Christian Medical Fellowship

Questions

1 Do you have any comments on the proposal that applicants must live in their acquired gender for at least 3 months before applying for a GRC?

Yes

If yes, please outline these comments.:

Introduction

The Scottish Government seeks to make the existing process to obtain legal recognition under the Gender Recognition Act 2004 a better service for those trans and non-binary people who wish to use it. One option for streamlining would be to remove the requirement for a medical diagnosis, replacing it with a simple self-declaration process.

The approach being considered by the Scottish Government is in line with the recommendations of the House of Commons Women and Equalities Committee report on Transgender Equality (December 2015). That report was itself influenced by the 'Yogyakarta Principles' (November 2006) and Resolution 2048 of the Parliamentary Assembly of the Council of Europe (April 2015).

Neither of these documents is legally binding. The Yogyakarta Principles were drawn up by an ad hoc body that did not include clinicians with expertise in gender dysphoria. These Principles have never been accepted by the UN's General Assembly; neither are they generally endorsed by academic experts working in the field. They should not be regarded as a reliable starting point for legislative purposes. In contrast, we note that the European Court of Human Rights (Garcon and Nicot v France [2017] ECHR 338), in a judgement which is legally binding, held that an 'assessment model' is compatible with human rights and thus with best practice.

CMF represents some 5,000 medical practitioners in a wide variety of clinical settings across the UK. We oppose the move to a self-declaration model, not because we wish to endorse the assessment model in its current form, but because we believe the proposed change would lead to a worse outcome.

Currently, under the Gender Recognition Act 2004, in order to legally change gender a person needs to be over 18, have been diagnosed with gender dysphoria by a medical practitioner, and have lived in their new gender identity for two years before applying to a gender recognition panel for a Gender Recognition Certificate (GRC). The recognition process is lengthy, interviews may be experienced as intrusive and the gathering of evidence in support of the application can be costly, complex and inaccessible to some trans people. Some reform is therefore required.

The new proposals - Chapter 4, Gender Recognition Reform (Scotland) Bill (1) – we believe would be harmful for individuals, their families and society generally. They

rely on a self-declaration process that would make gender identity a matter of a person's subjective feelings and changing legal gender a matter of personal choice. It encourages the view that gender identity defines reality and that biological sex is but a social construct, something 'assigned' at birth. This new ideological dogma has no evidence-base in science, but self-declaration would appear to reinforce it as if proven fact.

Answer to Q1.

It is unworkable

Nowhere in the consultation documents is a rationale provided for the three-month requirement. Why not three weeks or three days? If the reasons for doing away with the current two-year requirement are to 'protect applicants from prejudice or abuse', and to avoid 'problems created when an individual's personal documents are inconsistent or do not match the gender presented', then why accommodate any delay? Self-declaration removes the requirement for medical reports and the proposals do not indicate if or how the three-month requirement will be attested. If the requirement is intended to avoid 'frivolous' applications, there must be some means of confirming that the requirement has been met. In the present climate, such scrutiny is likely to be characterised as discriminatory.

We suggest this proposal would be unworkable in practice.

It is unsafe

1. It is clear from a recent Australian study(2) that gender dysphoria in young people is often accompanied by mental health disorders such as anxiety and depression, including attempted suicide. In another study(3) of 579 patients with gender dysphoria, 349 (60.3%) were the female tonmale (FTM) type, and 230 (39.7%) were the malentonfemale (MTF) type. Concurrent psychiatric comorbidity was 19.1% (44/230) among MTF patients and 12.0% (42/349) among FTM patients. The lifetime positive history of suicidal ideation and self-mutilation was 76.1% and 31.7% respectively among MTF patients, and 71.9% and 32.7% among FTM patients. A Dutch study(4) also reported the co-occurrence of autistic spectrum disorders (ASD) and gender dysphoria. The incidence of ASD in a sample of 204 children and adolescents with GD (mean age 10.8 years) was 7.8%, tenfold the national prevalence of ASD.

Self-declaration would deprive these people of contact with mental health professionals at the time when their assessment and advice could be crucial. There is a real risk that individuals who require psychological support and specialised psychiatric treatment will not receive it.

According to trans activists these symptoms are due simply to 'minority stress' resulting from society's negative attitudes towards trans people, a claim without supportive evidence. The results of another recent study(5) suggest otherwise. It offers no proof that radical therapies such as puberty-blocking drugs, double mastectomies and cross-sex hormone treatment will prevent adolescents from attempting suicide. If anything, the findings of the survey underline the need for

serious scientific research into the potential environmental causes of gender dysphoria and the risks—both physical and psychological—of medical transition. Paediatrician Michelle Cretella observes: '[The Toomey study] shows that the much higher rate of attempted suicide among female-to-male, non-binary, and questioning transgender youth has more to do with factors relating to their biological sex than it does with anything related to gender identity. If confirmed, this may help explain the causes, since it is possible that common underlying psychological and environmental factors may be at play triggering both gender dysphoria and suicidal tendencies in a subset of these adolescents.'(6)

A comparatively recent phenomenon, known as rapid-onset gender dysphoria, has been observed to begin suddenly in an adolescent or young adult (usually a biological girl) who would not have met criteria for gender dysphoria in childhood. A peer-reviewed study published in August 2018 noted: 'the worsening of mental wellbeing and parent-child relationships and behaviours that isolate adolescents and young adults from their parents, families, non-transgender friends and mainstream sources of information are particularly concerning'.(7) The role of social media in spreading a form of 'dysphoria contagion' among contacts needs further research.

