Chapter 6: Transgendering the young 2: Criticising policy capture—paediatrics, GIDS and WPATH

In this chapter I first discuss paediatrics in the US, the UK and elsewhere (although the information about the Australian profession's involvement is sparse). This is followed by a more detailed discussion of Tavistock's Gender Identity Development Service (GIDS). The main reason for my continued focus on the latter (which was mentioned a number of times in the last chapter) is the immense influence it has had on the transgendering of the young in the UK, as well as the sheer volume of information available, including a large number of critical accounts.

I discuss those critical accounts, arguing that some of them don't go far enough, especially those with any official imprimatur, e.g. the Care Quality Commission and Cass reviews (UK CQC, 2021; Cass, 2022). They accept the existence of 'gender identity' (unavoidably, since it defines the terms of reference); they don't acknowledge that the transgender agenda is based on a lie (unavoidably, since that lie constitutes their starting point); and they don't recommend the complete cessation of transgender medical procedures (unavoidably, so entrenched has the transgender agenda become). They do, however, cast glimmerings of doubt on the process of transgendering children, even to the extent (in the case of the Cass review) of leading to the closure of GIDS (although that is by no means an unmixed blessing—see below).

The Endocrine Society

The Endocrine Society is the world's largest and most influential organisation in the field of endocrinology and metabolism, affiliated with numerous similar organisations worldwide. They advertise themselves as 'a global community of physicians and scientists dedicated to accelerating scientific breakthroughs and improving patient health and well being'.[1] They were well-captured by 2009, when they issued guidelines recommending that 'transsexual adolescents' could be dosed with puberty blockers from Tanner stage 2 until the age of 16, 'after which cross-sex hormones may be given' (Hembree et al, 2009: abstract).[2] The authors include three clinicians from the Amsterdam clinic, and Norman P. Spack, transgender luminary and leading purveyor of the transgender message.

They didn't recommend, the authors said, 'endocrine treatment of prepubertal children', giving as their reason that 'a diagnosis of transsexualism in a prepubertal child cannot be made with certainty'. So if a diagnosis of transsexualism [sic] in a prepubertal child *could* be made with certainty, it would be perfectly fine to dose them with puberty-suppressing hormones, it would seem. This might not be what the Endocrine Society meant, and the endocrinologists who wrote these guidelines might be horrified at the very thought. But then they're not horrified at the thought of suppressing normal pubertal development once the young person has reached puberty, so who knows.

In their later corrigenda, they expanded their recommendations to allow for *cross-sex hormones*, not just puberty blockers, to be given to children younger than 16:

> We recognize that there may be compelling reasons to initiate sex hormone treatment [i.e. cross-sex hormones] prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age (Hembree et al, 2017: 3870, 3871).

They gave no examples of these 'compelling reasons', and appeared to be unconcerned by the fact that there is 'minimal' research about what happens when children below the age of 13 are dosed with cross-sex hormones.

The Endocrine Society shows no signs of re-evaluating its transgender commitment. While most of its list of 'thematic issues' for endocrinology are entirely appropriate—e.g. diabetes, renal and thyroid diseases, endocrine-disrupting chemicals—there is also 'a special collection of journal articles … focused on transgender health and medicine', from 2016 to 2021, from their own house journals.[3] One of these is a case report from Canada of 'lactation induction in a transgender woman [sic—a man] wanting to breastfeed [sic]' (Wamboldt et al, 2021). (For a discussion of this 'second case in the medical literature to demonstrate successful [sic] breastfeeding in a trans woman [i.e. a man]', see the 'Journals' section in the 'Evidence?' chapter).

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[1] https://www.endocrine.org/

[2] The Tanner Scale measures stages of puberty development. Stage 2 starts between the ages of nine and 11 for girls, and around the age of 11 for boys. This internet site is trans-friendly—'Sex and gender exist on spectrums'—but the information about the Tanner Scale is accurate (https://www.healthline.com/health/parenting/stages-of-puberty#tanner-stages).

[3] https://academic.oup.com/endocrinesociety/pages/thematic_issues

There is no transgender thematic issue listed in either 2022 or 2023. There is no way of telling what the absence of pro-trans articles in the Endocrine Society's more recent house journals means. It's unlikely that they've changed their minds about the benefits of trans medicine, since all the previous articles are freely available, including the update of their guidelines.

The paediatrics profession

From what was said in the last chapter ('The transgendering of the young 1: harm'), it wouldn't be surprising if the medical specialty of paediatrics was complicit with the transgender agenda, as indeed it is, although with some exceptions. My discussion is largely focused elsewhere than on Australia because I have been unable to find any Australian paediatrics organisation overtly embracing the transgender cause. The websites of the Australian Paediatric Society ('The Voice of Rural Child Health'), the Australian Paediatric Endocrine Group, Australian Paediatrics and the Australian Paediatric Research Network contained no mention of 'LGBT' or 'transgender'. Although the websites of the latter two organisations have no 'Search' function, none of their publications contained a transgender theme. That doesn't mean that Australian children have not been caught up in the transgender phenomenon. They have, and as far as I know, these paediatricians' peak bodies have not raised the alarm.

While the Australian paediatrics organisations appear not to have been influenced by transgender demands, the Child Health Division of the Royal Australasian College of Physicians has succumbed. Their submission to the Justice Select Committee of the New Zealand parliament supported that government's Conversion Practices Prohibition Legislation Bill (RACP, 2021). Prohibiting 'conversion practices' is a transgender strategy designed to make it illegal not to affirm children in the 'gender identity' they say they are, and governments everywhere have fallen into line. (For a detailed discussion of such legislation, see the 'Piggybacking' chapter).

The same College of Physicians were also co-signatories to a letter to the NSW Minister for Health, proposing the establishment of a 'network "hub" in Sydney to initiate development of a child, adolescent and young adult gender dysphoria health service in NSW' (Galambos et al, 2016). The letter was also signed by the Chair of the NSW Branch of the Royal Australian and New Zealand College of Psychiatrists, and by the Executive Director of the trans lobby group, the Gender Centre, who has clearly managed to convince Australia's physicians and psychiatrists, or at least their peak bodies, of the reality of 'gender identities'.

In 2016, the Royal Australian and New Zealand College of Psychiatrists issued a 28-page statement outlining the 'gender hub' proposal, citing favourably the Gender Centre and WPATH's Version 7. They had, they said, 'consulted closely with Dr Michelle Telfer, Acting Head of Department of Adolescent Medicine at the Royal Children's Hospital in Melbourne, who is the current clinical lead of the gender service' (RANZCP, 2016: 28). As far as I am aware, the 'gender' hub did not eventuate, probably because NSW has had a conservative government since 2011. Nonetheless, there is plenty of support among medical professionals in Australia for the transgendering of children. The Queensland Children's Gender Service advertises itself as a statewide service 'through telehealth and local partnerships'.[4]

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[4] https://www.childrens.health.qld.gov.au/service-gender-clinic/

In the US

On 12 September 2018 the American Academy of Pediatrics issued its first policy statement on 'support and care of transgender and gender-diverse children and adolescents' (AAP, 2018). The statement is wholly 'gender-affirming'—the statement is intended 'to provide guidance for parents and clinicians through a gender-affirming approach'—and it makes a number of recommendations about 'health care' for these children.

The first recommendation advises pediatricians to 'provide youth with access to comprehensive gender-affirming and developmentally appropriate health care'. The statement does not give any examples of what might be 'developmentally appropriate care' in the context of 'gender affirmation'. But the lead author of the statement gives more detail in the article he wrote at the same time for the journal, *Pediatrics*: 'Gonadotrophin-releasing hormones … can … be used to prevent development of secondary sex characteristics' (Rafferty, 2018: 5). In other words, 'developmentally appropriate' is a code for pubertal suppression.

The next recommendation made by the AAP's 2018 statement is that health records should 'respect the asserted gender identity of each patient', i.e. records are to be kept in the name and pronoun of the child's preferred 'gender'. Pediatricians are also advised to 'support insurance plans that offer coverage specific to the needs of youth who identify as transgender, including coverage … when appropriate, [for] surgical interventions'. In the case of 'surgical interventions', more detail is once again given in the author's academic article. Examples are: breast amputation (for girls who want to be 'men'); breast augmentation (for men who want to be 'women'); amputation of the genitals and reproductive organs; etc. This is not, of course, the terminology used by the author. For breast amputation (in girls/women) and augmentation (in boys/men) and genital amputation in either sex, he uses the usual transgender euphemisms: 'top surgery' and 'bottom surgery' (Rafferty, 2018: 6). That 'surgical interventions' that destroy healthy tissue may not be advisable for young people (or anyone else), seems not to have occurred to the AAP's decision-makers. Their statement expresses no qualms about it.

The last recommendation in the AAP's statement is that paediatricians 'advocate within their communities for policies and laws that seek to promote acceptance of all children without fear of harassment, exclusion or bullying because of gender expression'. This is a fine feel-good sentiment that no one would disagree with. But the reference to 'all children' is, at the very least, disingenuous. At most, it is a deliberate attempt to deceive since the statement is not about 'all children', only the supposedly 'transgender' ones.

The lead author of this statement issued under the imprimatur of the American Academy of Pediatricians is Jason Rafferty, a prolific author of pro-transgender treatises. Why an organisation supposedly devoted to the health and well-being of children should have given him a hearing, much less such a prominent role in defining their policies, is not explained. But it would seem that it was not the whole organisation that was responsible for the statement. While the organisation had 67,000 members at the time, there were only 36 people involved in creating the policy, four of whom were not even members of the American Academy of Pediatrics. The whole membership were not consulted or even informed, and neither were any other groups consulted (Higgins, 2018a, b; Kearns, 2018b). This is the trans agenda's usual practice of policy capture by stealth (see the 'Piggybacking' chapter). Why they should be allowed to do this, how they can convince experts in the field they are intruding upon, is an interesting question (discussed in detail in the 'Explaining transgender' chapter).

The American Academy of Pediatrics is not the only the paediatric organisation in the US to embrace the transgender agenda. The peak organisation, the Pediatric Policy Council, is on side too. Its membership includes the American Pediatric Society and the Society for Pediatric Research, and representatives from the Academic Pediatric Association and the Association of Medical School Pediatric Department Chairs. It is based in the American Academy of Pediatrics's Washington DC office. In June 2021, along with 18 other organisations the Council submitted an *amicus curiae* brief to the Arkansas District Court,[5] objecting to that state's law prohibiting health-care providers from performing or referring adolescent patients for what the brief called 'gender-affirming care'.[6] In other words, these organisations supposedly devoted to children's welfare were objecting to a law that would prohibit unnecessary medical interventions on the bodies of healthy children.

