December 18, 2020

Dear Donna and the Leadership at SickKids Hospital,

Thank you for your letter. I'm writing to you to share some observations based on your response and information we hope you'll take into consideration.

No doubt you are now aware of the verdict in the case of a single detransitioner in the UK, Kiera Bell. The UK National Health Service updated it's service specification immediately to state: "Patients under 16 years must not be referred by the Gender Identity Development Service to paediatric endocrinology clinics for puberty blockers unless a 'best interests' order has been made by the Court for the individual in question."

The other amendments include the need for "wider care pathways" and very cautious guidance for patients aged 16 and 17 years based on the decision of the Court that an order be sought if there is any doubt about the patient's best interests. These may be of interest to you here:

https://www.england.nhs.uk/wp-content/uploads/2020/12/Amendment-to-Gender-Identity-Development-Service-Specification-for-Children-and-Adolescents.pdf

Evidence and study of inappropriate medical transitioning in this new population of adolescents is a very recent phenomenon. (Butler & Hutchinson, 2020; Entwistle, 2020; Griffin et al., 2020). The evidence basis for medical gender treatments in general is widely recognized to be "low" or "very low quality," as acknowledged by the Endocrine Society and several recent systematic reviews to date (Hembree et al., 2017; Heneghan, Carl & Jefferson, Tom, 2019; Hruz, 2020).

The significant increase in the number of youth reporting gender dysphoria, with a poorly understood change in clinical presentation from prepubescent boys (previously the typical presentation), to the current predominant presentation of adolescent females with no visible history of gender dysphoria prior to puberty; (Bewley et al., 2019; de Graaf, Carmichael, et al., 2018; de Graaf, Giovanardi, et al., 2018; de Graaf & Carmichael, 2019; de Vries, 2020; Hutchinson et al., 2020; Kaltiala-Heino et al., 2018; Littman, 2018, 2020) needs to be taken into consideration with the increasing number of detransitioners coming forward, most from this novel cohort.

These factors alone, in any other area of medical practice, would be reason to reconsider evidence and treatment protocols.

In particular, we're concerned that a child-led approach where your assessment process has been designed to affirm a child's "goals" is not clinically appropriate and is not grounded in a substantial evidence-base that would make it appropriate. Further, rather than an assessment process that allows for a number of different alternatives to care, including agenda-free psychotherapy services to manage and ameliorate feelings of gender dysphoria, and support for

youth who are struggling with issues that can arise in adolescence including difficulty coming to terms with same-sex attraction or co-occurring mental health challenges, your assessment process only validates whether youth meet very minimal criteria to proceed with hormones and seem to be capable enough to sign a consent form.

We caution you that the adoption of such a narrow treatment pathway is ill-advised given the rapidly evolving nature of this field and growing global debate over best-practices due to the lack of evidence to support current interventions.

Only months ago, for example, the author of the original medical gender treatment protocol for youth (puberty blockers followed by cross-sex hormones and possible gender-confirming surgeries) published a commentary in *Pediatrics* alerting the medical community that this protocol, designed for cases of childhood-onset gender dysphoria, is now being applied inappropriately to a new group of youth (those with no documented history of childhood gender dysphoria). de Vries asserts that it is not clinically appropriate to apply the same protocol to this new patient segment as it is without an evidence basis; it is unknown whether benefits will outweigh harms; and that mental health supports may be more appropriate for these patients (de Vries, 2020).

Several studies have come out in the last 24 months that demonstrate the potential for exploratory developmentally-informed psychotherapy to effectively and ethically resolve gender dysphoria without invasive medical treatments (Churcher Clarke & Spiliadis, 2019; D'Angelo, 2020; D'Angelo et al., 2020; Lemma, 2018; Spiliadis, 2019)

Further, a very methodologically sound University of Toronto research study published last year found a specificity link between autism and gender dysphoria (Leef et al., 2019). Are you at all concerned or curious, in the spirit of "evidence-informed practice" to which you claim to adhere, about whether children who are autistic would benefit from a different approach to care? Have you initiated any processes at your clinic to screen your young patients for autism in order to understand how this condition interacts with gender dysphoria and whether medical transition for this population is in their long-term best interests?

I understand that your clinicians have witnessed firsthand the benefits of medical transitioning and therefore understandably defend the current system. But it is also becoming abundantly clear that young people exist for whom medical transition has been a mistake and where your assessment process failed to determine who is a good candidate for medical transition and who is not.

Equating a long wait time for a first appointment as an advantage for youth who are "considering options" is not evidence the system is working when youth are prescribed hormones after only one or two visits. The singular and narrow treatment pathway offered at SickKids is a disservice to those children who are struggling with gender dysphoria and often other co-occurring conditions. They are coming to you for help; all you are offering are hormones.

If no valid effort is made to determine who will benefit from medical interventions and who needs different assessments or supports, the current system will continue to approve unnecessary treatments for adolescents who need more complex help.

We respectfully ask that you reconsider your narrow treatment pathway for youth presenting with gender dysphoria and determine whether the way our society cares for children and adolescents with gender dysphoria would benefit from independent and objective oversight to ensure that the best interests of all children are being protected.

Sincerely,

Pamela Buffone
Founder, Canadian Gender Report
www.genderreport.ca

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