Shortening the waiting period from two years to an (unworkable) three months will mean that many young people, whose dysphoria could have been alleviated by treating co-existent mental health disorders or by giving appropriate support where family breakdown/social isolation are factors, will instead pursue transgender recognition and reassignment for which evidence of effectiveness is lacking. The same caution is needed in treating adults with gender dysphoria. The largest study(8) following adults who have undergone medical gender transition was conducted in Sweden. Thirty years after their transition, the suicide rate was 19 times higher among transgender adults than among the cisgender population. It is clear that these results do not support the alleged curative effects of transition.

The Scottish Government is to be commended for seeking to reduce the burden of the current gender recognition process, and It might indeed be possible to improve aspects of the existing law, but removing sensible 'barriers' to overly-easy transition will result in more people embarking on early medical transition with insufficient thought, more people living to regret irreversible changes to their bodies and an overall increase in co-morbid mental health issues including suicidality.

2. Gender changes are momentous decisions at any stage of life. Recent years have seen an exponential rise in the number of young people, mainly girls, being referred to GIDCs because of gender dysphoria.(9) It is our opinion that these young people are unable to make fully informed decisions to change their gender and that shortening the period required to have lived in the preferred gender from two years to three months, minimises the seriousness of the decision, removes a helpful safeguard against premature transitioning and is likely to result in increasing numbers of subsequent requests to de-transition.

Development psychologists consider identity development to be a process that continues long after adolescence. Modern neuro-imaging techniques have shown that brains continue to develop into our mid-twenties. It has even been suggested that a term such as 'emerging adults' should be adopted to designate 18-25 year

olds, for whom it is normal to continue a significant exploration of their own identity.(10) The Australian expert on adolescent health Prof Susan Sawyer puts it this way: 'An expanded and more inclusive definition of adolescence is essential for developmentally appropriate framing of laws, social policies, and service systems. Rather than age 10–19 years, a definition of 10–24 years corresponds more closely to adolescent growth and popular understandings of this life phase and would facilitate extended investments across a broader range of settings.'(11)

It is unrealistic to expect a person whose sense of personal identity, including gender identity, is still forming, to be able to confirm that they have a settled and sober intention to live for the rest of their lives in their preferred gender. As this would be a requirement under the new proposals, we believe them to be unsafe and, if introduced in their present form, likely to bring the whole process into disrepute as a result of a high rate of requests to de-transition.

For consent to be valid it must be fully informed. Recent discoveries in developmental psychology suggest that the capacity to make fully informed decisions about one's own gender identity is not reliably mature before one's mid-twenties. Removing the two-year period as a requirement will mean that more people make an immature decision to transition, and more will live to regret their decision. For consent to change legal gender to be valid we suggest that the process must involve expert medical and psychological assessment.

2 Do you have any comments on the proposal that applicants must go through a period of reflection for at least 3 months before obtaining a GRC?

Yes

If yes, please outline these comments.:

CMF welcomes the intention behind the proposal that a period of reflection is required before confirming so momentous a decision. However, as stated in answer to Q1, many of those applying to legally change their gender will be either too young, too uninformed or both to be able to make the decision safely, and a reflection period of three months is not what is needed.

For anyone, at any stage of maturity, to be able to give fully informed consent to a legal change of gender, more than time is required. They need to understand the consequences of the decision. They need to be able to make a settled and sober decision that will last a lifetime. They need to make the decision of their own free will, free of duress arising from peer-group pressure or co-existent mental health issues.

Extending the legal right to change gender to teenagers will increase their ease of access to puberty blockers and trans-sex hormones. The long-term effects of puberty blockers in this clinical situation are largely unknown – it is an experimental treatment without any evidence base in science. It is known that puberty blockers lead to stunted growth and subfertility, and impair normal neurodevelopment affecting, among other things, the developing sense of identity! Cross-sex hormones may produce permanent infertility, bone changes, clotting disorders, raised blood pressure and more. It is impossible for teenagers to give informed consent to

medical transition when even the doctors don't know what the consequences might be.

It is impossible for anyone to make a settled, permanent decision to change gender when they can have no idea how they will feel as a result of medical and/or surgical transition. Indeed, a strong voice among transgender activists insists that gender identity is flexible – a settled and permanent decision is impossible according to this view. It is impossible for someone with symptoms that suggest gender dysphoria to know how much of their distress is due to co-existent mental health conditions without assessment by qualified practitioners and a satisfactory period of treatment for those conditions.