And yet the policy statement of the American Academy of Pediatrics (not to mention the transgender phenomenon more generally) is easily shown to be false, once its claims are investigated in detail. James M. Cantor (2018), Director of the Toronto Sexuality Centre, examined the evidence the American Academy of Pediatrics's statement cited for its recommendations and found the usual transgender evasions and outright lies. 'AAP's statement', he said, 'is a systematic exclusion and misrepresentation of entire literatures'. It excluded the literature on outcomes (except for the citation of a single study without mentioning its findings), all of which found that most children presenting with 'gender dysphoria' no longer wanted to 'transition' when they reached puberty. When the AAP statement did quote research, Cantor found that the reports of that research did not say what the AAP said they did. In fact, they contradicted the AAP's policy 'gender affirmation' approach, recommending 'watchful waiting' instead. Cantor concluded

> In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all … Not only did AAP fail to provide *extraordinary* evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence (Cantor, 2018: 4—original emphases). (See also the 'Evidence' chapter of this present work)

The above organisation, the American *Academy* of Pediatrics is not to be confused with the American *College* of Pediatricians (ACP). The College broke away from the AAP in 2002 after the AAP published a report favourable to same-sex parenting and arguing that there were no meaningful differences between children raised by same-sex and heterosexual couples (Kranish, 2005; Perrin, 2002). While their stance on most things is right-wing, as far as I have been able to find out they are the only paediatrics group in the US that has taken a genuinely human stance (Thompson, 2020) against the transgender push.

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[5] https://downloads.aap.org/DOFA/AmicusBriefARtransgenderlaw.pdf

[6] https://www.aps1888.org/ppc-capitol-connection-july-2021/

The American College of Pediatricians is one of those organisations on the political Right that has come out strongly against the transgender push, especially the medicalising of children.[7] Its values otherwise are clearly right-wing. It champions 'the intact family' (i.e. one that includes a man), as well as decrying same-sex marriage and parenting, rejecting any system of universal, government-provided, 'single payer' healthcare (for typically right-wing reasons),[8] and deploring 'the dissolution of Western civilisation'.[9] The president, Michele Cretella, who is also an Executive Director of the Heritage Foundation, has been 'an active prolife [i.e. anti-abortion] advocate for over twenty years', and has served 'as a certified [sexual] abstinence educator for her local Catholic school'.[10]

While not against homosexuality as such ('Homosexuality and "gay" relationships [are] not among [the ACP's] concerns … the principle of equal human dignity must apply to gay and lesbian persons'), the College is opposed to same-sex marriage: 'marriage exists to bring a man and a woman together in a sexual relationship—one publicly recognized and approved because of its unique aptness for the bearing and rearing of children. In particular, marriage attaches a father to his children—and to his children's mother—and fulfills the societal need for children to have the love and care of both mother *and father*' (George and Anderson, 2007—original emphasis).

Not surprisingly, it has received the usual dismissive criticism from the 'progressive' Left. The Southern Poverty Law Center has declared the ACP a 'hate group' and accused it of 'distorting legitimate research,[11] and the Wikipedia entry is wholly antagonistic, quoting a number of pro-trans groups including The Southern Poverty Law Center. Snopes has described it as 'a fringe group of politically motivated pediatricians'. The Snopes author was concerned to point out that they were 'not the respected American Academy of Pediatrics', and that 'leading pediatricians (or even a majority of pediatricians)' didn't agree with the ACP's position that 'promoting or tolerating gender dysphoria … in children constitutes "child abuse"'.[12] But transgender and its acolytes are far too free with their accusations of 'hate', which usually refers only to disagreement; and the distorting of legitimate research is not unknown among transgender affiliates.

That resistance to the transgender push has come from the political Right, while the Left has enthusiastically embraced it throwing women under a bus in the process, has caused some consternation in feminist circles. If feminism has a political home

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[7] https://acpeds.org/assets/imported/9.14.17-Gender-Ideology-Harms-Children_updated-MC.pdf. In February and March 2023, I was unable to get access to the ACP's website. This URL brings up the message 'Hosting Server Read Timeout, HTTP 502—unable to connect to the Origin Server', and 'American College of Pediatricians' in a search engine brings up the same message. Censorship?

[8] 'There must always be heightened concern for the potential of devastating evil in a system with powerful, centralized control' [i.e. the federal government] (https://www.acpeds.org/wordpress/wp-content/uploads/Capstone-BioethicalImplications_100408.pdf)

[9] https://www.acpeds.org/the-college-speaks/perspectives

[10].https://illinoisfamily.org/wp-content/uploads/2019/03/IFI_WorldView-Conf_2019_flyer_NEW.pdf

[11] https://www.splcenter.org/hatewatch/2015/11/13/meet-anti-lgbt-hate-group-filed-amicus-brief-alabama-supreme-court

[12] https://www.snopes.com/fact-check/americas-pediatricians-gender-kids/

anywhere within malestream politics it is on the Left. But with the transgender issue the male Left has once again betrayed women, preferring to side with yet another dissociated entitled masculinist project. This is discussed in detail in the chapters 'Feminism and the Left' and 'Feminism and the Right'.

In the UK

As far as I am aware, the British Society for Paediatric Endocrinology and Diabetes had still not come to the transgender party at the beginning of 2023. There is no mention of 'transgender', 'gender identity', 'LGBT', etc. on their website or among their research projects or publications. In 2005, they were insisting that children could not be given puberty blockers until they had reached full sexual development, usually 15 (Biggs, 2019: 2), although the more reasonable stance is to reject puberty blockers altogether. They are, however, affiliated with the Royal College of Paediatrics and Child Health, which has wholly embraced the transgender project, announcing their intention 'to eliminate discrimination and stigma' supposedly suffered by 'LGBTQ+ people'.[13]

GIDS

GIDS did not directly employ any paediatricians, even before the announcement of their closure: 'The staff … form a specialist, integrated inter-disciplinary team, which includes psychologists, endocrinologists, endocrine nurses, psychiatrists and psychotherapists'.[14] However, they did work with paediatric endocrinologists and received referrals from paediatric services.

Established in 1989, GIDS was commissioned by NHS England in 2009, and extended to Leeds in 2012, at the Leeds Children's Hospital in 2013. In 1989, its first year, it received only two referrals (Butler et al, 2018: 631; Adams, 2016). As GIDS describes itself:

> The Gender Identity Development Service (GIDS) is for children and young people, and their families, who experience difficulties in the development of their gender identity. It's a national specialised service, based in London and Leeds, and is the only one of its kind in Great Britain.[15]

In the 2019 NHS standard contract for GIDS, they are instructed by the Department of Health to use the WPATH Standards of Care as a guideline in their clinical practice (UK Department of Health, 2019: passim), thus providing support at the highest level for incorporating children, even two-year-olds, into the transgender agenda. In its report on referrals in 2018-2019, GIDS didn't say there were any two-year-olds, but there were 10 three- to four-year-olds, 21 five-year-olds and the same number of six-year-olds, and 42 seven-year-olds. (Some of these referrals were rejected but GIDS doesn't say why or how many). Altogether, there were 2590 children and young people in England referred to the GIDS in 2018-2019 (GIDS, 2019).

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[13] https://www.rcpch.ac.uk/resources/supporting-lgbtq-children-young-people

[14] https://tavistockandportman.nhs.uk/about-us/news/stories/gender-variant-children-and-young-people-need-access-to-specialist-services/

[15] https://tavistockandportman.nhs.uk/care-and-treatment/our-clinical-services/gender-identity-development-service-gids/

Under instructions from the Department of Health, GIDS and the NHS more generally must take on the version of reality purveyed by the trans agenda. GIDS, the Department tells us, is 'for individuals who need support around their gender identity … including psychological support and physical treatments, to help reduce the distressing feelings of a mismatch between their natal (assigned) [sic] sex and their gender identity' (UK Department of Health, 2019: 1). 'Gender identity', we are told in inarguable trans-speak, 'refers to an individual's subjective sense of being male, female, both, neither or something else' (p.3).

The Department says that adolescents can be dosed with puberty blockers and cross-sex hormones. There is a proviso: the adolescents must 'fulfil the eligibility and readiness criteria for these'. That there might not be any valid criteria for blocking an adolescent's normal development through puberty appears not to have occurred to those policy-makers captured by the trans agenda. Fortunately for GIDS' eventual reputation, they cannot provide the surgery. This cannot happen until after the young people have turned 18, and then they have to go to 'adult gender identity clinics' (UK Department of Health, 2019: 7).

Criticism of GIDS

Criticisms of GIDS/Tavistock have been in the public domain for some time now. This criticism is of two types. There's the criticism that accepts the transgender notion that children can change sex, and that medical intervention is the appropriate method to achieve this, but objects to the way it is carried out. This kind of criticism, which is to be found in court hearings, official reports and sometimes from GIDS' own staff, doesn't find fault with the notion itself, only with the ways in which it is implemented. This first type of criticism leaves the transgender claim intact, it simply attempts to improve the procedures used to attain it, ignoring the fact that it is unattainable. The malestream organisations investigating GIDS' practices—the High Court, the Care Quality Commission, and the Cass review (see below)—exemplify this type of criticism.

The second type is the trans-critical position, which completely rejects the notion that children (or anyone else) can change sex, and hence rejects any need for children to be medicated in pursuit of that egregious goal. This type of criticism argues for the abolition of the transgender claim that children can change sex on the grounds that it is false, and for the abolition of medical 'treatments' to achieve that spurious aim. As Transgender Trend put it in a discussion of the Keira Bell case in the High Court, 'in the real world, there *is* no justification for serious medical intervention on children's healthy bodies' (Transgender Trend, 2020b—original emphasis).

By staff

GIDS' staff have been raising concerns about GIDS' practices for many years. For example, Susan Evans, a former Senior Clinical Lecturer at the Tavistock who had worked at GIDS, had raised concerns in the early 2000s. While not rejecting the medical treatment of young people altogether, she was worried that was harmful because it was experimental, and that the young patients were being processed too quickly instead of being 'assessed in depth and given support and psychological treatment over several years'. She was also worried about the influence of "'support' groups and charities … such as Mermaids and Gendered Intelligence'. She said that, after only a few months in the job, she had noticed that 16-year-olds were being approved for puberty blockers not long after they had arrived at the clinic (Evans, 2019). "On one occasion", she told a journalist, "a teenager was approved after a handful of sessions with a nurse. When they told me they were being taken onto the next clinic to get puberty blockers, my heart just sank" (Lyons, 2020).

Her concerns were ignored and in 2004 she resigned rather than continue to work in that environment. She said that her interest in the issue was revived after her husband also resigned in 2019 over many of the same concerns she herself had raised. She did not explicitly call for an end to the medication regime at that time, although that was implied by her preference for 'young people [to] be assessed in depth and given support and psychological treatment over several years' (Evans, 2019).

