

3rd February 2020

**Deborah El-Sayed
Bristol, North Somerset
and South Gloucestershire
Clinical Commissioning Group**

Dear Ms El-Sayed

RE- Formal Complaint regarding SARI Toolkit

We are a group of concerned clinicians and are contacting you to formally complain about the trans toolkit for which you are the Sponsoring Director. From information available on the internet, we note the toolkit was produced by SARI and endorsed at the BNSSG CCG Governing Body Meeting on 5th November 2019.

We have a number of concerns about this guidance which we wish to raise directly with the CCG. We believe that if the recommendations contained within the toolkit were to be adopted, a number of groups will be at risk of significant harm, particularly young gender non-conforming people, and girls and women.

In December, Dr Griffin asked that a copy of the Equality Impact Assessment (EIA) be forwarded through a Freedom of Information request (1). The response she received from the CCG was that an EIA has not yet been completed (2). Confusingly, she was also informed that the toolkit has not been endorsed by the CCG, although this is contradicted by the minutes of the Governing Body Meeting dated 5th November 2019 stating that “the Governing Body endorsed the toolkit and its dissemination to relevant practitioners” (Page 10 of the minutes). It is also clearly documented on the Governing Body Agenda, dated 5th November 2019, under Risk and Assurance that there are ‘No specific risk implications’.

We have itemised individual concerns as follows:

1. Terminology (Page 3-5)

The toolkit describes sex as being ‘assigned by medical practitioners at birth’. This is scientifically incorrect and misleading. Sex is determined at the point of fertilisation and revealed at, or often before, birth. It is simply not true that anatomy is not a good guide to the sex of a child. The presence of rare disorders of sexual differentiation (DSD) does not negate the fact that sex is both binary, and necessary for human reproduction. People born

with DSD's have requested that their unique situation is not used to further trans-activist agendas.

Throughout the pages on definitions, sex, gender and sexual orientation are confusingly conflated. Gender is a socially constructed mechanism through which human behaviour deemed acceptable for either sex is rigidly enforced. Many people reject the notion of an inherent gender identity. The notion of 'cis-gender' (meaning simply 'not trans') is therefore increasingly contested as many people, particularly women, regard it as offensive to suggest they naturally identify with second class status.

2. Relationship with mental illness (Page 6)

The toolkit emphasises that being transgender is not a mental illness but cites research suggesting that 66% trans people have been users of mental health services. This number would seem very high, and the lack of curiosity as to why is troubling. If being trans is not an illness, why the urgent need for invasive medical intervention on an otherwise healthy body?

The same section also asserts that treatments provided by gender clinics 'are highly successful'. This is untrue. There is very little evidence of any kind with regard trans healthcare outcomes, and the little data available on long term outcomes suggests that high rates of mental illness and suicide remain post-transition (3).

3. Young people (Page 9 & 12)

The document references the use of puberty blocking drugs, but fails to report the controversy surrounding the adopting of this prescribing policy by the UK's primary gender service for children at the Tavistock Clinic. The toolkit suggests that GnRH analogues, or puberty blockers, are entirely reversible and alleviate distress. There is no evidence to support this assertion. The Tavistock has been criticised for not publishing the results of its own study on these drugs which showed, among other things, a rise in suicidal thoughts amongst young people on blockers (4). Despite these findings, the study was deemed a success and this treatment was rolled out to pubertal dysphoric children (5). Data suggests almost all children prescribed blockers go on to receive cross-sex (or 'gender-affirming') hormones, suggesting children are being put on a one-way medical pathway (6). The claim of reversibility would therefore seem disingenuous. A recent BMJ review of the evidence undertaken by independent academics from the Oxford Centre of Evidence-based Medicine is critical of hormonal intervention in young people, stating "the current evidence base does not support informed decision making and safe practice" (7).

The toolkit also refers to breast binding but fails to provide any of the potentially serious consequences of this practice. Is the CCG satisfied that it is promoting a practice without mentioning that it may result in fractured ribs, respiratory problems and permanent damage to breast tissue in young females (8)?

