underlying trauma or mental health issues were not examined before the puberty blockers and cross-sex hormones were prescribe, and which have resulted in irreversible damage to their bodies.

While we welcome the prohibition of conversion therapy for people whose sexual orientation is towards members of the same sex, **we strongly oppose**, for the above reasons, the inclusion of "gender identity and gender expression" in this Bill.

According to our own Health Services Executive (HSE) website, "The Endocrine Society found that 75-80% of children who were diagnosed with gender dysphoria before they reached puberty did not have the condition after puberty. Therefore, endocrine treatment is not recommended until after puberty, when a diagnosis of gender dysphoria can be confirmed."

Yet, and notwithstanding this, the HSE goes on inexplicably to set out the pathway to medicalisation of children under 16 who are diagnosed with gender dysphoria to commence puberty blockers up to age 16, and then to commence cross sex hormones, leading to "gender confirmation surgery" at 18 years of age.

We are seriously concerned at this. Three High Court judges in the UK, having reviewed 3,000 pages of evidence (Ref, Bell v Tavistock Judgement)[5], stated that children cannot make decisions on their own that will affect them for life. (See Appendix 3) We believe that the measures outlined in these Bills (while well meaning) will have a negative impact on the lives of a cohort of vulnerable young Irish children and young people.

The main arguments in the "born this way/ born in the wrong body" campaign by the trans industry have been readapted from the LGB model. However, being LGB **does not** require you to take medication or have surgery.

[5] In December 2020, the High Court in London in Bell v Tavistock ruled against prescribing puberty blockers for children under 16 (See Appendix 3) An appeal by the Tavistock has been heard but not yet decided.

In the case of young gender dysphoric children, if the therapist is forced to insist that the gender dysphoric person is the opposite sex to their biological sex, (the "affirmation model") then we would argue that they **will be** engaging in conversion therapy.

Consequently young people will be set on the pathway to medicalisation (the complete opposite of anti-conversion therapy for gay people) – i.e. changing their body to fit in with their perceived gender identity. **This is conversion therapy - In reverse.** Many of these children and young people may be coming to terms with being gay and dealing with homophobia/lesbophobia/biphobia at school, at home, or internalised. Encouraging them to transition is not the solution. They should be supported, as they are, a gay, lesbian or bisexual young person.

Being gender-nonconforming, as lesbian or gay people often are, is now seen as a reason to transition and **this is a form of conversion therapy.**

According to the Society of Evidence-Based Gender Medicine (SEGM.org) in their article in the Archives of Sexual Behaviour entitled: One size does not fit all: In support of Psychoanalysis for Gender Dysphoria (November 2019)

> *"We believe that exploratory psychotherapy that is neither "affirmation" nor "conversion" should be the first-line treatment for all young people with GD, potentially reducing the need for invasive and irreversible medical procedures. This is especially critical now, when we are witnessing an exponential rise in the incidence of young people with GD who have diverse and complex mental health presentations and require careful assessment and treatment planning."*[6]

(2) The Bill to amend the Gender Recognition Act 2015

This Bill as currently drafted provides a right to self-determination for those who have reached the age of 16 years; to introduce a right to legal gender recognition for those under the age of 16 years; and to ensure inclusion of the status of non-binary persons into Irish Law.

A lower age limit has not been included in the draft legislation and there is no requirement for supporting medical documentation from a medical practitioner.

It is clear that children under the age of 16 years will be enabled, and facilitated to socially transition to the opposite gender in the absence of proper therapeutic investigation and evaluation. Studies show that if this "social transition" is encouraged in this way, it leads to a pathway of medication, starting with puberty blockers, cross-sex hormones and ultimately gender affirming surgeries (see Appendix 1).

According to Dr de Vries, as evidenced in the Tavistock –v- Bell Judgement (see Appendix 4) *"of adolescents who started puberty suppression, only 1.9% stopped the treatment and did not proceed to cross-sex hormones."* Therefore 98% of adolescents who were prescribed puberty blockers, progress to cross-sex hormones.

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6 Roberto D'Angelo, Institute of Contemporary Psychoanalysis, SEGM; Ema Syrulnik SEGM; Sasha Ayad SEGM; Lisa Marchiano SEGM; Diane Theodora Kenny SEGM; Patrick Clarke SEGM.

