

## TransWrites Article October 2023

### INTRODUCTION

NHS England (NHSE) is holding a public consultation on a proposal to ban puberty blockers for transgender children. The consultation is open until November 1st. This article will explain the proposal in some detail with the aim of providing guidance for respondents. It will also explain the general context of NHSE's treatment of trans patients so allies and activists who are not up to speed on the situation in the UK can understand what is happening and what must be done.

### CONTEXT

Any discussion of trans healthcare in the UK has to start from the understanding that the NHS is segregated.<sup>1</sup> Medicine - including puberty blockers - is provided to cisgender patients much more easily than trans patients, who have to jump through hoops and wait years for basic interventions like HRT. The NHS has been told for over a decade (by its own internal reports,<sup>2</sup> by patient consultations, and by its own Gender Identity Program Board) that it should desegregate. Indeed, in 2018 a previous consultation recorded patients' demand for desegregation and an informed consent system.<sup>3</sup> This will be important later.

Under the leadership of Head of Specialised Commissioning Jeremy Glyde, NHSE has refused<sup>4</sup> to desegregate. Segregation causes long waiting lists which have resulted in deaths: the coroner's reports into the deaths of Sophie Williams<sup>5</sup> and Alice Litman<sup>6</sup> concluded that a lack of timely gender affirming care was a contributing factor in both cases.

It is worth underscoring this point: it is a matter of publicly recorded fact that NHS England's failure to provide timely gender affirming care has resulted in the deaths of multiple patients. Nobody has resigned from NHSE or faced any consequences for this at time of writing.

Until 2019 the NHS provided just one clinic for trans children in all four countries of the union. This clinic was called the Gender Identity Development Service or GIDS. GIDS was strongly disliked by patients and parents.<sup>7</sup> Waiting lists frequently ran so long that trans children were forced through the wrong puberty. Patients who did manage to be seen at GIDS reported humiliating and intimidating behaviour by staff, including unnecessary

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<sup>1</sup> For a comprehensive rundown of the state of British trans health see Ruth Pearce, *Understanding Trans Health*

<sup>2</sup> Louis Bailey and Jay McNeil, *Monitoring and Promoting Trans Health Across the North West*

<sup>3</sup> NHS England and NHS Scotland, "Analysis of public consultation on proposed service specifications for specialised Gender Identity Services for Adults"

<sup>4</sup> NHS England, "Specialised Gender Identity Services for Adults; Report on outcome of public consultation and update to Equality Impact Assessment"

<sup>5</sup><https://bhattmurphy.co.uk/files/SRN%20cases/Sophie%20Williams%20-%20Regulation%2028%20Report.pdf>

<sup>6</sup> Mabel Banfield-Nwachi, "NHS gender care delays 'contributed' to trans woman killing herself, coroner says," in *The Guardian*

<sup>7</sup> Cal Horton, "Depathologising diversity: Trans children and families' experiences of pathologisation in the UK," in *Children and Society*

and invasive questioning about their sexual histories.<sup>8</sup> In 2020 the High Court ruled in *Bell V Tavistock* that under 16s probably could not consent to puberty blockers and GIDS immediately stopped prescribing them. In 2021 the Court of Appeal overturned this decision, but GIDS did not resume prescribing.

This point is also worth underscoring: there is much concern about the NHS potentially stopping blockers for trans kids. They already stopped, years ago.

In July of 2022 NHS England announced that GIDS would close and be replaced by Something Else. They did not say immediately what Something Else would be, or put the resources in place to make it happen. They took so long to act that GIDS' own clinicians wrote an open letter<sup>9</sup> condemning NHS England's managers. Nobody has resigned from NHSE or faced any consequences following this letter.

In October 2022 NHSE finally published a proposal for Something Else.<sup>10</sup> This proposal recommended, among other things, that trans children not even be allowed to socially transition without a doctor's permission. A joint statement was issued by WPATH, ASIAPATH, EPATH, PATHA, and USPATH condemning the proposal as "unconscionable... unevidenced... ludicrous and dangerous," - very strong language for medical organisations to use! Nobody has resigned from NHSE or faced any consequences following this condemnation by the international medical community; there has been no investigation into how the first proposal was written, who wrote it, or how it came to be published in such an awful state.