4. Safeguarding (Page 13 & 15)

It seems doubtful that the CCG should be advocating for practitioners to refer children and young people for life changing medical intervention without parental consent. There is evidence that up to 85% transgender children 'desist' if left alone (9). In addition, there are a growing number of detransitioners who are speaking out about the harm they believe trans healthcare has caused them. It is therefore unsurprising that many parents are reluctant to automatically affirm their child's trans status. At present, a case is being brought against the Tavistock gender service, by an ex-patient who halted her own transition, and a mother of a trans child, who believe medical intervention has proved harmful (10).

The only mention of safeguarding in this document is in relation to dealing with parents who are perceived as 'unsupportive'. It might be more pertinent to consider the wisdom of allowing adults, with adult agendas, access to gender confused children and young people under the guise of 'support provision' in youth groups, schools and social and community spaces, as is promoted throughout the document.

5. Medical Care (Page 16)

The CCG appears to be endorsing an uncritical affirmation of trans healthcare despite lack of available evidence as to its efficacy and safety. There is limited data concerning long term outcomes, and most of the earlier research and clinical guidelines concern older male-to-female subjects. We are witnessing an exponential increase in numbers of younger people seeking interventions, primarily natal females. It is unclear if existing clinical guidelines are suitable for this group. Whilst the toolkit cites the debunked 1% detransition rate, clinical experience would suggest that more of the younger patient group are coming to regret early medical and surgical intervention (11). It is worrying that the CCG appears to be endorsing rapid and unquestioning intervention when the consequence of this intervention is permanent bodily modification, including infertility, loss of breasts and serious medical conditions stemming from hormonal treatment. The statement: "Doing nothing or delaying treatment **CAUSES HARM**" is debatable.

6. Single sex spaces (Page 19)

Under the Equality Act 2010, when there is a conflict between the needs of various groups with protected characteristics, it is still permissible to discriminate on the grounds of sex if it is a proportionate means in achieving a legitimate aim (12). A good example of this would be the necessity of a female-only psychiatric ward for seriously ill women. It is surprising that the CCG sees fit to endorse a document that recommends the 'needs of the [trans] patient be given priority' when considering which ward to admit to. In the context of the document as a whole, which gives only the vaguest definition of 'trans', including such terms as 'divergent gender expression', 'genderqueer', 'questioning' and those 'who have not yet started treatment', it would seem impossible to differentiate between a trans patient, and a male patient who wishes to access a women's ward for other reasons. Given the high rate of

sexual trauma that female psychiatric patients have experienced, it seems callous to give so little regard to the safety, privacy and dignity of this group. Where trans prison policies have been similarly implemented without any regard for the safety of women, some egregious abuses are known to have occurred (13).

7. Changing sex marker on medical records (Page 18)

It would be important to understand the consideration that the CCG has given to the clinical consequences of responding to requests for change of sex recording on medical records. For a detailed discussion on why this might be unsafe for patients, as well as the resultant confusion in data collection, please see the case study from NHS Scotland (14).

In conclusion, we believe the CCG needs to urgently review its endorsement of this toolkit. It uses selective poor quality evidence to back up claims that are underpinned by ideology, rather than empirical research. In view of the ongoing debate around what constitutes best practice in this area, coupled with the growing evidence that poorly thought-out guidance is causing harm, it might be more appropriate for the commissioners to hold a neutral perspective. It is worrying that the CCG does not appear to be familiar with the legal requirement to assess the impact on groups with protected characteristics when implementing a new policy, especially when there is a high risk of significant harm on vulnerable groups.

We look forward to your response.

Yours sincerely

Lucy Griffin, Consultant Psychiatrist, Bristol

Responding on behalf of:

Richard Byng, GP and Professor in Primary Care Research, University of Plymouth

Damian Clifford, Consultant Psychiatrist, Cornwall

Katie Clyde, Consultant Psychiatrist, Hampshire

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Tessa Katz, GP, London

Julie Maxwell, Associate Specialist Community Paediatrician, Hampshire

David Pilgrim, Professor of Clinical Psychology, University of Southampton

Ellen Wright, GP, London

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