Introducing trans ideas to school- going children and the Rapid Rise in Referrals

To introduce the concept of Gender Identity to children before they develop a cognitive ability for sex constancy is unethical to say the very least, and will confuse children before they can understand fully the immutability of biological sex. We note the recommendations from some trans advocacy groups to speak to schools in the guise of "diversity training" and that children's books that deal with the topic of trans be introduced at a very young age.

The Irish Times on 4 May 2021 reported that there has been an "exponential" growth in referrals to the National Gender Services (NGS), which sees patients over the age of 18. These referrals increased from 50 new patients in 2012*, to* approximately 275 in 2020, while the average age of referrals has lowered significantly. Crumlin Children's Hospital has also experienced a rapid growth in demand for its services.

We believe that social media and the Government's own actions may have played a role in driving this trend.

Moreover, the age of onset of gender dysphoria has increased from preschool-aged male children to adolescents, and seems to be occurring in adolescents with no childhood history of gender dysphoria.[7] "Between 2016 – 2017 the number of gender surgeries for natal females in the U.S. quadrupled, with biological women suddenly accounting for 70% of all gender surgeries.[8] In 2018, the UK reported a 4,400% rise over the previous decade in teenage girls seeking gender treatments.[9]

In this regard, it is notable that the social media platforms like YouTube, Twitter, Instagram, Tumblr, TikTok, Reddit and Facebook are all popular hubs for sharing and documenting a sexual transformation; seething over "transphobia"; celebrating the superpowers conferred by testosterone; offering tips for procuring a prescription; and commiserating on how hard it is to be trans today.

In Canada, Sweden, Finland, and the UK, clinicians and gender therapists began reporting a sudden and dramatic shift in the demographics of those presenting with gender dysphoria – from predominately pre-school aged boys to predominately adolescents girls.[10] In a 2018 study, 65% of Rapid Onset Gender Dysphoria (ROGD) cases were found to be due to social contagion from prolonged social media immersion.[11]

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[7] From Abigail Shrier's Book "Irreversible Damage"

[8] (2017 Plastic Surgery Statistics Report, American Society of Plastic Surgeons.)

[9] Gordon Rayner, "Ministers orders inquiry into 4,400% rise in children wanting to change sex"

[10] (Nastasja M. de Graaf et al., "Sex ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK; Referrals to GIDS, 2014/15 to 2018/19; Gender Identity Development Service, June 25, 2019; Madison Aitken Xen al., "Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria,' Journal of Sexual Medicine 12, no. 3 (January 2015), 756-63.)"

[11] L. Litman, "Parents report of Adolescents and Young Adults perceived to show signs of a Rapid Onset of Gender Dysphoria," PLoS One 14, no.3 (August 16, 2018).

Social Transition

Dr. Stephen B. Levine, M.D. in his Expert Affidavit, to Wisconsin Circuit Court in February 2020, as part of his summing up, stated:

> *"Enabling and affirming social transition in a prepubescent child appears to be highly likely to increase the odds that the child will in time pursue pubertal suppression and persist in a transgender identity into adulthood."*
>
> (See Appendix 2 for further details)

Overall Conclusions

It is particularly worrying that there has been very little public and political debate in this country on these issues, which have such potentially adverse effects for children and for our society at large.

This is all the more surprising when contrasted by the growing international trends to end the medicalisation of children and young people.

In the UK for example, in a case brought against the Tavistock Clinic, the Court there ruled, inter alia, that children under 16 years of age 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 it is doubtful that children under the age of 15 could understand the long term risks of puberty blockers. (See Appendix 3)

Sweden has now ended the practice of following the WPATH model and will no longer be prescribing puberty blockers to children less than 16 years of age. (Karolinska Policy change March 2021)

Finland revised its guidelines, and now recommends psychological treatment in preference to drugs.

While in the U.S. in April 2021 the Arkansas Legislature passed a sweeping law to prohibit doctors from treating transgender youth with hormone treatments, puberty blockers or surgery.