Her husband, Marcus Evans, resigned from the Board of Governors of the Tavistock and Portman NHS, only six months after he had joined in 2018. (He had been in private practice, and it was only after he retired that he had joined the Tavistock Board). He didn't explicitly recommend an end to the practice of medication either. But again, it was implied by what he did say, i.e. that 'the concept of gender identity is dubious', and his conviction that

> the goal of exploratory therapy should be to understand the meaning behind a patient's presentation in order to help them develop an understanding of themselves, including the desires and conflicts that drive their identity and choices (Evans, 2020).

His attention was drawn to problems at GIDS by a letter he received from a group of parents worried that their children had not been adequately evaluated before being fast-tracked through the system. He circulated copies of his reply to that letter to the other governors.

He said that around the same time another governor, Dr David Bell, a senior consultant at the Tavistock, presented a critical report to management, after he was approached by 10 staff members with concerns similar to those raised by the parents. Tavistock management, he said, dismissed both the letter and Bell's report. As well, they attempted to undermine the report by lying (not that Evans said so explicitly). They questioned Bell's credentials and accused him of making up the case studies he used. They also refused to circulate the report to some of the governors and prevented him from attending a meeting with the Medical Director to discuss the response to his report. Evans commented, 'such efforts to dismiss or discredit serious concerns … typically are driven by those seeking to evade accountability and shield their methods from criticism' (Evans, 2020; Lyons, 2020).

Dr Bell had worked at the Tavistock for more than 25 years, and hence he was one of its most senior doctors. His report *had* recommended that GIDS suspend all hormone treatment of children, "as a matter of urgency", until there was better evidence of the outcomes. He said 10 clinicians had told him that children were being referred for puberty blockers and cross-sex hormones after only a few sessions and without proper investigation of their complex personal histories. (He was reported to have said that these 10 clinicians were one-third of the staff members) (Cooke, 2021).

"The GIDS service as it now functions is not fit for purpose", Dr Bell wrote, "and children's needs are being met in a woefully inadequate manner and some will live on with the damaging consequences". He said that the Tavistock Trust responded with disciplinary action against him, accusing him of "bullying", although without being told who it was that he had supposedly bullied. He was also told not to speak any further to Sonia Appleby, the Trust's director of child safeguarding (see below). Various dates for the disciplinary hearing against him kept being suggested but they were always dropped, and he retired before the Trust managed to settle on a definite date (Bell, 2019; Bannerman, 2020; Gilligan, 2019).

As the child safeguarding lead at the Tavistock, Sonia Appleby's job was to ensure that children were protected from maltreatment and that nothing was done to impair their well-being. She was the person staff went to with any concerns about the treatment of children, and a number of staff did so, worried about the high numbers of children being referred to GIDS and the inadequacy of the explorations of their circumstances. She reported these concerns to her manager, but the Trust refused to address them. Instead, she was subjected to what she referred to as a "full-blown organisational assault". She was ostracised and staff were told she had "an agenda". The Trust of course denied it, lying once again. '[S]afeguarding issues that were raised during the GIDS review', they said, 'were fully explored and issues identified were further investigated' (Kirkup, 2020).

Appleby disagreed and so did the employment tribunal she took her case to. It concluded that she had been subjected to "quasi disciplinary treatment", that there was "obvious unfairness" in the way she had been treated, and that the Trust had "prevented her from proper work on safeguarding". In September 2021, the tribunal awarded her £20,000 in compensation for the damage to her professional reputation (BBC, 2021; Connett, 2021). The tribunal's ruling in Appleby's favour was not a ruling against unnecessary medical treatment of children, but against the way she was treated by GIDS as her employer. Nonetheless, the way she was treated by her employer was a result of her going to management with her concerns about what was happening to children. This tribunal ruling against GIDS does raise the question of what it has to hide.

Another GIDS staff member who has publicly raised concerns about how children are being treated there is Kirsty Entwistle, a former GIDS clinician at Leeds. In July 2019, she wrote an open letter to the Director of GIDS, Dr Polly Carmichael (Entwistle, 2019). It was an open letter, she said, because she feared that what she had to say would be ignored if she wrote privately. She was worried that decisions were being made about the bodies and lives of young people 'without a robust evidence base' for the interventions. Not only was there no evidence that puberty blockers were 'fully reversible' as GIDS claimed, there was little discussion of 'gender identity' in her own field of psychology. It was 'as though the gender identity issue has come out of the blue'. Staff training was inadequate to non-existent. She herself didn't get any training on WPATH or legal issues or indeed on 'gender identity' more generally, and referrals were being dealt with by junior members of staff, even trainees.

Entwistle also said that there was too little exploration of any other pressing issues the children might be facing, e.g. parental abandonment, sexual abuse, domestic violence, extreme poverty, while the issue of 'detransition' was being ignored There was also unspoken pressure not to admit that children were *not* 'transgender'. She herself had experienced being called 'transphobic' when she had tried to raise these issues, and she said that she knew of GIDS staff who had resigned without saying anything about their concerns (Entwistle, 2019). She was also worried about the influence of

Mermaids on GIDS, especially given their association with the Webberleys (Entwistle, 2019).

The Webberleys are a married couple and doctors who were debarred from practising in the UK. They were originally proprietors of GenderGP, an online clinic where anyone could buy puberty blockers without any consultation, medical oversight or safeguarding measures. GenderGP was bought by Harland International Ltd, an LGBT advocacy organisation based in Hong Kong, although Helen Webberley remained as a non-medical advisor prominently displayed on the website's front page. She was barred from practicising medicine in the UK in 2018 and fined £12,000, after she was convicted of running an unlicensed practice treating 'transgender' patients, some of them children, from her home in South Wales. Her husband was also subsequently suspended.

After her conviction the Webberleys moved to Spain, but continued treating people in England using a legal loophole allowing drugs prescribed by doctors in Europe to be dispensed in the UK. After the High court ruling in the Bell case (see below), that children under 16 were not legally competent to consent to being dosed with puberty blockers, Helen Webberley reacted with defiance. She was reported to say that GenderGP would be "continuing to prescribe blockers for people who are on blockers, and continuing to prescribe new blockers for anybody who is able to give consent to that treatment" (Das et al, 2020). In 2023, Helen Webberley's suspension was overturned by the High Court, which ruled that the original suspension by the Medical Practitioners Tribunal Service panel was 'wrong'. "This appeal", the judge was quoted saying, "does not raise any wider issues about the wisdom or otherwise of administering puberty blockers to the younger age group" (Bird, 2023).

Another report said that 35 clinicians had resigned from GIDS in the three years to December 2019 because they were concerned that children were put on puberty blockers when they were probably not 'trans' (Donnelly, 2019). In April 2019, *The Times* interviewed five clinicians who had resigned from GIDS because they disagreed with giving adolescents body-altering drugs when they were probably not 'transgender' at all, but gay. They, too, were worried about Mermaids' influence and they too felt pressured to refer young people for treatment without careful investigation (Bannerman, 2019). *The Times* had published a number of articles critical of GIDS, and the Tavistock and Portman NHS Trust finally replied in a short blog, 'strongly reject[ing] the claims made in the articles in the *Times*', and denying there were any problems, or none that they couldn't fix 'over the next 12 months'. But then they would say that, wouldn't they.

There is a strong implication in all of these criticisms that the medical treatment of children and young people for 'transgender' reasons should be abolished. Not only does their criticism strongly imply it, so does the gradually growing evidence of the harm caused by the so-called 'treatments'.

For another discussion of staff concerns and the Tavistock's reaction, see: Barnes and Cohen, 2020;

for a discussion of all these criticisms, plus an account of the critical BBC program, *Newsnight*, see: Transgender Trend, 2020a.

The Bell case

Concerned former staff are not the only people to express disquiet about what is happening to the children and young people referred to GIDS. In 2020, the UK High Court heard a claim for judicial review of GIDS' practice in relation to the Gillick competence of children of various ages to give informed consent. (For a discussion of 'Gillick competence', see the 'Parents' section of the previous chapter).

On 1 December 2020, the Court ruled that the ability of children to give consent to being dosed with puberty blockers and cross-sex hormones was dubious, and that even in the case of older children, the courts should be consulted before 'treatment' took place. Those under the age of 13 were 'highly unlikely… [to] be competent to give consent to the administration of puberty blockers'; it was 'doubtful' that children aged 14 or 15 'could understand and weigh the long-term risks and consequences of the administration of puberty blockers'; and, in the case of 'young persons aged 16 and over … clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment' (UK High Court, 2020: paras.151, 152). The Court gave two reasons for this decision: the treatment is 'truly life changing, going as it does to the very heart of an individual's identity'; and it is 'innovative and experimental' (paras.145-9).

The case was instigated by Susan Evans as a test case asking the Court to adjudicate on the question of whether or not children were legally competent to consent to what she called 'radical experimental medical treatment' (Evans, 2019; Patel, 2020). She crowdfunded £50,000 to pay the legal fees. The claimants were two women: Keira Bell (named 'Quincy Bell' in the court case-report), a 23-year-old woman who had been started on the transgender pathway at the age of 15 at GIDS and had been through all three stages, but had begun to regret it at the age of 20; and Mrs A, the mother of a 15-year-old autistic girl who was 'desperate to run away from all that made her female' (Transgender Trend, 2020b; Lyons, 2020). (The Court ruled that Mrs A's input was not relevant because it was 'largely theoretical'. Her daughter had not actually been treated by GIDS, and it was unlikely that she would be, given the lack of parental consent) (UK High Court, 2020: para.89). The court had rejected the submissions of both Stonewall and Mermaids on the grounds that the court already had that evidence, or that it was irrelevant (Transgender Trend, 2020b).

For a statement by Mrs A about her concerns for her daughter, see: Evans, 2019.

Bell had been referred to GIDS by a psychologist she was seeing—'because I kept insisting that I wanted to be a boy'. There she was diagnosed with 'gender dysphoria' and put on puberty blockers at the age of 16 after, she said, 'a series of superficial conversations with social workers'. A year later she was receiving testosterone, and at the age of 20 she had a double mastectomy. 'By then', she said, 'I appeared to have a more masculine build, as well as a man's voice, a man's beard, and a man's name: Quincy, after Quincy Jones' (Bell 2021).

But soon after, she began to realise that she wasn't a man and never would be. The doubts, she said, 'were brought on by for the first time really noticing how physically different I am to men as a biological female', and by the fact that she couldn't relate to male experiences 'due to being biologically female and socialised in society as a girl' (UK High Court, 2020: para. 80). She admitted that one psychiatrist had tried to dissuade her from going through with the 'transition' medical procedures, but this had made her even more determined. 'Now', she said, 'I wish I had listened to her' (para.79).