Changing the law to make gender recognition dependent only upon self-declaration would thus seriously undermine the importance of valid consent as an essential precondition to all forms of treatment. A three-month period of 'reflection' without mandatory professional assessment may have the flavour of a safety measure but would be woefully inadequate in practice.

3 Should the minimum age at which a person can apply for legal gender recognition be reduced from 18 to 16?

No

If you wish, please give reasons for your view.:

Studies show adolescents and young adults to be less risk-averse, more open to novel experiences and more motivated by potential rewards than more mature adults.(12) As a result, teenagers are more inclined to risky behaviours. Two neurodevelopmental factors are thought to play parts in the genesis of this risk taking propensity. One is the sudden and dramatic release of sex hormones that bathe the brain at the beginning of puberty. The other is the relative delay in the maturation of their cognitive control.

Can it be right to consider someone, considered too young legally to purchase or consume alcohol in licensed premises, too young to purchase cigarettes or tobacco, too young to place a bet or get a tattoo, mature enough to change their legal gender? Teenagers are hormonally primed to take risks, and traditionally the law has put legal barriers in their way to save them from making decisions they might later regret.

That gender identity is not fixed is a fundamental tenet of the new ideology – changes of mind are to be expected. What would be the position in law of a person who underwent full medical and surgical reassignment at an early age but who later wishes to de-transition? Would that person be liable to prosecution?

The vast majority (at least 80%) of children with gender confusion choose to identify with their birth gender before or during puberty. We believe the current trend towards early social transitioning, and the use of puberty-blockers and trans-sex hormones in children and young people under 18 years lacks a supporting evidence base and is misguided. In our opinion, a 16-year-old lacks the necessary maturity to provide

informed consent and, as such, lowering the age of application from 18 to 16 would be unsafe.

4 Do you have any other comments on the provisions of the draft Bill?

Yes

If yes, please outline these comments.:

In 2006, the Scottish Government published Delivering a Healthy Future: An Action Framework for Children and Young People's Health. This was geared to improving the quality, sustainability and access to health care services for young people in Scotland, prioritising mental health. It was welcomed to the extent that the WHO recommended other nations follow suit.(13)

For the Scottish Government now to put its weight behind an ideology that lacks a sound basis in science would hardly provide an example worthy to be followed. A recent (2019) Scottish Government report reveals that the mental wellbeing of Scotland's youth, particularly girls, is deteriorating. It is quite possible that these figures reflect the sudden surge in the number of adolescents being referred to GIDCs with gender dysphoria. The coexistence of psychopathology and gender dysphoria needs urgent research. Mood disorders, anxiety and depression, and stresses associated with family breakdown or dysfunction all need to be assessed, rather than assuming that gender dysphoria with 'minority stress' is necessarily the root issue.

Anecdotal stories of re-assignment regret, with or without requests to de-transition, are beginning to pile up. It is essential that the Scottish Government call a moratorium on the current rush towards early social transitioning, puberty blockade and cross-sex hormone treatment of children. Failure to do so now could mean that in five or ten years' time the health services in Scotland are faced with many thousands of sterile young adults whose mental health was not improved by gender transitioning and who wish to de-transition and have fertility treatment to enable them to become parents. Not to mention a slew of expensive court cases brought by those who claim they were catapulted along the road to transition and reassignment, without careful assessment of their mental health and without the maturity necessary to provide fully informed consent.

We would ask that consideration be given to maintaining a record of a person's biological sex on their medical record, alongside but separate from their gender identity. We believe it to be in the best interests of the trans person that clinicians who look after them have this information to hand.

As Sarah Dahlen(14) has stated, if a trans man presents to a doctor in A&E with lower abdominal pain, and his medical record does not reveal that he was born biologically female, the doctor will not consider certain possible causes of his pain. The patient may find himself being referred to a gastroenterologist when a gynaecologist is what he needs. The same man, now officially categorised as male, will no longer receive reminders to attend for regular cervical screening and must remember to book in himself. Should he forget, he might be at greater risk of cervical

cancer going unrecognised. Likewise, a natal male, newly designated female as a trans woman, may be distressed to receive an inappropriate invitation to attend for a smear test, lacking the anatomy.

Biological differences between females and males have an impact on many aspects of medical interpretation. For example, reference ranges for common blood tests differ between the sexes. Retaining natal sex as a category on patient notes, alongside gender identity, would prevent doctors from being misled and avoid added stress for trans patients caused by repeatedly having to explain their situations.

Research results will be impacted by obscuring trans patients within medical records. The particular health needs of trans patients will be impossible to identify. Separation of sex from gender identity is necessary in order to generate accurate research data.(15)

Endnotes

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4. Annelou L. C. de Vries et al. Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents. Journal of Autism and Developmental Disorders, Vol 40, Issue 8, 2010: 930–936.
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12. Gardner M and Steinberg L. 2005. Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood: An Experimental Study. Developmental Psychology, Vol. 41, No. 4, 625–635
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15. Clayton, T., and Tannenbaum, C., 2016. Reporting sex, gender or both in clinical research? JAMA, 316 (18), 1863–1864

5 Do you have any comments on the draft Impact Assessments?

No

If yes, please outline these comments.: