

Gender Healthcare for Children: Rights-based V Evidence-Based

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The discussion of Gender and Gender dysphoria has exploded over the past decade and seems to be seldom out of the headlines. The separation of gender versus sex, was first suggested by Money in 1955¹. Biological sex is the genetic/physical makeup of a person and is described as binary, Male and Female. Gender is an expression and sense of self and identity and described as a bipolar spectrum between Masculine and Feminine. When these do not align, this is termed gender incongruence (GI) or gender dysphoria (GD).

The concept of gender is disputed between its traditional, socially understood meaning and various political and academic theories including feminism, identity politics and human rights fundamentalism. The traditional view of Gender is that it is an innate quality of a person, expressed and experienced as preferences in dress, personal styling, and social or behavioral modalities, which correlate with biological sex within that culture. The political and academic paradigms, view gender as a social construct or a personal choice. While there is some neuroscience evidence supporting the traditional/clinical concept of gender, it is far from conclusive, whereas the case for the political/ideological concept of gender is based on theoretical argument rather than evidence. There is little mutual regard or understanding between the clinical/scientific and the ideological/political proponents of gender concepts and care.

The provision of healthcare to people who experience gender dysphoria requires an understanding of this, and the unique issues that present within this cohort. While gender healthcare is a clinical issue, it has been pulled into a battlefield of broader ideologies to the detriment of patients, especially children and their services and professionals who work within them.

Gender services first developed for adults in 1966 in the UK, as a specialist psychiatric service and expanded to children and adolescents in 1989, named the 'Gender Identity Development Service' (GIDS) based at the Tavistock & Portman NHS Foundation Trust Clinic, London². In Ireland, the National Gender Service (NGS) at St Columcille's Hospital in Loughlinstown, beginning initially as a psychiatry & endocrinology service, and subsequently developing into a fully multidisciplinary service providing holistic care³. Waiting times currently stand at 3-3.5 years³. Child & adolescent services have not yet been established and instead gender-questioning youth are referred to the London based GIDS, funded by a scheme similar in nature to the 'Treatment Abroad' scheme.

The GIDS atypically accepted referrals by non-medical services, meaning that many young people accessed the service with no prior mental health assessment. As the GIDS evolved, the patient cohort also changed from predominantly birth registered males with early onset GI, to predominantly birth registered females with adolescent onset. The average age of presentation dropped and there was an increase in youth attending with comorbid neurodiversity, mental illness, and children in social service care⁴. As the service grew, (500%-fold increase), its waiting list lengthened, increasing patient distress, reducing quality of service, and elevating expectations of patients for medical interventions when services were finally accessed. The Cass report, commissioned by NHS England⁵ identified these factors as setting the scene for an overly confirmatory non-exploratory approach of GI, driven in part from expectations of children and parents, and resulting in a lack of systematic assessments, clear care planning and follow-up. Following this report, the NHS announced phased closure of the GIDS and replacement with two regional services⁶. The findings of the Cass report have raised both practical and philosophical concerns for clinicians working with this cohort of gender questioning youth in Ireland.

With the current dearth of knowledge about etiology, natural history, clinical outcomes following medical and/or surgical interventions, GI service development and delivery in ROI needs to be carefully planned, accessible, equitable, publicly available, adequately resourced and regularly updated. Medical interventions need to be carefully recorded, documented, and evaluated to ensure benefits outweigh any adverse effects and with named clinicians being responsible for decision-making treatments offered. Services must be governed by clinical need and outcome rather than activist pressure or undue influence. Experience from GIDS reminds us of risks associated with confining care to isolated, singular specialist services and highlights the need to involve local CAMHS and other support services. Substantial investment in CAMHS is required, given the already over-stretched nature of the CAMHS, identified by the recent Maskey report⁷, and heightened by the adverse MH impact of the Covid-19 pandemic on youth⁸. Seamless transition from youth to adulthood is a fundamental component and aligning child gender services with the NGS is essential. Gender services need to be embedded in the HSE annual service reviews, with adequate and systematic data collection, allowing follow up of outcomes, clear clinical and administrative governance, and excellent standards of quality care.

Such specialist GI services should function as a resource for local services, providing consultation and training, and have structured engagement with patients, families, educators, and other clinicians and HSE providers and innovate changes based on updated research. The importance of education about this sensitive topic cannot be underestimated and such specialist services are ideally placed to engage with media outlets and assist with responsible reporting. In her report, Dr Cass was aware of, and sensitive to, the sensitivity of the topic and vulnerability of this group. She brought her expert clinical experience and leadership skills to the review with a consultative and evidenced approach, person centered, with engagement of patients, stakeholders and the public. Now is the chance for us to for the same for youth in ROI.

While the debate about gender in ideological and political terms is of interest and importance to doctors as much as anyone, as clinicians, we have an additional responsibility and a duty of care to keep patients (especially children) safe and work within an evidence based rather than ideological rights-based approach. This is at the root of the Cass report and requires doctors to consider assessment of the whole person rather than adopting a simply gender affirming approach. We agree with Dr Cass with the necessity of Medical Colleges and professional organizations to support and facilitate their members 'to engage in meaningful and respectful debate about the underlying issues'⁹.

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