It is important to be clear about what kind of hearing this was, and what it was not. It was a judicial review, that is, it was 'a challenge to the way in which a decision has been made [by a public body], rather than the rights and wrongs of [that decision]'.[16] It was not evaluating GIDS' actual procedures, the 'rights and wrongs', simply the way they were done, i.e. without legal oversight. It was not a tort action, i.e. a claim for recompense for injuries, and Keira Bell was not claiming damages (Bell, 2021). Neither was she claiming criminal negligence on the part of GIDS, despite the mutilating effects on her body. The Court's ruling doesn't say it is wrong for health services to dose children with puberty-blockers, nor does it make it a crime. The Court's focus was only on the question of children's ability to consent to being given puberty-blockers. The judges were not concerned about the validity or otherwise of such 'treatment':

> The court is not deciding on the benefits or disbenefits of treating children with GD [gender dysphoria] with PBs [puberty-blockers] … the nature of GD and the treatments that may or may not be appropriate … is not a matter for us. The sole legal issue in the case is the circumstances in which a child or young person may be competent to give valid consent to treatment in law and the process by which consent to the treatment is obtained (UK High Court, 2020: para.9).

In other words, the Court's decision didn't make it unlawful to dose perfectly healthy children with life-changing drugs. The public body (GIDS in this case) could continue to make the same decision, i.e. continue to give children puberty-blockers, 'so long as it does so in a lawful way',[17] i.e. by consulting the courts.

In response to this ruling and to the rating of 'inadequate' by the Care Quality Commission (see below), the GIDS Executive leadership team was disbanded and a number of outside psychological experts were recruited (Transgender Trend, 2021b. See also: Biggs, 2020: 13-15; Cunningham, 2020; Lane, 2020; Vigo, 2020).

Appeal

Then GIDS appealed and won. The Court of Appeal overturned the High Court decision on 17 September 2021. They said it was "inappropriate" to require medical professionals to consult the courts, that there was no legal obligation to do so. "[I]t was for clinicians rather than the court to decide on competence [to consent]", the Appeal Court said; and besides,

> "[i]t placed patients, parents and clinicians in a very difficult position. In practice the guidance would have the effect of denying treatment in many circumstances for want of resources to make such an application coupled with inevitable delay through court involvement" (Siddique, 2021).

For GIDS, the Appeal Court's judgement meant business as usual:

> [It] confirms that children under the age of 16 may … be assessed as legally competent to give informed consent for [puberty blockers] … **For**

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[16] https://www.judiciary.uk/you-and-the-judiciary/judicial-review/

[17] See previous footnote.

> **children under 16 years** … the processes followed by GIDS … must be assured by an independent Multi-Professional Review Group … there is no requirement for [GIDS] to seek a prior Best Interest order from the Court in regard to an individual (GIDS, 2021b: paras.2, 4—original emphasis).

That is not, however, the end of the matter. Bell and her legal team plan to appeal to the Supreme Court. Although there is no guarantee that they will even be permitted to do so (Phillimore, 2021), these court cases are a public record of what is being done to children in the name of 'gender identity'. As Bell herself said, "A global conversation has begun and has been shaped by this case" (Siddique, 2021). The two court cases, as Transgender Trend pointed out, 'have brought the issue of preventing puberty in children to global public, professional and political attention' (Transgender Trend, 2021c).

As well, the High Court in the Bell case put on record a number of criticisms of GIDS, criticisms that highlighted at least some of the problems. These were largely in relation to the lack of evidence for the efficacy of the 'treatments' and hence for the policies and practices of 'gender' clinics. The justices found themselves 'surprised', they said, at the lack of data in crucial areas. Information on the age distribution of the children treated with puberty blockers between 2011 and 2020 had not been collected, an important omission 'given the young age of the patient group, the experimental nature of the treatment and the profound impact that it has' (UK High Court, 2020: para.28).

The Court was also surprised that there was no information on the proportion of children who had been diagnosed with autism (UK High Court, 2020: para.35), nor on the numbers and proportion of those on puberty blockers who moved on to cross-sex hormones (para.59). The Court also noted that GIDS' representatives had no explanation for the recent increases in the numbers of young people presenting to the clinic (para.32). It would seem that they were also surprised to learn that puberty blockers 'will now be considered for any children *under the age of 12*', given the emphasis they placed on that phrase (para.26—the Court's emphasis). The Court did not reject the idea behind 'gender' clinics like GIDS, that children can be changed into the opposite sex, but they were clearly highly critical of some of GIDS' operations.

Although the Appeals Court ruling that clinical decisions belonged with clinicians not courts might be valid, handing the decision-making back to the doctors solves nothing, as Sarah Philimore pointed out. Trusting the ethical competence of the medical profession is what has led to the current situation. It is the decisions of the medical profession that have led to a 'general environment that "affirms" transition as a positive good without further investigation', and that thrives on poor record-keeping and a complete lack of curiosity 'about why their client base had suddenly shifted to be mostly teenage girls, many with autism' (Phillimore, 2021). But then, transferring the decision-making to the courts would not change matters, because the courts on the whole are already officially committed to trans ideology. (See the 'Law' chapter).

For extended discussions of the question of children's competence to consent to medical procedures, see: Kenny, 2020: 61-4; Levine et al, 2022; Transgender Trend, 2021d.

The CQC review

Shortly after the High Court handed down its ruling, the regulator of health and social care in the UK, the Care Quality Commission (CQC), gave GIDS a rating of 'inadequate' in January 2021 (UK CQC, 2021). The CQC periodically inspects healthcare providers and rates them on a four-point scale, of which 'inadequate' is the lowest rating. The others are 'outstanding', 'good', and 'requires improvement'.[18] The 'inadequate' rating means, Transgender Trend said, 'that a service is "performing badly"' (Transgender Trend, 2021b). 'Inadequate' was their rating for GIDS overall, and also for their 'responsiveness to people's needs' and whether it was 'well-led'. The ratings for the service's safety and its effectiveness were both 'requires improvement', although their 'caring' was 'good' (UK CQC, 2021).

The CQC said that their inspection of GIDS was not influenced by the High Court's ruling. It took place before that ruling was announced. They undertook it because of concerns raised by health care professionals and by the Children's Commissioner for England 'relat[ing] to clinical practice, safeguarding procedures and assessments of capacity to consent to treatment' (UK CQC, 2021: 2-3). I have been unable to find any statement of the Children's Commissioner's concerns about GIDS, and one statement by the newly appointed Children's Commissioner seems to imply the opposite. She said that she wanted 'to hear previously unheard voices, from minority or vulnerable groups of course, but also from the child whose identity may fall between definitions which might confer a particular need or disadvantage' (de Souza, 2021).

Whatever 'falling between definitions' might mean, it does sound suspiciously like the transgender-speak that insists that sex is a matter of definition and that some individuals 'fall between' the two sexes. It implies that, whatever the Commissioner's concern, she is not concerned about the transgender agenda, and hence with how GIDS is treating children. She seems to agree that there *are* children who fall between the sexes—unless, of course, the muddled language suggests some lingering doubt (or she's not talking about transgender at all, but in that case, what *is* she talking about). The brief mentions of 'LGBT' on the Children's Commissioner's website make it clear that it, too, accepts the trans agenda.

The Care Quality Commission's earlier inspection of GIDS, in 2016, had resulted in a rating of 'good'. This early favourable rating, Transgender Trend (2021a) argued, was a result of institutional capture by the trans lobby, both of the CQC and of the Tavistock Trust. The CQC has been working with Stonewall since 2012, they are one of Stonewall's 'Diversity Champions', and in 2014 they ran one of Stonewall's 'LGBT Role Models course'. Transgender Trend found evidence of the CQC's capitulation to the trans lobby in their guidance for their inspection staff and social care providers, and in their 2018 publication, 'Sexual safety on mental health wards'. In the first publication, there was no mention of sex, even in a section called 'What is sexuality?', and 'sexuality' was defined to include 'gender identity'. In the second publication there was no recognition of the danger to women of housing them with men in the wards of psychiatric hospitals, despite the evidence of CQC's own findings that sexual offences were largely committed by men against women. Their sole concern was to

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[18] https://www.cqc.org.uk/guidance-providers/independent-healthcare/levels-ratings-independent-healthcare-services

"[r]espond to the needs of people who identify as lesbian, gay, bisexual, or non-binary or who are transgender", although there was no evidence that so-called 'LGBT people' were a high-risk group (Transgender Trend, 2021b).

This institutional capture did not bode well for the next CQC review. When the NHS announced in September 2020 that the CQC would undertake an 'independent review', Heather Brunskell-Evans expressed doubts about its neutrality, both because of the CQC's own preference for the trans agenda, and because of the publicly-expressed preference of two of the three appointed reviewers, Helen Stokes-Lampard, Chair of the Royal College of General Practitioners and Dr Michael Brady, the Government's National Adviser for LGBT Health. Brady had been outspoken in his support for the transgender agenda, especially on his Twitter feed. The latter includes links to a number of trans-positive organisations, including Mermaids, Gendered Intelligence and, most egregiously, GenderGP (Brunskell-Evans, 2020a).[19]

The Royal College of GPs, of which Stokes-Lampard was Chair, was a signatory to the trans-positive Memorandum of Understanding on Conversion Therapy (MoU). The Board of the UK Council for Psychotherapists also ratified it, in 2017, although in typical transgender fashion the vast majority of the members had no say in that decision and many are still unaware of it (Brunskell-Evans, 2020a). The original version of the MoU, drawn up in 2015, was an agreement among therapeutic professional associations to ban any attempts to convert gays, lesbians or bisexual people to heterosexuality. In 2017, 'trans gender identity' was included (Jenkins, 2022a, b), and the MoU took on 'the ethos of a *trans activist political lobby*, rather than demonstrating the values of a professional body which is committed to science-based research, open debate and tolerance of minority view' (Jenkins, 2022b—original emphasis). (See also: Brunskell-Evans, 2020b; Charlesworth, 2021. For a discussion of the transgender-led push for 'conversion therapy' legislation, see the 'Conversion therapy' section of the 'Piggybacking' chapter).

The 'inadequate' rating of GIDS by this second CQC inquiry might seem to imply that the trans influence was waning, especially as one example of good practice was 'staff encourage[ing] the young person to have a "cooling off" period before proceeding with treatment to allow time for them to reflect on their decision' (UK CQC, 2021: 4). However, this 'cooling off period' comment would seem to be an aberration, and the CQC continued to be committed to the trans agenda. Clues are scattered throughout the report. One example is the uncritical use of the term 'transphobic' (UK CQC, 2021: 8). Another example occurred in a section on 'learning when things go wrong'. What went wrong in this instance was a 'young person's preferred name being written on a letter but their given name, which they did not like to use, … written on the envelope'. For this heinous mistake, '[t]he service sent the young person a formal apology' (p.9). That something so trivial could be highlighted while the problems raised by the whistleblowers are ignored, leaves no doubt that the trans agenda continues to influence the CQC.

None of the problems identified in CQC's report of the inspection were acknowledged to stem from GIDS' standard operating procedures. The majority, if not all, of them—the long waiting times, the failure to deal adequately with 'risk' or to develop adequate care plans—were attributed to the increase in the numbers of

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[19] originally titled "The Care Quality Commission: An executive arm of Stonewall?'

children and young people presenting to the clinic (see the 'Increase' chapter). This was the first point of inadequacy mentioned: 'The service was difficult to access. There were over 4600 young people on the waiting list. Young people waited over two years for their first appointment' (UK CQC, 2021: 3).

Any 'risks' mentioned were external to GIDS, e.g. 'sexual exploitation' (UK CQC, 2021: 6), 'parental neglect and sexual abuse', 'living independently in inappropriate housing', 'poor physical health', 'not receiving any support', 'harassment and discrimination' and 'homophobic and transphobic attitudes' (p.8). Managing those 'risks' involved, at least in part, working with 'young people's local services' (p.7), not investigating GIDS' own procedures. And if staff 'did not always assess and manage risk well', that was due to 'the size of the waiting list' (p.3).

Attributing the problems to the increase in numbers exonerated GIDS. After all, they can hardly be held responsible for that increase, and that is indeed the way their 'inadequacy' was interpreted by management. A GIDS spokesperson said 'we have submitted our plan to improve the management of our waiting list to the CQC and are working with our commissioners, NHS England, and others to improve access to the service'. The CEO, Paul Jenkins, said that GIDS 'has found itself in the middle of a cultural and political battleground … [which] followed a rapid rise in referrals which has been hard to manage, both in terms of the numbers but also the wide range and often complex needs of patients seeking support … As a result [of the growth in referrals], vulnerable young people and their families have not had adequate access to the care they expect and deserve' (GIDS, 2021a).

The troubles identified by the staff whistleblowers and concerned outsiders—the harmful and experimental nature of the drugs administered, the haste with which young people were processed through the system, the refusal of management to listen to whistleblowers and their treatment of them, and the trans lobby influence—weren't mentioned in the CQC's report. None of those who had publicly raised concerns about GIDS were consulted, and at least one of the CQC's findings directly contradicted what staff had been saying: 'The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff' (UK CQC, 2021: 4).

That was not the experience of Susan Evans, Marcus Evans, David Bell or Sonia Appleby, nor of the many other staff who had resigned because they could not continue to support the transgendering of children. The report said they had spoken with the GIDS safeguarding lead (UK CQC, 2021: 3), but at the time the inspection was taking place (October and November 2020), Sonia Appleby was GIDS' safeguarding lead. She started taking legal action against the Tavistock in July 2020 (Kirkup, 2020), and she was still the Named Professional for Safeguarding Children in September 2021 when she wrote the last update on her case.[20] And yet the CQC's report contains no mention of her or her concerns.

But what exposes the transgender influence most clearly is the belief that there *are* children and young people who need to have their healthy bodies subjected to medical treatment because they are 'questioning their gender identity or experiencing gender incongruence' (GIDS, 2021a). The main recommendation accepts that

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[20] https://www.crowdjustice.com/case/gids-concerns/

transgender lie, by requiring GIDS only to improve the waiting times (UK CQC, 2021: 4). If the service is causing harm (as so many critics have pointed out), improving access to the services that cause it will only exacerbate it.

For a summary of key points in the Commission's report, and a more optimistic reading in support of the trans-critical position, see: Transgender Trend, 2021a.

The Cass review

The subsequent Cass review, the interim report of which was released in March 2022, also accepted the reality of trans identification. The 'group' of 'children and young people needing support around their gender' comprised an identifiable 'population', the report said. The 'significant increase in the number of referrals' was the main problem here, too, as in the CQC report (Cass, 2022: 7). This is not surprising, given that its Chair, Dr Hilary Cass, was also the Chair of the CQC's review (Brunskell-Evans, 2020a). Cass hastened to reassure 'young service users' that she was not going to recommend that 'services should be reduced or stopped'. '[T]his is absolutely not the case', she said, 'the reverse is true'. She believed that more services were needed, both because of the increase and because they needed to be spread around the country rather than concentrated in just two places (Cass, 2022: 9).

This is hardly likely to improve matters, since the transgender lobby is active all over the country. The transgender agenda is already being written into NHS policy in Bristol, South Gloucestershire and Devon regions, as well as for the North Somerset NHS Clinical Commissioning Group, for example. The chief architect of this policy 'guidance'[21] is reported to be a man calling himself Cheryl Morgan (Egret, 2019) (although authorship is attributed to 'Michelle Smith'). Morgan has publicly demonstrated his misogyny, calling women 'terfs', 'maniacs' and 'an infestation', and he insists on the trans delusion that he is a woman—he attended a menopause event and claims to be able to breastfeed (Egret, 2019). But he would have no influence if it weren't for the fact that he is supported by so many other people. Indeed, he was *invited* to the menopause event by the women organisers;[22] and the NHS 'guidance' was produced under the auspices of a number of seemingly well-meaning NGOs, including Stand Against Racism and Inequality.

That the Cass review might uncover evidence that would bring down the whole transgender medical enterprise was ruled out by the review's terms of reference. The review was 'to make recommendations on how to *improve* services for children and young people experiencing issues with their gender identity or gender incongruence' (Cass, 2022: Appendix 1, p.87—emphasis added). There is no suggestion that the review might explore the option of stopping those 'services' altogether, at least those that involve unjustifiable medical interference with healthy young bodies.

The interim report of the Cass review did contain criticisms of GIDS' procedures, any one of which should have raised serious questions about these procedures, even to the extent of recommending they be halted. This Cass does not do. Instead, the vital importance of those problems is downplayed, or they are written up as though

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[21] https://bnssgccg-media.ams3.cdn.digitaloceanspaces.com/attachments/govbody_5Nov19_item6.4.pdf

[22] https://archive.ph/qTW5N

they can be solved within the existing structure. Over and over again the report mentions the lack of evidence, although the text uses euphemisms like 'gaps', 'limited' and 'inconclusive'. For example, the report says that the review is unable to provide advice on the use of puberty blockers or cross-sex hormones 'due to gaps in the evidence base … [and] limited research on the sexual, cognitive or broader developmental outcomes' (Cass, 2022: 15, para.1.5; 19, para.1.27).

There is no comment about the ethics of a medical practice devoid of evidence either for its efficacy or for any harm it might cause. The report simply goes on to say that 'recommendations will be developed as our research programme progresses'. But if there is already no evidence despite the 30 or more years GIDS has been in operation, it's not just a matter of 'gaps'. Or of 'limited data': the report says there is 'limited' follow-up data for those

> who have received physical interventions; who were transferred to adult services and/or accessed private services; or who desisted, experienced regret or detransitioned (Cass, 2022: 19, para.1.24).

But in fact there is none.

Other problems the report mentions include: the 'pressure to adopt an unquestioning affirmative approach' (Cass, 2022: 17, para.1.14), and 'important healthcare issues that … can sometimes be overlooked' (p.17, para.1.16). Note the euphemistic 'can sometimes be' rather than 'are'. Also mentioned is the lack of 'therapeutic support prior to starting hormone blocking treatment' (p.18, para.1.20), and the 'drop off … [in] the frequency of appointments … once young people are started on hormone treatment'. This 'reflects a lack of service capacity' and hence could be remedied with 'more staff time' (p.18, para.1.22). But none of these is seen as a reason to halt the procedures.

The review also found 'a lack of a conceptual agreement about the meaning of gender dysphoria [which] hampers research, as well as *NHS clinical service provision*' (Cass, 2022: 19, para.1.24—emphasis added). In other words, these clinicians who are prescribing life-changing drugs to the young cannot even agree on what it is they are treating. Again, note the euphemistic language: 'lack of a conceptual agreement' rather than the more forthright 'disagreement'; 'hampers' rather than 'rules it out altogether'. Disagreement about the basic concept surely undermines the validity of both research and service provision.

The report also quite rightly points out that much of what is written about 'children and young people with gender incongruence and dysphoria' focuses on males, with very little about the recent surge of girls in their early teens, 'particularly in relation to treatment and outcomes' (Cass, 2022: 19, para.1.28). Together with the euphemistic language, the soft-pedalling of the problems continues with the lack of any mention of the influence of trans lobby groups such as Mermaids and Stonewall. The report does say at one point that 'there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint' (p.19, para.1.29). But this is again a euphemistic avoidance of the real issue, focused as it is on 'authors' rather than on the subordination of clinical practices to political influences. Who those authors are is not mentioned, and while debates are acknowledged to be 'polarised and adversarial' (p.26, para.2.4), there is no mention of who the adversaries are nor of the content of those debates.

As well as the lack of criticism of the influence of trans lobby groups, it would seem that no trans-critical groups or individuals were consulted. There *are* hints of disagreement throughout, even 'polarised and adversarial', and there is a mention of 'criticism of the service' (Cass, 2022: 16, para.1.12). But the disagreement is euphemised as 'conceptual' or 'a lack of consensus', and there is no discussion of what those criticisms are (just that criticism is one reason for 'rapid turnover of staff and inadequate capacity to deal with the increasing workload').

The review ruled out from the beginning any consideration of the beliefs underpinning 'the broader cultural and societal debates', and refused to take a position. These debates, the report said, 'related to the rights of transgender adults', and hence presumably were irrelevant to 'the clinical services provided to children and young people who seek help from the NHS to resolve their gender-related distress' (Cass, 2022: 8). But the belief that people can change sex is crucial to the transgendering of children, and right at the heart of the transgender agenda. Stated like that, it is obviously a lie. But refusing to acknowledge the lie, arguing it away with euphemisms, false equivalences and deletion of the facts, is not going to improve matters for the young caught up in it.

Read carefully, the Cass review's interim report is a devastating critique of transgender-influenced medical practices, but the critique is weakened by the absence of any consideration of the possibility that they should be rejected altogether (and by the euphemistic language). It's true that the report says that the GIDS model 'is not a safe or viable long-term option', just as one critic said (Bannerman, 2022). But the reason the report gives for that is not GIDS' actual practices of medicalising healthy young bodies, but the fact that it is 'a single specialist provider model' (the solution to which, mentioned above, is to spread it around the country). Another reason is 'lack of peer review', but the children's safety is unlikely to be improved if the 'peers' work at policy-captured universities, or are trans activists masquerading as 'charities' or 'support groups'. And then, of course, there's 'the increasing demand' as the main reason why GIDS is not safe or viable (Cass, 2022: 20, para.1.33; 69, para.6.6).

Transgender Trend (2022a) initially welcomed the interim report of the Cass review, saying that it vindicated many of the points they themselves had been making for the last six years. They said they were grateful to those who had worked on the review for the care they had taken to examine past failings and make recommendations. They said they were also pleased with the tone of the report, especially '[t]he placing of the welfare of the individual child at the centre of everything'.