A second proposal was later published recommending that trans children only be prescribed blockers as part of clinical trials. At the time NHSE claimed this was in line with the Cass Review, an "independent" investigation by paediatrician Hillary Cass into the NHS' treatment of trans children. They also claimed it was in line with WPATH SOC8, the World Professional Association of Trans Health's latest guidelines on treating trans patients. This is particularly interesting when we look at...

## **THIS CONSULTATION**

And now, from the same people who brought you the "ludicrous and dangerous" previous proposals, comes this new one. This proposal once again claims to be in line with the Cass Review. Nowhere does it mention that the trans community's trust in the Cass Review is at rock bottom because the review excluded trans people from its governing body and some of its members have been observed interacting with transphobic hate groups. Interestingly, this time around NHSE have dropped all pretence of following WPATH guidelines. In prior consultations they claimed to be following WPATH SOC8, but trans people have pointed out that SOC8 recommends desegregating primary care, which NHSE refuses to do. Since SOC8 was first published NHSE has tried to pick and choose which bits they follow and performatively cite it to shield themselves from criticism, but now they've dropped the act, saying, "*WPATH standards of care do not determine clinical commissioning decisions for the NHS... NHS England does not commission based upon guidelines or treatment protocols e.g. WPATH 8.0 or practices in other countries.*" They have now given themselves explicit permission to ignore international best practice and any evidence they don't like from other countries, which they were already doing. Britain continues to be a bizarre pariah in the way we treat trans people.

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<sup>8</sup> Cal Horton, "Of Course, I'm Intimidated by Them. They Could Take My Human Rights Away," in *Bulletin of Applied Transgender Studies*

<sup>9</sup><https://medium.com/@GidsStaffGroup/an-open-letter-to-nhs-england-from-concerned-gids-staff-4e075dd574d2>

<sup>10</sup> <https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/>

In a nutshell, NHSE propose that puberty blockers should no longer be provided to trans children on the NHS. They say they have reviewed all the relevant medical literature and in their opinion there is insufficient evidence to support the practice of prescribing blockers to trans children, or children who think they might be trans. They say that maybe some trans children will get them as part of clinical trials which have yet to be designed. Maybe.

Before going any further, we should note that this proposed change would apply to all *new* patients, not existing ones. We are not yet at the stage of forced detransitions. Nevertheless, there are thousands of trans children on the waiting list for blockers and if this proposal is accepted they will all be forced through the wrong puberty unless they can obtain blockers elsewhere.

In general, the proposal makes two fundamental and related errors:

- 1) It pathologises transness, and therefore
- 2) It assumes that NHSE have the right to control who may transition and who may not

The whole proposal starts with the question, “Are puberty blockers an effective treatment for gender incongruence/dysphoria?” This starting point colours what evidence the proposal regards as relevant, and it is the wrong question to be asking. The correct question is, “Do patients want puberty blockers?” Blockers are just one part of a happy, healthy transition. Asking whether blockers have a clinically measurable outcome on gender dysphoria is a bit like asking whether the act of reaching for the ripcord has a clinically measurable outcome on skydivers’ ankles when they land - the true impact of reaching for the ripcord can only be understood by looking at the process of skydiving holistically. It’s easy to zoom in on one part of a transition and pick it apart, but this distorts the view of the whole. This is the epistemic harm that pathologisation does.

The proposal details what evidence it is relying on and what evidence it thinks is irrelevant. Its overly narrow focus leads to a great deal of evidence being ignored, for example it rules out several studies comparing outcomes for trans youth on blockers with cis youth on blockers, and several studies looking at regret rates or mental health outcomes for trans kids who receive blockers as part of an overall package of affirming care. (They also rule out any study not published in English.) By setting this very narrow question NHSE is able to stack the deck and get the answer they want - the answer that legitimises the thing they’ve already been doing since 2020, which is refusing to let trans kids transition.

In response to this it is tempting to insist that the evidence *does* show puberty blockers to be effective. However this is playing into NHSE’s hands. As this proposal shows, they are quite capable of setting questions in overly narrow ways to restrict the evidence pool being considered and justify what they’re already doing. For the time being, the final word on what the evidence does or does not say will always be had by cis people and cis-controlled institutions.

Instead, I prefer to centre bodily autonomy. Suppose a cisgender child had a terminal illness and there was a 1% chance a blood transfusion would save their life - that is to say, the medical evidence overwhelmingly showed that 99% of the time blood transfusions are ineffective. Suppose the child’s parents opposed the transfusion but the child themselves wanted it. In that case, I would argue the child has a moral right to get a transfusion even against their parents’ wishes because people should have a right to choose what happens to their own body and this includes the right to take risky or unevidenced treatments that might work, however slim the chance. From this thought experiment we can conclude that even if the evidence showed what NHSE claims it does about blockers (and it doesn’t, because they’ve stacked the deck), it would still be wrong to ban them. The fact that the bodily autonomy of patients is not the first priority of this proposal (or indeed, any priority) is why we must reject its approach wholesale.

Before diving into details, I'd like to briefly address an argument that is usually made in bad-faith, just in case any good-faith readers are at risk of being suckered in by it. "Why can't we just let kids be kids?" the bad-faith interlocutor asks. Sometimes this is expressed gently, as in, "Kids should be given time to think," and sometimes it's expressed with venomous queerphobia, as in "Leave kids alone, groomer!" My response to this is simple. Some children want to transition. Who are you to tell them no? We know that attempts to eradicate this desire through conversion therapy don't work and end up harming the child. We know that if they are prevented from transitioning they will suffer and perhaps even seek to destroy themselves. So given that they want to, and given this desire runs so deeply and cannot be eradicated, again - who are you to say they shouldn't? Who is anyone to say that about any trans person of any age? By all means, they should be told the risks and trade offs: some childhood transitioners detransition later, some endure medical complications, some become award-winning singers or film stars. Most live normal lives, and the vast, vast majority of people who transition are happier and healthier for it. Doctors can and should inform them of the facts, but the decision of whether or not to transition is always, always the right of the person considering it. My stance on this is greatly informed by feminist principles of bodily autonomy in medical decisionmaking, especially abortion.

### **THE EQUALITY AND HEALTH INEQUALITIES IMPACT ASSESSMENT (EHIA)**

NHS England is obliged to conduct an Equality and Health Inequalities Impact Assessment (EHIA) - a report investigating how this proposal is likely to affect legally protected minorities including trans people, who are protected in UK law under the category of 'Gender Reassignment.' It is worth examining this Assessment in detail as an example of how the very same documents ostensibly meant to protect trans people are turned against us.<sup>11</sup>

The EHIA acknowledges that cis children will still be prescribed blockers for precocious puberty - remember, the NHS is segregated! It says this does not constitute discrimination because the evidence base for giving blockers for precocious puberty is "not contested," whereas the evidence base for giving them to trans people is "contested." However, they fail to consider that whether a particular medical intervention is "contested" is dependent on nonmedical factors: it is possible to generate controversy around a medical intervention quite separately from its clinical effectiveness. With enough money, media reach, and selective evidence-gathering it would be possible to make just about any treatment "contested" no matter what the evidence actually says, as we saw in the early noughties with the MMR vaccine hoax. In this case there is a large, well-funded campaign in the USA and UK to restrict trans people's access to affirming care, and one of the strategies of this campaign is to sow doubt about the evidence. The capture of Florida's Medical Board by religious conservatives provides just one example of this strategy in action. The EHIA ignores this.

The EHIA says, "*The age of the individuals for whom risk and benefits cannot be defined because of the lack of evidence is in itself a contributory reason for taking steps to mitigate clinical risk and safety issues,*" which is to say that because we're talking about children, NHSE should be extra cautious. This is all well and good, however the EHIA does not consider the issue through the lens of bodily autonomy. Children, especially trans children, are at risk of having their bodily autonomy unfairly overridden by parents and carers, especially in medical settings: there have been high profile court cases about blood transfusions, abortions, and contraception for exactly this reason. Therefore it could be argued that NHSE has a special duty to ensure the bodily autonomy of trans youth is maximally protected. The EHIA ignores this too.

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<sup>11</sup> My approach in this analysis is indebted to the work of Sara Ahmed, in particular her book *Complaint!*

You might remember earlier in the article I mentioned a previous proposal, one which said trans children should only be prescribed blockers as part of clinical trials. At the time this was widely criticised for being unethical: denying patients medical care unless they become guinea pigs is clearly wrong. NHSE heard those complaints, and their response is the equivalent of saying, “Nuh-uh.” They say, *“The decision to take part in research is an individual choice and the policy proposition does not mandate participation in research.”* However, this neglects the fact that participation in research is mandated if trans children want to control their own bodies by suppressing their puberty. Again, the proposal fundamentally fails to consider the bodily autonomy of patients. The EHIA ignores this.

Nowhere in the EHIA is there any mention of the fact that trans youth are at risk of being exposed to conversion therapy or the potential for this proposal to affect that risk. The EHIA correctly notes that banning blockers may lead to an increase in risk-taking behaviour as patients seek private or grey-market sources for medicine, and they say *“NHS England has commissioned Health Education England to deliver on-line MindEd resources directed at parents and local professionals, and these will provide improved psycho-educational advice to mitigate the need for [blockers].”* This section is particularly worrying because it does not specify what “psycho-educational advice” consists of or what the evidence base is that allows NHSE to claim it will mitigate the need for blockers. In plain terms, this section seems to imply that NHSE has a more effective treatment for trans children in the form of online “psycho-educational services” without saying what it is. This is particularly worrying in the context of ongoing efforts by anti-trans hate groups to rebrand conversion therapy as “gender exploratory therapy.”<sup>12</sup> and <sup>13</sup> and <sup>14</sup> The November 2022 joint statement by WPATH, ASIAPATH, PATHA, EPATH, and USPATH drew attention to this very problem, saying, *“The denial of gender affirming treatment under the guise of “exploratory therapy” has caused enormous harm to the transgender and gender diverse community and is tantamount to “conversion” or “reparative” therapy under another name,”* but the proposal does not mention that statement anywhere.

This is worth underscoring, because it is very serious. Previous proposals by NHSE have been condemned by the international medical community as “ludicrous, unevicenced, unconscionable and dangerous.” The November 2022 joint statement warned against exactly this sort of overly narrow focus, saying, *“We are deeply concerned that the NHS is taking inappropriate approaches to evaluating the established body of evidence and is therefore drawing erroneous conclusions underestimating the effectiveness of puberty suppression.”* It is very worrying that this new proposal does not acknowledge those condemnations and repeats many of the same mistakes of previous ones.

The proposal makes reference to several bodies like the Research Oversight Board, the National Research Collaboration Programme, the Medical Research Council etc - all of which are supposed to reassure cis readers that the proposal would be implemented with proper safeguards. However, the EHIA fails to note that all of these bodies are run by cis people. Occasionally trans people are allowed to voice concerns through advisory boards or consultations, but members of NHSE’s Trans Clinical Reference Group have described to me in private how they are ignored or even punished for expressing views that centre trans bodily autonomy. Indeed, the words ‘cisgender’ and ‘cis’ are not mentioned at all by the EHIA.

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<sup>12</sup> Florence Ashley, “Interrogating Gender-Exploratory Therapy,” in *Perspectives on Psychological Science*

<sup>13</sup> Erin Reed, “Gender Exploratory Therapy”: A New Anti-trans Conversion Therapy With A Misleading Name”

<sup>14</sup> Mallory Moore, “NHS Trust uses “Gender Exploratory” training materials promoting conversion therapy lobbyists”

In general, the EHIA entirely buys into the same flawed assumptions that the rest of the proposal started from and functions to give legitimacy to them. It pathologises transness, and therefore assumes that NHSE has the right to control who may transition.

