

September 11, 2024

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Dear Mr Nagler,

We would like you to review our complaint concerning the claim in Andrew Lam's [video](#) that "the treatment (with puberty blockers) is reversible". We received Nancy Waugh's reply and would like your office to review our response below. Our position is that the claim that puberty blockers are reversible in the context of treating youth with gender-related distress is neither accurate nor impartial and that in the field of human health, the CBC should be extremely cautious that it acts in the public interest and does not present information that could mislead the public about the scope of the results of medical or scientific data. Your journalistic standard "Implications and Validity of results of scientific research" states:

We ensure that we understand and reflect the true scope of the results of the medical or scientific studies from which we obtain the results, particularly with regard to statistical data.

We are cautious about results disclosed at conferences if they have not yet been published in a scientific journal supervised by an editorial board of experts.

In the field of human health, we are careful not to create unfounded hopes or fears in people with serious illnesses or in people whose loved ones are seriously ill. In addition, we avoid exaggerating risks or dangling unproven health benefits related to changes in food or pharmaceutical consumption habits.

Puberty blockers are an "off-label" medical treatment for youth experiencing gender distress. Puberty blockers have not been approved for this use in Canada or anywhere else. The only evidence supporting the claim that puberty blockers are reversible is based on treatment for precocious puberty, and even then, there is no data for natal females to ascertain whether ovulation will eventually re-occur. ([Hembree et al., 2017](#))

In precocious puberty, puberty blockers are used to correct an abnormally timed flow of hormones while in gender medicine they are used to disrupt a normally timed process. The two conditions are significantly different. There is no actual research which has found that children can have their puberty blocked during the normal window for puberty and then resume normal

puberty without any permanent effects from the blockage. All studies of puberty blockers have found that more than 95% of children given puberty blockers for gender dysphoria proceed to cross sex hormones and never go through normal puberty. Clinicians, including Dr Cass hypothesize that this may be due to puberty blockers “locking in” gender distress and the desire to change one’s physical characteristics. This is in stark contrast to the watchful waiting model of care where puberty blockers were not given in the course of treatment, and where there is clear evidence that [80-95% of children would eventually outgrow feelings of gender distress](#) without the need for pharmaceutical interventions.

Further, the Endocrine Society Clinical Practice Guideline clearly states that treatment of adolescents in later pubertal stages leads to irreversible effects ([Hembree et al., 2017](#)):

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

We realize that many trusted institutions in our country and around the world have been touting puberty blockers as a “pause” button for the treatment of gender distress. Responsible health authorities such as those in the UK, Sweden and Finland who have completed independent investigations into the benefits and risks of gender affirmation care no longer use that kind of language. NHS England [changed its guidance on puberty blockers](#) to drop the claim they are reversible in 2020.

We would like to address some of the points that your Senior Manager, Nancy Waugh, made in response to our initial complaint. The topic of gender affirmation treatments for minors is currently the subject of much controversy and we would like the CBC to understand the need for scrutiny of Canadian institutions.

Canadian Pediatric Society Position Statement

The CPS position statement [An affirming approach to caring for transgender and gender-diverse youth](#) is cited in support of the position that puberty blockers are reversible. This position statement is a blatant example of citation laundering that has become a regular practice in gender medicine. We rely on this [fact-check of the CPS position statement](#) that provides a detailed analysis of this practice. We would like your team of journalists to familiarize

themselves so that they can question the CPS in an appropriate manner rather than take their word at face value.

There are no actual studies which have found that the effects of puberty blockers during the normal window for puberty are reversible, however, there is evidence of possible serious irreversible effects including [reduced bone density](#), [loss of fertility](#) and sexual functions and interference with [brain development](#).

The CPS Position Paper ignores these concerns, however, and states:

Hormonal suppression is reversible, and endogenous sex-steroid production and/or effects will resume if hormone blockers are discontinued (62,64,85-89).

This statement skirts around the key controversy. Hormone production will indeed resume once puberty blockers are stopped but that does not mean there has been no permanent effect. Puberty is a developmental milestone where there are many physical, psychological and social changes which are affected by sex hormones. If these changes occur without the normal flow of hormones there may be permanent effects which cannot be reversed later.

The list of seven references for the CPS claim appears to provide evidence for their claim, but if you examine each reference, you will see that not a single one refers to a study or even a case report which examines the effect of giving a child puberty blockers during the normal window for puberty and then discontinuing them without proceeding to cross sex hormones.