However, Transgender Trend (2022a) didn't mention that Cass might have been remiss in failing to consider the possibility that the administering of hormonal medication to the young should be abandoned, that there is no good purpose to be served by it because the promise of changing sex is a lie. This Transgender Trend commentary accepts the necessity of hormonal treatment of the healthy young, while recommending that it be done more carefully. 'Any child or young person being considered for hormone treatment', they said, 'should have a formal diagnosis and formulation', and 'the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear'. Of course, no one who hopes to influence the powers-that-be could recommend doing away with transgender medication, so entrenched is the transgender agenda. But tinkering around the edges of a lie while leaving it basically intact is hardly likely to lead to any change worth making.

Later, however, Brunskell-Evans qualified her original optimistic reaction to the Cass report. She now feared, she said, that her hope that the new regional centres would 'put an end to medical malpractice … may have been naïve'. The values behind GIDS' practices—'the unevidenced but unwavering faith in the "gendered soul"—hadn't changed, and it was highly likely that they would 'live on in the reformed regional centres'. She concluded by saying that 'Only time will tell' (Brunskell-Evans, 2023).

The closure of GIDS

In July 2022, it was announced that GIDS was to close, largely as a result of the findings of the Cass review (Finlay, 2022; Hayward and Bannerman, 2022; Lane, 2022a). This was initially seen as a positive move by those who had been sounding the alarm about GIDS' practices. Keira Bell was reported to say she was "over the moon", and that "[m]any children will be saved from going down the path that [she] went down" (Gregory, 2022). The Society for Evidence-Based Gender Medicine saw it as 'a move away from the "gender-affirming" intervention care model, and toward whole-person-affirming care that is rooted in developmental psychology', because the centres would have better access to local services based in community mental health (SEGM, 2022a).

In a reaction to the GIDS' closure, Kathleen Stock has a delightful take on the dissociation involved in the use of the word 'thoughtful' by GIDS' defenders.[23] 'Perhaps the [transgender] sirens are somewhat quietened now', she said, 'thanks to Dr Hillary Cass and her review. Unfortunately, though, there are Mermaids still out there. With a bit of luck and a following wind, the closure of GIDS will eventually spell the end of them too' (Stock, 2022).

Not all the critics' reactions to GIDS' closure were so optimistic. As one Twitter user pointed out, GIDS might be closing but it was being replaced with many more clinics around the country: "They are replacing this 1 clinic with 8 new regional clinics … This isn't a win" (Lane, 2022a). Moreover, a senior NHS source told the *Guardian* that there would be 'no immediate changes for patients already under the Tavistock's care' (Gregory, 2022).

However, Phase 1 of the NHS' new specification guidelines for the first two of the new clinics, one in London and one in 'the North' (NHS, 2022b), was favourably received on the whole by those concerned about GIDS' practices. Bernard Lane noted that 'the "gender-affirming" ethos' was largely absent—it 'makes just one appearance'—while '*exploration* of a young patient's various problems—not just gender issues but mental health disorders or autism, whatever troubles them—is repeatedly stressed'. Lane commented that 'Dr Cass made the case for "a fundamentally different service model", and that 'that is what's emerging, not more gender-affirming sameness' (Lane, 2022d—original emphasis).

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[23] Stock's commentary is somewhat in the style of *The German Ideology*: 'And all this took place in the realm of pure thought'—not that Stock drew this parallel. Victoria Smith also likened the seemingly inescapable lure of transgender ideology to a 'siren song', in her article, 'Gender sirens: beware Mermaids singing a sad song' (Smith, 2022).

The Society for Evidence-Based Gender Medicine listed a number of improvements in the new NHS specification which, they said, 'sharply curb[s] gender transition of minors'. Among those improvements are that it '[e]liminates the "gender clinic" model of care and does away with "affirmation"', by ensuring that the children will receive 'standard care in children's hospital settings'. It also '[r]einstates the importance of "biological sex"' by interpreting the children's distress 'as a misalignment between the individual's experience of their gender identity and their biological sex', and by insisting that research and outcomes be tracked by sex, not just 'gender identity'. SEGM were also relieved to note that '[p]sychotherapy will be provided as the first and usually only line of treatment for gender dysphoric youth' (SEGM, 2022b).

Transgender Trend (2022b) said that they were only in partial agreement with some of the new specification's recommendations. For example, they disagreed that the specification provided sufficient clarity about social transition. It didn't say that it was false to tell the young they were the opposite sex. As a consequence, it colluded 'in telling lies to children about the fundamental reality of their sex, which cannot be changed'.

Again, in reaction to the statement in the specification that 'service design and improvement [must be] coproduced with experts by experience' (NHS, 2022b: 19), Transgender Trend asked who these 'experts' might be and what sort of 'experience' might count for service design and improvement. As an example of inappropriate experience, they gave 'a middle-aged male cross-dresser' who 'can have no experience of the issues teenage girls face'. However, there were a number of points on which they were in agreement with the NHS' new specification, and they did say that they were 'very pleased' with it, seeing it as 'a move away from ideology and forward to a proper clinical care model'.

For another favourable commentary on the new guidelines, see: Hayward, 2022;

for the non-response to the closure of GIDS by the Scottish government and Scotland's 'gender' clinic, the Sandyford clinic in Glasgow, see: Massie, 2022;

for explanations for what happened at GIDS, see: Barnes, 2023; Freeman, 2023; Lloyd, 2023.

Reactions by Australian 'gender' clinics to the Cass review and the closure of GIDS were to muted to non-existent (Genspect, 2022; Robinson, 2022). Those that did respond to journalists' questions simply doubled down on their standard operating procedures, with no suggestion that there might be any need to re-evaluate anything. The clinic at the Royal Melbourne Children's Hospital was reported to have said that they 'defended their methods … and [that] they followed best Australian practice'. The Children's Hospital at Westmead in Sydney was reported to have said "Children are only ever considered for stage 1 treatment (puberty blockers) once this assessment has taken place and in close consultation with the patient, parents and treating medical teams". The hospital spokesperson quoted went on to give the (false) reassurance that, "This treatment is reversible" (Robinson, 2022).

It remains to be seen whether the closure of GIDS will finally put an end to the medicalising of children in the UK. Although the NHS has reportedly said that "puberty-suppressing hormones should not be routinely commissioned for children and adolescents", they are still permitted in "a research setting" (Lawless, 2023). This might keep some children from transgender's grasp. But what is going to happen if the research projects find that puberty blockers are damaging, or even that they don't lead to any improvement? The Tavistock has already run a trial of puberty blockers (see below) that came to the conclusion that dosing children with puberty blockers doesn't lead to any improvement in the children's well-being.

Until 'gender dyshoria' is utterly rejected for the sham it is, nothing very much has been achieved. There is no way of making a lie a little bit truer. Perhaps the emphasis on psychotherapy means that 'gender dyshoria' will be reinterpreted to mean something other than wanting to be the opposite sex, and that the real causes of the child's distress are dealt with. But until the transgender agenda is brought into utter disrepute, it will remain influential. As the trans-critical alliance, Genspect, said 'Ideological capture is the problem. Until that is broken, no amount of shifting the deckchairs will rectify the woeful state of paediatric "gender medicine" wherever it is practiced' (Genspect, 2022).

The Tavistock's experiment

In 2010 GIDS announced that they were starting a trial of puberty blockers for children under 16. Before that, they had only administered them to young people 16 years of age and older. The trans lobby, particularly Mermaids and the Gender Identity Research and Education Society (GIRES), had been clamorously calling for the age limit to be abolished. The study, called 'Early pubertal suppression in a carefully selected group of adolescents with gender identity disorders', initially recruited 61 children aged between 12 and 15, and 44 of them were given puberty blockers between 2011 and 2014 (Biggs, 2020: 3).

In 2014, Carmichael announced that the study had been successful and GIDS had decided to continue with the puberty blocking regime for under-16-year-olds, but GIDS was reluctant to share those supposedly positive results with the public (Biggs, 2019). Indeed, no results had been published by the time the High Court heard the Bell case in 2020, nine years after the study had commenced and six years after the last child was recruited in 2014. As the Court commented, 'we note that though this research study was commenced some 9 years ago, at the time of the hearing before us the results of this research had yet to be published' (UK High Court, 2020: para.24).

GIDS did provide the Court with a paper which briefly summarised some of the study findings (para.25). That summary admitted that '*there was no overall improvement in mood or psychological wellbeing*' in the children who had been taking the puberty blockers (para.73—the Court's emphasis). Despite this, GIDS' Director, Polly Carmichael, made public statements to the effect that, because the results were positive, GIDS was justified in continuing to prescribe puberty blockers to children under the age of 16, e.g. "Now we've done the study and the results thus far have been positive we've decided to continue with it". On the basis of these supposed 'positive' results, by 2018 around 300 new prescriptions a year were being issued, and by 2019 over 1,000 adolescents had been dosed with puberty blockers (Biggs, 2020: 3). The prescriptions did stop momentarily after the High Court decision in 2020, but then the Appeals Court overturned that decision.

The study was approved by a Research Ethics Committee in February 2011. It had been rejected earlier by the NHS Research Ethics Committee, not on the grounds that experimenting with children's bodies was unethical, nor on the grounds that the children and their parents were provided with insufficient information, but because it was not a randomised trial (Biggs, 2019), i.e. there was no control group of children who were not given puberty blockers.

There are many genuinely ethical reasons why this research should have been rejected. The drugs given to the children are off-label, having never been intended for the 'suspension' of normal puberty. They are used to treat endometriosis, fibroids, ovarian cysts and precocious puberty. They are also used in *in vitro* fertilisation to stimulate the woman's ovaries to produce more ova than the usual single one. They can also have unpleasant, even serious, side effects. Using them to treat 'gender dysphoria' is a rebranding to take advantage of a new market (Marrs, 2022).

Another reason for rejecting the research proposal is that the information given to the parents and children for their 'informed consent' was either false or inadequate. For example, the Patient Information Sheet said that 'The hormone blockers will not harm your physical or psychological development'. But the chief investigator himself had said in the research proposal that they actually didn't know whether they were harmful or not: "*It is not clear* what the long term effects of early suppression may be on bone development, height, sex organ development, and body shape and their reversibility if treatment is stopped during pubertal development" (Biggs, 2019—Biggs' emphasis). The Information Sheet contained no mention of the well-documented side-effects of the drugs, nor of the fact that suppression of male puberty stunts the growth of the genitals.

The Health Research Authority's investigation of the study (UK HRA, 2019) summarises the reasons the Ethics Committees gave for their decisions. Neither of the Ethics Committees mentioned the concerns raised above, and neither did the HRA's investigation comment on their absence. As Michael Biggs noted, this investigation was 'predictably bland' (Biggs, 2020), but in fact it was worse than that. It was exculpatory. It absolved GIDS' practices, at least the ones in the study, of any harmful effects at all, e.g. 'Worsening behavioural and emotional symptoms of dysphoria in the study participants would … not in itself be unexpected [nor] warrant a safety report to the [Research Ethics Committee]' (UK HRA, 2019). The blandness is a consequence of the euphemising necessary to disguise what is really going on.