## Conclusions

I take no joy in pointing out that I predicted this might happen. In an essay for *TransWrites* in 2022 I said “gender dysphoria” as a clinical diagnosis could be used to restrict trans people’s access to affirming care by falsely claiming that more effective treatments are available, for example conversion therapy.<sup>15</sup> I said this because it had already happened in Florida and now NHSE is trying to do it here. I have faced criticism from some in the trans community for my insistence that “gender dysphoria” discourse is not and cannot be liberatory, that since its invention by the cis medical establishment it has been used by cis people to control who may transition and who may not, that it is undeniably one of the master’s tools and therefore cannot dismantle the master’s house. Sadly, I was right.

What can we, those of us who seek trans liberation, conclude from this latest consultation?

Firstly, the NHS does not provide trans healthcare; it controls trans people. Therefore we remain committed to our goals of completely desegregating it, implementing an informed consent system, and bringing the architects of segregation to justice. In the meantime we will continue to provide each other with the resources to transition when the NHS refuses: the self-medication scene is growing both in scale and sophistication because we know who keeps us safe. Relatedly, let us reject the narrative so prominent in Britain that the NHS are “doing their best, they’re just underfunded!” Desegregating trans health would save the NHS millions but managers refuse on ideological grounds as we’ve seen. The healthcare situation for trans people in the UK is as dire as many US states and we must be clear in identifying whose fault this is: senior managers at NHSE believe they have the right to control trans lives, even if that means spending more money on a system that kills patients. They must be removed from their jobs and held accountable for the deaths they have caused.

Secondly, this is another reminder that transmedicalism - the practice of appealing to medical authority to determine who may transition and who may not - is a losing strategy. Let us all reaffirm our commitment to the principle that we should control how and whether we transition. We should never have to demonstrate to a cis person that transition would be acceptable to them, or that it expresses an “authentic self” that they are in a better position to know than us, or that our pains and dreams fit the pathetically narrow criteria of their textbooks. The fact that we want it is enough.

Third, trans children and their families will likely continue to be harmed by the NHS. It is possible they will be harmed even if they go private, if private treatment ends up being ruled a safeguarding issue. The cost of private treatment will unfairly burden families with trans children - another thing the EHIA fails to note. Some trans children may die or be permanently affected by being forced through the wrong puberty. Let us reaffirm our calls to see them receive damages, compensation, and public apologies when NHSE is eventually held accountable. In the meantime, no doubt affirming families will continue to cope as best they can and trans children will continue to exhibit extraordinary courage in the face of cis-supremacy, courage they should never have been called on to develop.

Should you respond to the public consultation? Some in the British trans community might point to the history of NHSE ignoring consultations that return answers they don’t like, for example the 2018 consultation

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<sup>15</sup> Abigail Thorn, “Why I Don’t Like the Word “Dysphoria”” in *Transwrites*

demanding desegregation. They might also say this “death by a thousand consultations” strategy functions to exhaust us as we and our allies are called upon to sacrifice our time and energy explaining to cis people why we should be allowed to continue living. They might reject any involvement in these consultations, saying that our time can be better spent organising to A) Get healthcare for ourselves, and B) Inflict consequences on gatekeepers and conversion therapists with our own hands. I chose to engage with the consultation as an exercise in clarifying my own thoughts and to contribute to a counter-discourse that we can use to challenge NHSE’s cis-supremacist framework, but I have some sympathy with this viewpoint. You, reader, must answer this question for yourself.

If you have found this article useful then I encourage you to use it in your responses to the public consultation should you choose to send any. I also encourage journalists and activists to use it (with attribution please!) in summaries and reports. I have asked TransWrites to donate my fee for this article to an organisation working to protect the lives of Palestinian people.