

Written evidence submitted by Professor Richard Byng [GRA1913]

I am a medical academic with expertise in development and evaluation of interventions for those from excluded and marginalised groups. I work as a GP in deprived area of Plymouth and care for young people with gender dysphoria in this role and also as a GP with a Special Interest in Mental Health (not as part of a specialist gender dysphoria service). I am part of a wider national and international network of clinicians, campaigning for improved care of gender questioning individuals within primary, secondary and tertiary services ([SEGM](#)).

I wish to give evidence on the following questions:

1. Should the requirement for a diagnosis of gender dysphoria be removed?
2. Should there be changes to the requirement for individuals to have lived in their acquired gender for at least two years?
3. Should the age limit at which people can apply for a Gender Recognition Certificate (GRC) be lowered?

I consider these issues to be linked. The lack of evidence, the current pathways and the recent shift in some medical organisations away from automatic support for transition suggest a more cautious approach is required. While having a GRA certificate and having medical intervention are separate they are inevitably linked – each encouraging the other. This means that demedicalising the GRA may paradoxically result in more individuals being seen suitable for potentially harmful medical interventions without the safeguards of a medical assessment, especially as for adults in England requirement for psychological therapy has been removed. Similarly while there are problems with requiring two years of living in role, this does provide an opportunity to consider the importance of decision. And given that there are good arguments for increasing the age of acquiring GRA certificate and receiving irreversible medical treatment, and in the light of weak evidence and coexisting mental illness in young people with gender dysphoria, any move to reduce the age would be problematic. Below I summarise my personal position, outline the well known problems with the medical evidence and provide a summary of pathways and organisational positions.

I am concerned about the wellbeing of gender questioning people, particularly young people. I supported my sister to transition. But in the last years, through experience in practice, I have become concerned that rather than mainly supporting male to female transitions (such as my sister) with long standing dysphoria, services are now responsible for the care of much younger mainly female individuals, many of who have complex mental health and neurodevelopmental disorders. Irreversible medical interventions are being given to those under 25 whose identity and brain are still changing rapidly. My change in view has been hard. I am a fierce advocate of autonomy for young people, but have come to the conclusion that encouraging a medical response to gender questioning is now likely to be doing more harm than good. The stories of detransitioners is most convincing. They testify how as adolescents they would do anything to obtain medical interventions and yet years later regret their decisions and those of medical practitioners agreeing to intervene. While the 'diagnosis' of gender dysphoria' is highly problematic (it is based on subjective view) the alternative being contemplated of removing it and offering individuals medical treatment based on how they seem themselves makes even less sense.

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The population changes are important to understand. Previously, the population being referred to Gender Identity Clinics was mainly adult trans women (natal males), often with early childhood onset, although normally a high proportion desisted during adolescence (60-80%).

- Recently, referral numbers escalated exponentially although the upward trend is now slowing. Younger adolescent and adult trans men (natal females) with onset after childhood now predominate.
- The nature of the patient population has also changed. They have many mental health comorbidities (abuse, foster care, autism etc) as compared to the wider population. <https://adc.bmj.com/content/103/7/631>.

This is especially problematic in the absence of evidence of benefit. We simply do not know whether it is right to apply medical treatment models developed for older natal males to young people approaching or during female puberty. And do so at much greater scale. In the last 50 years medicine has turned a welcome corner to become evidence informed, guided by high quality evidence – both qualitative and quantitative. The evidence for medical intervention in the area of gender dysphoria is very weak:

- Advocacy groups have claimed that ‘affirmation’ & medical transition prevents suicides. There is no robust evidence to support this. Long term studies have shown continuing very high rates of suicide after transition (<https://pubmed.ncbi.nlm.nih.gov/26835611/>)
- In 2020, a large epidemiology paper using reliable Swedish data initially appeared to show improved mental health after surgery. Due to poor, non-comparative methodology, it became the subject of rebuttal and had to be corrected after a better reanalysis (<https://pubmed.ncbi.nlm.nih.gov/31581798/>, <https://pubmed.ncbi.nlm.nih.gov/32741280/>)
- Thus, there is no quantitative evidence of overall long term mental health benefit from hormones or surgery in adults.
- With respect to young people, the best summary is probably this readable piece from the Oxford Centre of Evidence-Based Medicine looking at the global literature. <https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/>. It concludes that the use of puberty blockers & cross-sex hormones in children and adolescents is “experimental”.

Despite the weak evidence it is regrettable that medical societies worldwide tend to support medical intervention. Fortunately this is now changing as a growing group of practitioners from outside the specialty provide a different stance emphasising evidence based practice and well established professional standards in relation to shared decision making and ‘First do no Harm’.

Over several decades the World Professional Association for Transgender Healthcare has brought together special-interest clinicians, researchers and practitioners. WPATH Guidelines/ Standards of Care advocating ‘affirmation’ and medicalization are based primarily on consensus and not on demonstrable benefit from high quality trials as is expected for such major interventions. This has coincided with substantial shifts towards medicalization of children in the last 10 years despite the evidence of both desistance (change of internal view whilst offering supportive ‘watch and wait’ before physical

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intervention) and detransition (after intervention). In the UK and elsewhere, many Medical, Psychological and Nursing bodies and NHS guidance have generally supported WPATH values and guidance, although not going so far as to strongly advocate medicalization of children. Notable exceptions include the Royal College of GPs (<https://www.rcgp.org.uk/policy/rcgp-policy-areas/transgender-care.aspx>), the Swedish Ethics body and most recently the Finnish national guidelines which advocate psychological treatment as first line.

Given the high rates of comorbid conditions in young people presenting to gender clinics adults living with gender dysphoria it is potentially harmful to eliminate the need for an assessment and diagnosis of gender dysphoria before legally changing gender markers. Young people with complex psychological and mental health comorbidities should be supported using a whole person shared decision making framework, with treatment offered that is neutral and supportive. It makes sense for such a process to be required for any application to GRA rather than separate. Until a coherent and well tested integrated process has been developed, I argue there are significant risks in removing diagnosis, the two year period of living in role and in reducing the age threshold.

November 2020