In 2019, under the auspices of Transgender Trend, Professor Michael Biggs from the Department of Sociology at the University of Oxford undertook an investigation to see what he could find out about the study (Biggs, 2020: 7). He couldn't find a report of the study itself, but he did find some conference abstracts, a brief report in an appendix to a report by Carmichael to Tavistock's Board of Directors, and a paper co-authored by Carmichael that used some of the study's findings. Evidence of improvement was equivocal, and evidence of negative outcomes was downplayed or not reported. For example, Carmichael's report to the Board noted that there was a significant increase in positive answers to the statement 'I deliberately try to hurt or kill self', but Carmichael made no comment on this (p.3).

The most important outcome of the study, Biggs said, was the fact that 43 of the 44 young people continued on to cross-sex hormones. The implication of that finding is that puberty blockers are not reversible, but rather the first step on a pathway of 'lifelong medicalization with cross-sex hormones and surgeries, with irreversible consequences for sexuality and fertility' (Biggs, 2020: 19). There is the same implication in the title of the paper that first argued for puberty suppression, 'The feasibility of endocrine interventions in *juvenile transsexuals*' (emphasis added) (p.19). Already the children are labelled 'transsexuals', even though what evidence there is strongly suggests that most of them will grow up to be gay or lesbian if left alone. 'The question is', Biggs said, 'whether the GIDS has the moral authority and scientific expertise to designate children as young as 10 as juvenile transsexuals' (p.19).

For an eventual write-up of the research, see: Carmichael et al, 2021;

for further criticisms of GIDS' research, see: Cohen and Barnes, 2018.

The WPATH update—Version 8

WPATH's response to criticism is to double down on its commitment to the transgender agenda, reaffirming its system by dismissing, euphemising or ignoring evidence disconfirming its preferred narrative. That approach was already apparent in the draft revision of their Version 7 Standards of Care, released in 2021. Focused specifically on adolescents, it gives a number of reasons for the revision, none of which mentions to the mounting wave of criticism. Those reasons are: that there has been an 'exponential growth' in the numbers of adolescents presenting to 'gender' clinics; that there has been an increase in the studies addressing 'adolescent gender diversity-related care'; and that 'this age group' has 'unique developmental and gender affirming care issues' (WPATH, 2021: 1/46).

There is no attempt to provide an explanation for the increase in numbers; nor is there any suggestion that the unprecedented increase might indicate a qualitatively different population—largely adolescent girls rather than adult male transsexuals—requiring a quite different approach. The word 'girls' doesn't even appear in this revision—except to refer to boys, i.e. 'transgirls' (WPATH, 2021: 27/46); and the 'care issues of this age group' are 'unique', not because adolescent girls (and boys) have different needs from adult men, but because of the different medical interventions required. There is no point, after all, in dosing adult men with puberty blockers.

Evidence critical of the transgender medicalising of children and young people is either treated dismissively or ignored altogether. For example, although this revision was released after the High Court decision in the Bell case, that decision is not mentioned. There is a reference to an article by the Dutch team that discusses it at length (i.e. de Vries et al, 2021), but WPATH ignore that discussion. They cite this article in the context of their agreement that 'the long-term effects of gender affirming treatments initiated in adolescence are not fully known'. But they then dismiss this insight, going on to say, 'the potential negative health consequences of delaying treatment should also be considered' (WPATH, 2021: 28/46). There is no attempt to account for the fact that those children who have never had the 'treatment' at all have *no* 'potential negative health consequences'.

WPATH's revision is also dismissive of Littman's research, saying it 'contained significant methodological challenges'. It only surveyed parents and not 'youth perspectives', they said, and it recruited its respondents 'from community settings in which treatments for gender dysphoria are often characterized as pathological or undesired' (WPATH, 2021: 4). This latter point is at least partly true, although the 'community settings' Littman surveyed object to the treatments, not because they are 'pathological or undesired' (whatever that means), but because they are harmful. But trans apologists are not the best judges of methodological flaws, given the methodological weaknesses of their own research, selection bias among them (see the '… and statistics' chapter and the 'Research' section of the 'Evidence' chapter). Anyway, Littman answered her trans-identified critics, and their attempt to censor her work failed (see the discussion in the 'Social contagion' section of the 'Transgendering the young 3' chapter). WPATH's 2021 revision doesn't mention this.

As for the increase in studies addressing 'adolescent gender diversity-related care', there have indeed been a lot of them. But the methodologies are so suspect that only the most ideologically blinkered would find them credible. (See the 'Evidence' chapter).

As already mentioned (note 1 in the previous chapter), WPATH released Version 8 of their 'standards of care' in September 2022 (Coleman et al, 2022). Criticism is still ignored. There is no mention of the interim Cass review (Cass, 2022), which was released six months before Version 8. Neither is there any mention of the proposed closure of GIDS, announced in July, two months before Version 8 was released. Two months might be insufficient time to address the implications of GIDS' closure for WPATH's self-proclaimed 'mission … to promote evidence-based care' (Coleman et al, 2022: S3, Abstract). The producers of the Version 8 document could have postponed its release in order to make time to consider that fact, especially as two of the authors were employed at the Tavistock. But no. The furore around the proposed closure of GIDS might not have happened, for all the attention paid to it by the authors of WPATH's Version 8.

The 'research' they do cite has the usual methodological flaws, for example, the study (Olson et al, 2022) that supposedly found that 'detransition occurs with only a small percentage of youth five years after a binary social transition' (Coleman et al, 2022: S77). (Here, 'binary' means that the youth 'transitioned' into the opposite sex, as opposed to a 'transition' into no sex at all—'non-binary'). This research, along with numerous other studies that purport to show 'small percentages' of regret and detransition, is designed to inevitably exclude any real level of regret, dissatisfaction or detransition. (See the 'Evidence' chapter).

In the case of 'social transition', Version 8 eschews the caution displayed by Version 7 (and the Dutch team). No longer is 'social transition' acknowledged to be controversial. It is simply 'a process by which a child is acknowledged by others and has the opportunity to live publicly … in the gender identity they affirm' (Coleman et al, 2022: S75). It is admitted that '[a] child's social transition (and gender as well) may evolve over time and is not necessarily static' (p.S76); and there is a partial acknowledgement of the Dutch team's caution. Social transition might make it difficult for a child to accept their actual sex if they decide they don't want to 'transition' after all. In a sentence marked by faux-scholarly jargon ('negative sequelae'?) as well as the usual trans-speak, they say, 'a child may suffer negative sequelae if they revert to the former gender identity that matches their sex designated at birth' (p.S78). But encouraging a child to revert to their actual sex means *dis*couraging them from proceeding with their 'gender transition', and Version 8 is opposed to that: 'Neither assessments nor interventions should ever be used as a means of covertly or overtly discouraging a child's gender diverse expressions or identity' (p.S71). Moreover, parents and clinicians are advised to ignore the fact that children might change their minds. '[R]ecognition that a child's gender may be fluid and develop over time', they say, 'is not sufficient justification to negate or deter social transition for a prepubescent child' (p.S76).

It would seem, though, that the NHS is ignoring WPATH's recommendations on this question of 'social transition'. In its public consultation document preparatory to the release of its interim specifications for 'specialist gender dysphoria services for children and young people' (NHS, 2022a), the NHS was clearly in disagreement with Version 8. It maintained that 'social transition in pre-pubertal children' *was* 'controversial', that there *was* disagreement among health professionals, and that there was insufficient evidence 'to predict the long-term outcomes of complete gender-role transition during early childhood'. 'Social transition', they said, 'should not be viewed as a neutral act', but rather (citing Cass), 'as an "active intervention"', because 'it may have significant effects on the child or young person in terms of their psychological functioning'. In other words, it might convince children that they have 'gender dysphoria' when they don't. As a consequence, their interim specification (NHS, 2002b) will be clearer than their previous specifications that 'in most cases gender incongruence does not persist into adolescence'. So the NHS has refused to follow WPATH's doubling down on their support of the social transitioning of young children.

For further critiques of Version 8 from a number of knowledgeable commentators, see: Lane, 2022b, c. See also: Esses, 2022; Gluck, 2022a.

The abandonment of age limits

Version 8 has no minimum ages for transgender 'medical' treatment, not even for surgery. That is despite the fact that WPATH's pre-Version 8 draft (WPATH, 2021) did have minimum ages, below which children would not be eligible for the procedures. 'Statement 12G' said: 'The adolescent is the following age for each treatment: 14 years and above for [cross-sex hormones] … 15 years and above for chest masculization … 16 years and above for breast augmentation, facial surgery [etc.] … 17 and above for [genital surgery]' (WPATH, 2021: 27/46). Even there, though, the way was left open for treating younger children with these procedures. Every age limit was followed by the proviso: 'unless there are significant, compelling reasons to take an individualized approach', i.e. to ignore these age limits. No examples of 'significant, compelling reasons' are given.

Version 8 does include one lower age limit. It quotes Versions 6 and 7 to the effect that adolescents weren't eligible for 'irreversible surgeries' until the age of 18, with the exception of 'chest "masculinizing" mastectomy', which could be performed on 16-year-old girls (Coleman et al, 2022: S43). But Version 8 doesn't endorse these limitations, although they don't say so outright. It is simply taken for granted that adolescents will have surgery before the age of 18. The term 'surgical care' is reiterated throughout the chapter on 'Adolescents'; the chapter on 'Surgery and postoperative care' is intended for both adults and adolescents; and health care professionals are advised to 'support the adolescent' throughout all the treatments, including 'gender-related surgery', until the move to adult care at the age of 18 (p.S48).

It has been reported that WPATH issued an online 'correction' to Version 8 on 15 September, which removed any age guidelines (Gluck, 2022b; Lane, 2022b). I have been unable to find what it is that was removed, understandably. WPATH is unlikely to make what they have deleted available to the general public. The hyperlinks provided go to a 'Statement of removal' which simply says: 'This correction notice has been removed as it referred to a previous version of the article, which was published in error'. Presumably, what was removed were the lowest permissible age limits for transgender medical procedures listed in the pre-Version 8 draft (WPATH, 2021).

Although Version 8 refuses to set any age limits below which it is inadvisable (although not forbidden) to medicalise the young, it does have a lot to say about the ages of the children and young people who present to 'gender' clinics. The chapter on children refers to them as 'prepubescent' with no specific age, although 'pre-schoolers, school age, early puberty prior to adolescence' are mentioned (Coleman et al, 2022: p.S72). Thankfully, they 'are not eligible to access medical intervention'. But presenting to a 'gender' clinic means they will be subjected to 'aspects of medical [sic] necessary care intended to promote the well-being and gender-related needs of children', by health care professionals who specialize in 'psychosocial supports and gender development' (p.S67). And they are encouraged to 'transition' socially.