APPENDIX 1

WPATH Guidelines (Global Education Initiative)

WPATH Ethical Guidelines for Professionals – Treatments Options for Gender

Dysphoria *"Stage (1) Puberty Suppression*

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. Some children may arrive at this stage at very young ages (e.g. 9 years)."

Stage (2) Gender-affirming Hormones

"Adolescent girls may be eligible to begin masculinizing hormone therapy, preferably with parental consent. In many countries, 16 year-olds are legal adults for medical decision making and do not require parental consent."

Stage (3) Gender-affirming Surgery

"Genital surgery should not be carried out until patients reach the legal age of majority in a given country. Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after 1 year of testosterone treatment."

WPATH claim that puberty blockers are fully reversible interventions.

Concerns regarding Puberty Blockers

The following concerns have been expressed by medical professionals regarding WPATH and the medicalisation of adolescents.

• Puberty Blockers stop normal puberty – they halt the normal developmental process and no one knows if puberty blockers are fully reversible or what the long-term effects are.

- Puberty blockers are NOT licensed for the purposes set out by WPATH

Licensed use of puberty blockers

• Prostate cancer in men (first developed for this purposes)
• Short-term use for precocious puberty in young children
• Endometriosis and uterine fibroids in women, for less than 6 months because of side effects

• 'Severe sexual deviation' in men (chemical castration) – A review in 2018 stated that they should only be reserved for patients with a paraphilic disorder and the highest risk of sexual offending because of their extensive side effects.[12]

Problems Associated with Cross Sex Hormones / HRT

• Females who take puberty blockers and cross sex hormones will experience menopausal symptoms, uterine pain; and testosterone within a short space of time will cause irreversible changes including body hair growth, loss of scalp hair, deepening of the voice, and clitoral enlargement.[13]

- These changes are lifelong and cannot be reversed. [14]

• Kidney and liver damage.

• Bone density is diminished.[15]

• Women who take testosterone have approximately 4 -5 times higher risk of developing heart disease. The claim that women will have the same risk of heart disease as men is incorrect.[16]

• Infertility is very likely, and sterility is certain if the testes and ovaries and uterus are removed.

• There is also question over full adult sexual function. Normal sex life is not achievable with a medically constructed vagina or penis. Even without surgery, testosterone makes penetrative sex too painful and orgasm impossible.

Swedish child and adolescent psychiatrist, Professor Christopher Gillberg, has said, that treating young women who want to become men with cross sex hormones is "one of the biggest scandals in medical history."

Dr Karl Heneghan, Editor in Chief, British Medical Journal, Evidence Based Medicine Division, stated that the use of Hormone Blockers on Transgender Children is "An Unregulated Live Experiment."

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[12] Daniel Turner, PhD, MD, and Peter Briken, MD, FECSM

[13] Dr. Will Malone, Endocrinologist

[14] Sunday Times, July 12th, 2020: The detransitioners; what happens when transmen want to be women again;

[15] **Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study** (*Janet Y Lee, Courtney Finlayson, Johanna Olson-Kennedy, Robert Garofalo, Yee-Ming Chan, David V Glidden and Stephen M Rosenthal*

[16] **Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population (*Talal Alzahrani, Tran Nguyen, Angela Ryan, Ahmad Dwairy, James McCaffrey, Raza Yunus, Joseph Forgione, Joseph Krepp, Christian Nagy, Ramesh Mazhari, Jonathan Reiner*)**

Types of Gender Affirmation Surgeries currently being sought and performed

Gender-affirmation surgery is considered important in the treatment of gender dysphoric patients, but there is a high complication rate in the reported literature. Further research and implementation of standards is necessary to improve patient outcomes.[17]

Double Mastectomy

Plastic surgeon Dr. Patrick Lappert as quoted in Abigail Shrier's Book "Irreversible Damage" stated:

> *"There is no other cosmetic operation where it is considered morally acceptable to destroy a human function. None."*
>
> *"Eliminating biological capacities merely for the sake of aesthetics is wrong and – in virtually all other areas of medicine – strictly verboten."*
>
> *"I'm going to improve this guy's nose but take away his sense of smell; I'm going to improve the appearance of this boy's ears but he's going to be deaf. But in the case of an adolescent girl, surrendering her capacity to breastfeed so that she can appear to be a boy, that's considered correct?"*

Often referred to as "top surgery" by the Trans Industry: There are two main procedures for "top surgery" or radical double mastectomy, one sacrifices nipple sensation but places constructed nipples in the desired location; the other preserves nipple appearance and sensation but placement is not on target.

The procedure comes with a risk of infection, seroma (fluid accumulating under the skin), pain, bleeding, oozing, skin flaps, and nipples that resemble cooked hamburger meat.

36% of biological females identifying as "trans men" have had "top surgery" and another 61% desire it, according to the U.S. Transgender Survey of 2015.

"Bottom Surgery": Phalloplasty and Metoidioplasty

Only 3% of biological females who identify as trans have had phalloplasty and only 13% want it.[18]

[17] Clin. Anat. 31:191-199, 2018. © 2017 Wiley Periodical.

[18] Report of the US Transgender Survey 2015, National Centre for Transgender Equality.

Metiodioplasty: Another form of "bottom surgery"

This involves reshaping the clitoris into something that dangles and resembles a tiny penis. It is not meant to harden or penetrate, though the urethra can be run though the clitoris so that it urinates like a tiny penis as well.

Phalloplasty (Construction of a Penis) [19]

This is the construction of a penis, where a surgeon takes a skin flap from the body, most often by de-sleeving the forearm (peeling off the skin, fat, nerves and blood vessels). The surgeon must then connect nerves to restore sensation to the graft site.

This is a difficult procedure and requires a skilled micro surgeon, not always available to each patient. This surgery is beset by complications.

Blood clots are common, with an open wound that, because of inflammation, cannot be sutured closed.

Partial phalloplasty loss is one of the more common complications of phalloplasty. Monstrey *et al.* reported a 7.3% partial necrosis rate for the RFFFP in their large series of tube-in-tube constructs.[20]

Male to female (MtF) gender surgical procedure[21]

Firstly, orchiectomy and penile disassembly are performed. Both corpora cavernose are resected and neovaginal construction is accomplished with the incorporation of the penile urethra into the penile shaft skin. The glans is preserved and resized to form the neoclitoris. The assembled neovagina is inverted, then inserted into expanded rectoprostatic space, and secured to the sacrospinous ligament. Scrotal skin in tailored to create the labia.

Complications from MtF Surgery[22]

Serious complications arise with this procedure. Studies of 1,684 patients reported an overall complication rate of 32.5% and a re-operation rate of 21.7% for non-aesthetic reasons. The most common complication was stenosis of the neo-meatus (14.4%). Wound infection was associated with an increased risk of all

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[19] (Rashid and Tamimy, "Phalloplasty: The Dream and the Reality," Indian Journal of Plastic Surgery (2013)

[20] Monstrey S, Hoebeke P, Selvaggi G, et al. Penile reconstruction: is the radial forearm flap really the standard technique? *Plastic Reconstructive Surgery* 2009; 124:510-8. 10.1097/PRS.

[21] European Urology: Surgical Reconstruction for Male-to-Female Sex Reassignment (Bastian Amend, Joerg Seibold, Patricia Toomey, Armulf Stenzl, Karl-Deitrich Sievert

[22] *https://www.researchgate.net/publication/320565788_Complications_of_the_Neovagina_in_Male-to-Female_Transgender_Surgery_A_Systematic_Review_and_Meta-analysis_with_Discussion_of_Management_Systematic_review_of_neovaginal_complications*

tissue-healing complications. Use of sacrospinous ligament fixation (SSL) was associated with a significantly decreased risk of prolapse of the neovagina.

Variability in technique and complication reporting standards makes it difficult to assess accurately the current state of MtF gender reassignment surgery.

APPENDIX 2

What effect does "social transition" (a likely consequence of the draft Bill) of minor children have on outcomes?

Dr. Stephen B. Levine, M.D. in his Expert Affidavit, to Wisconsin Circuit Court, in February 2020, summed up his findings as follows:

> *"Enabling and affirming social transition in a prepubescent child appears to be highly likely to increase the odds that the child will in time pursue pubertal suppression and persist in a transgender identity into adulthood. I consider the ethical implications of this intervention in the next section. Here, I simply note that fact to observe that the MHP (and parent) must therefore consider long term as well as short-term implications of life as a transgender individual when deciding whether to permit or encourage a child to socially transition."*
>
> *In sum, therapy for young children that encourages transition cannot be considered to be neutral, but instead is an experimental procedure that has a high likelihood of changing the life path of the child, with highly unpredictable effects on mental and physical health, suicidality, and life expectancy. Claims that a civil right is at stake do not change the fact that what is proposed is a social and medical experiment. (Levine, Reflections, at 241.)*
>
> *Ethically, then, it should be undertaken only subject to standards, protocols, and reviews appropriate to such experimentation."*

Dr Levine also provided evidence regarding *"The inability of children to understand major life issues and risks complicates informed consent"*

> *134. Obviously, most children cannot give legally valid consent to a medical procedure. This is not a mere legal technicality. Instead, it is a legal reflection of a reality of human development that is highly relevant to the ethical requirement of informed consent quite apart from law. The argument that the child is consenting to the transition by his happiness ignores the fact just described.*
>
> *135. Each age group poses different questions about risk comprehension. (Levine, Informed Consent, at 3.) While the older patient is perhaps more likely to be formally mentally ill and delusional, the young child is chronically unable to comprehend large and complex issues such as the meaning of biological sex, the meaning of gender, and the risks and life implications attendant on social, hormonal, and ultimately surgical transition.*
>
> *136. In my experience, when clinicians actually attempt to understand patients' motives for the repudiation of their natal gender, the developmental lack of sophistication underlying their reasons can become apparent. What must a 12-year old, for example, understand about masculinity and femininity that enables the conviction that "I can never be happy in my body?" (Levine, Ethical Concerns, at 8.) Obviously, this unavoidable gap in comprehension and ability to foresee must be still larger for younger children.*

Similarly, one cannot expect a 17-year-old to grasp the complexity of married life with children when 38. One cannot expect a ten-year-old to understand the emotional growth that comes from a first long term love relationship including sexual behaviour. One cannot expect a six-year-old to comprehend the changes in his psyche that may come about as the result of puberty.

138. For this reason, it is my opinion that asking a child whether he or she wishes to transition to living as the opposite sex, or giving large weight to the child's expressed wishes, by no means satisfies the MI-IP's ethical obligation to obtain informed consent before assisting that child to transition to living as the opposite sex.

139. In light of the profound uncertainties in the field, and the many highly predictable or probable lifetime costs to the child if he or she persists in a transgender identity into adulthood, in my opinion it is not consistent with principles of medical ethics for physicians or other MHPs to suggest that parents should not or have no right to explore possible therapeutic options to assist their child to achieve comfort with the gender corresponding to his or her sex. The use of the label "reparative therapy" by some advocates to lump all such possible therapies together and disparage them does not change this equation. (Levine, Informed Consent, at 7.)

APPENDIX 3

Extract from:

December 2020, Bell –V – The Tavistock: Case No: CO/60/2020 the court

ruled:

OVERALL CONCLUSION

151. 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.

152. In respect of young persons aged 16 and over, the legal position is that there is a presumption that they have the ability to consent to medical treatment. Given the long- term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.

Appendix 4

Extract from: December 2020, Bell –V – The Tavistock: Case No: CO/60/2020, regarding the rate at which adolescents progress from puberty blockers to cross-sex hormones (98%).

57. No precise numbers are available from GIDS (as to the percentage of patients who proceed from PBs to CSH). There was some evidence based on a random sample of those who in 2019-2020 had been discharged or had what is described as a closing summary from GIDS. However the court did have the evidence of Dr de Vries. Dr de Vries is a founding board member of EPATH (European Professional Association for Transgender Health) and a member of the WPATH (World Professional Association for Transgender Health) Committee on Children and Adolescents and its Chair between 2010 and 2016, and leads the Centre of Expertise on Gender Dysphoria at the Amsterdam University Medical Centre in the Netherlands (CEGD). This is the institution which has led the way in the use of PBs for young people in the Netherlands; and is the sole source of published peer reviewed data (in respect of the treatment we are considering) produced to the court. **She says that of the adolescents who started puberty suppression, only 1.9 per cent stopped the treatment and did not proceed to CSH.**