Note, too, the agency attributed here. It's the children (and their parents) who 'access medical intervention', not the medical profession that recommends, provides and encourages the interventions, and lures people with a false promise of healing. The medical system is assumed to be simply a neutral resource that people can access or not as they will. The clinicians are only giving people what they want. Such terminology, which pervades the transgender literature, thus absolves the real perpetrators of responsibility: a medical profession policy-captured by an ideological apparatus that transgresses not only common sense, but also basic scientific facts.

Specific ages are mentioned in the case of adolescents. At a number of points, Version 8 says that puberty blockers aren't started until Tanner Stage 2. But WPATH expect clinicians to be screening girls from the age of seven and boys from the age of nine, for signs of incipient puberty:

> When a child reaches an age where pubertal development would normally begin (typically from 7-8 to 13 years for those with ovaries [sic—girls] and from 9 to 14 years for those with testes [sic—boys]), it would be appropriate to screen the child more frequently, perhaps at 4-month intervals, for signs of pubertal development (breast budding or testicular volume > 4cc) (Coleman et al, 2022: S112).

Children are followed up so frequently so that puberty 'can easily be detected before there are irreversible physical changes, and GnRHa [puberty blockers] can be started at that time with great efficacy' (Coleman et al, 2022: S112).

However, it would seem that even children in Tanner Stage 1 can be dosed, not only with puberty blockers, but also with cross-sex hormones ('gender-affirming hormone therapy', or 'GAHT'): 'the use of a GnRHa could be considered in a child who, due to a constitutional delay in growth and puberty, starts GAHT while still in Tanner Stage 1'. But whenever the medicalising starts, for WPATH, earlier is better than later: 'the suppression of the development of secondary sex characteristics is most effective when sex hormonal treatment [cross-sex hormones] is initiated in early to mid-puberty when compared with the initiation of sex hormonal treatment after puberty is completed' (p.S112). WPATH show no concern for the fact that 'early' means younger children, and hence, children even less likely to have the maturity to make life-changing decisions.

Eunuchs

The most extreme example of Version 8's doubling down on WPATH's already dubious policies is the new chapter on 'Eunuchs'. Here, I discuss simply the *fact* that the transgender agenda welcomes the castration of boys. There is further discussion of it in the 'Further explanations' chapter, as yet another sexual fetish embraced by the transgender agenda.

While Version 8's 'Eunuch' chapter is largely confined to adults, the authors do include a coy reference to children. 'Like other gender diverse individuals', they say, 'eunuch individuals may be aware of their identity in childhood or adolescence'. Note again the agency attribution—it's the children who 'may be aware', not a medical profession purveying the message that castrating boys is a perfectly fine thing to do. Version 8 'refrain[ed] from making specific suggestions', however, [d]ue to the lack of research into the treatment of children who may identify as eunuchs' (Coleman et al, 2022: S89). But whatever the reason for their reticence about making specific suggestions, WPATH has included children in the 'eunuch' category, thus continuing the age-long male supremacist tradition of castrating boys. Not incidentally, this latest version of WPATH's 'standards' was published in the *International Journal of Transgender Health*, another of WPATH's mouthpieces that has been welcomed into academe.

It's not usually called 'castration' in the transgender lexicon, of course (although the term 'castration' is used in one transgender-inspired article, in the context of 'an ethics perspective') (Milrod & Karasic, 2017: 631). The most common usage is 'vaginoplasty', terminology that implies that something is being given, not that something is being taken away. But this operation does take away the boys' genitals, and it would seem that ethical qualms can be set aside because, again, the agency is located with the children, vide: 'there has been an increase in the number of TGD youth seeking vaginoplasty' (Coleman et al, 2022: S66).

This is good news for trans-identified luminaries in the medical profession. Joanna Olson-Kennedy was quoted saying as early as 2015 that "full gender-affirming surgery" for minors was "on the horizon". She went on to say dismissively that "the difficulty of genital surgery is that it is surgical sterilization and people get super worked up about that" (as though boys being castrated were nothing to get upset about). She referred to this 'getting worked up' about castration as "a barrier we have to over-come", and expressed the opinion that 'we' (the transgender lobby) were going to do just that (Clayton, 2022: 692). As indeed they have. Version 8 has dropped the age restriction for genital surgery, introduced the category of 'eunuch' as yet another 'vulnerable and marginalised' category of persons, and surgeons on the US were already castrating minor boys, even before Version 8 deleted any mention of age limits, and despite Version 7's restriction of genital surgery to those over 18.

Version 8 tells us, as though it were simply a neutral fact, that 'a 2017 study of 20 WPATH-affiliated surgeons in the US reported slightly more than half [i.e. eleven] had performed vaginoplasty in minors' (Coleman et al, 2022: S66, citing Milrod & Karasic, 2017). The two transgender-friendly psychotherapists cited (Milrod & Karasic, 2017) airily dismissed concerns about the age at which adolescents are judged to be eligible for surgery. They interviewed 11 surgeons 'who had performed vaginoplasty on a transgender female [sic] minor', i.e. on boys younger than 18. (The other nine hadn't performed this surgery). The numbers of such surgeries performed by each surgeon ranged from one to 20, and the ages of the boys 'ranged from 15 to "a day before 18" years' (p.626).

The title of the article started with the phrase, 'Age is just a number', and they quoted one of their interviewees saying that "age is arbitrary". They said that 'an overwhelming majority' of those they interviewed cited 'psychological maturity' rather than age, as the main criterion they used to decide whether or not to go ahead with the surgery (Milrod & Karasic, 2017: 627 and passim). But how the surgeons judged this 'psychological maturity' is unclear. The authors said that most of them 'emphasized that mental maturity was related to the ability to understand the stressors of undergoing surgery and expectations of postoperative self-care, particularly the commitment to a consistent dilatation schedule to maintain patency [the condition of being open or unobstructed] of the neovagina' (p.627). But the decision about maturity has to be made before the surgery, because it is supposedly the reason for going ahead with it. It has to be made before the boy has demonstrated his 'commitment to a consistent dilatation schedule', which can only happen after his genitals had been removed and his 'neovagina' constructed.

Moreover, it would seem that the surgeons weren't relying on the boys' maturity after all. The boys who were most eligible for surgery were those who were still young enough to have the 'protective environment' of 'the parents' house'. One surgeon was quoted saying:

> Some of my biggest struggles have not been with the 16-year-old group because they are still at the parents' house—it is the 18-year-olds who disappear and go to college within a few months after their surgery. Those are the patients who are most likely to lapse in their aftercare (Milrod & Karasic, 2017: 627).

The article is silent about whether or not this surgeon would still go ahead with the surgery if the parents were opposed to it, or were just uncooperative.

For those who do not know what is involved, the article is a useful short account of the surgical procedures involved in turning adolescent boys into eunuchs. 'The preferred method of vaginoplasty', these authors said, 'was a one-stage penile inversion, most often augmented by a full-thickness scrotal skin graft' (Milrod & Karasic, 2017: 626). But 'a one-stage penile inversion' was usually not sufficient for the boys who had 'penoscrotal hypoplasia or limited penile shaft size' as a result of taking puberty blockers, sometimes for as long as three years. One surgeon was quoted saying that "they are coming in after being put on blockers, so they have 11-year-old genitalia". The usual solution among these surgeons for the undersized-penis problem was to take skin from the thigh: 'the use of flank skin grafts most commonly resolved the problem of inadequate tissue availability'. Other solutions involved 'implant[ing] a scrotal tissue expander that required periodic infusion during 2 months', and 'donor tissue matrix' (whatever that is). They tended not to use bowel tissue because of 'concomitant morbidities' such as 'diversion colitis, excessive secretion, persistent odors, and potential leakage of stool into the peritoneum' (p.627). The authors concluded by saying that '[t]he available research literature contains no data on vaginoplasty in transgender minors' (p.632). Perhaps that's because 'people get super worked up' about boys being castrated, even if the boys do 'identify' as eunuchs from early childhood, or think they do, or are persuaded that they do.

These authors didn't use the word 'eunuch'. Instead, they referred to the boys as 'transgender females'. But there's nothing female about human beings with penises, even if they subsequently lose those organs. The time-honoured way of referring to males who have been deliberately deprived of their genitals, usually just the testicles, is 'eunuch'. The transgender agenda's complacency about converting young males into eunuchs, welcoming or even inculcating their desire instead of gently reminding them that their genuine humanity does not require mutilation, is one of the worst consequences for males of male supremacy. As James Esses, barrister and co-founder of the internet resource, Thoughtful Therapists, was quoted saying, Version 8 was "one of the most shocking indictments of ideology infecting medicine that I have ever come across" (in Gluck, 2022b. See also: Esses, 2022). He doesn't name the ideology as 'male supremacist', of course. Nonetheless, that is the most appropriate term with which to denote the fetishistic meanings and values involved in the castration of the young.

For accounts of historical instances of the castration of boys, along with evidence of WPATH'S links to *The Eunuch Archive* with its violent castration fantasies involving children and other male sexual fetishes and pornography, and examples of the grooming techniques used to seduce young males into the transgender world, see: Gluck, Genevieve (2021);

for another account of historical instances of castration, involving the Phrygian cult of Cybele and the Russian sect of the Skoptzes, see: Warnes and Hill, 1974.

Conclusion

With its 'Eunuchs' chapter with its approval for the castration of boys, WPATH has surpassed itself in dehumanised dissociation. The dehumanisation should have been obvious from the beginning, with the initial transgender premise that men could be 'women' and the sexed body is irrelevant to human existence. But it would seem that it wasn't obvious at all, given that the transgender agenda has been embraced by institution after institution, even by the institution supposedly devoted to the best interests of children, the paediatrics profession. Perhaps that blindness to dehumanisation stems from the fact that we live in a society that itself is dehumanised in certain respects. (I call those aspects male supremacy, and the primal dehumanisation is the refusal to recognise the humanity of women). People are so used to dehumanisation that they don't recognise each new instance for what it is.

However, it is possible to recognise it, and the embrace of the transgender agenda has not gone uncontested. Despite the attempts of the trans lobby to censor criticism and cow people into silence (see the 'Strategies' chapter), there is an enormous literature criticising the transgender agenda, most of it online. Even the powers-that-be have come to recognise that there is something wrong (e.g. UK CQC, 2021; Cass, 2022). This recognition doesn't go far enough. It doesn't include rejecting the transgender agenda altogether. It still clings to a belief in a category of persons who are 'transgender' (or who are any or all of the ever-multiplying categories of persons who supposedly exist somewhere outside the reality of the sexed body). Nonetheless, the reviews can be read as outright rejection, e.g. the CQC's rating of GIDS as 'inadequate', the Cass review's recommendation that GIDS be closed.

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