References Examined ([credit Peter Sim substack](#)):

Reference 62 is to the [WPATH SOC8](#). It refers to “fully reversible puberty delaying blockers” at page S43 without any supporting references. Later on, it hedges a bit by warning that:

Gender-diverse youth should fully understand the reversible, partially reversible, and irreversible aspects of a treatment, as well as the limits of what is known about certain treatments (e.g., the impact of pubertal suppression on brain development (Chen and Loshak,2020)) [p. S61]

However, it then goes on to make a strong recommendation for pubertal suppression with the following statement:

In general, the goal of GnRHa administration in TGD adolescents is to prevent further development of the endogenous secondary sex characteristics corresponding to the sex designated at birth. Since this treatment is fully reversible, it is regarded as an extended time for adolescents to explore their gender identity by means of an early social transition (Ashley, 2019e). Treatment with GnRHAs also has therapeutic benefit since it often results in a vast reduction in the level of distress stemming from physical changes that occur when endogenous puberty begins (Rosenthal, 2014; Turban, King et al., 2020). [p. S112]

None of the four references in this paragraph contain any support for the claim of reversibility. Ashley [2019e](#) is an opinion piece by Florence Ashley which contains no primary research. [Rosenthal 2014](#) is a case report on two adolescents treated with puberty blockers. Neither patient had discontinued treatment at the time the article was completed. [Turban, King et al. 2020](#) is an article on pubertal suppression and suicidal ideation based on data-mining a 2015 survey of transgender adults.

Note that the claim that puberty blockers result in a “vast reduction” of distress is questionable. The systematic review commissioned by the Cass Review, as well as all prior reviews, have found that the evidence of any benefits from puberty blockers is low certainty.

Reference 64 is to the [Endocrine Society guideline](#), which does attempt to cite some research in support of its claims. However, this research is not directly relevant as it does not deal with adolescents receiving puberty suppression for gender dysphoria.

For “those designated male at birth” the guideline claims that “prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression.” In support of this claim it cites [one article](#) on the effects of puberty blockers on males with central precocious puberty, and two articles ([Buchter et al., 1998](#); [Liu et al., 1999](#)) on the treatment of adult men with gonadotropin deficiency. None of these studies consider the effects of blocking puberty in a physically healthy boy during the normal window for puberty.

For girls, the guideline makes the more cautious claim that “no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation.” It cites two studies ([Pasquino, 2008](#); [Magiakou, 2010](#)) on girls with precocious puberty.

It also clearly states that pubertal suppression in adolescents in later stages of puberty will have irreversible effects:

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Other References

The remaining references are to individual articles which have nothing to say about reversibility.

[Reference 85](#) (Vries et al., 2011) is to the initial Amsterdam clinic study on puberty blockers from 2011. All of the patients in this study either continued to cross-sex hormones and surgery

or were lost to follow up. (Including one patient who [died as a result of post-operative infection](#) after a vaginoplasty.)

[Reference 86](#) (Delemarre-van de Waal & Cohen-Kettenis, 2006) is to a 2006 article which describes the Dutch protocol and some preliminary results from the Amsterdam study. The article refers to puberty blockers as reversible but does not cite any supporting research. None of the patients referred to in the article had discontinued puberty suppression.

[Reference 87](#) (Costa et al., 2016) is a review article which does not contain any new research. As support for its claim that puberty blockers are reversible it cites the Endocrine Society guideline and an article on the Amsterdam study which is Reference 89 in the CPS position statement.

[Reference 88](#) (Cohen-Kettenis et al., 2011) is a preliminary report from 2011 by the researchers in the Amsterdam study which was published just prior to the article in Reference 85. It does not contain any additional evidence.

[Reference 89](#) (Kreukels & Cohen-Kettenis, 2011) is another review article based on the Amsterdam study. This article is cautious in its claims. It says, "If treatment with GnRHa is stopped, puberty in line with the natal sex will continue to develop. In this sense, the treatment is reversible." It does not cite any supporting research for this statement. This means that five of the seven references in the paragraph are based on the same clinical study which did not actually examine reversibility of puberty blockers.

As you can see, the CPS Position Statement cites weak or irrelevant sources to create the illusion of a strong scientific consensus. This problem of circularity in guideline development is why national health services in most of the developed world have decided to independently examine the evidence and develop new guidelines for treating gender distressed young people.

We're very concerned about the statements being made by the CPS about gender affirmation treatments. CPS leadership has shown their ignorance of the current research in a recent statement they made to the public about gender affirming care. In this statement, [the CPS misrepresented the results of several studies they were using to suggest that access to puberty blockers and gender affirmation treatments is necessary and evidence-based](#).

It would be helpful if the CBC wouldn't simply parrot the CPS statements about gender affirmation care, but rather, start asking some pointed questions to ascertain whether the CPS is really putting children's best interests first and is committed to an evidence-based approach to care.

From all accounts, the CPS has adopted a position that access to gender-affirming treatments should be regarded as a presumptive right despite growing evidence questioning the safety and effectiveness of this model of care. This is contrary to the principles of ethical medical practice

and we welcome media scrutiny, particularly as the rest of the Western world is quickly determining that gender affirmation medical treatments are putting children at unnecessary risk. Canada now has the most permissive and reckless access to these treatments.

Cass Review controversy

The Cass Review controversy is related to the recommendations resulting from the review, not the evidence we point to as the new gold standard. The Cass Review accomplished 2 distinct things:

- 1) the analysis of all the available evidence per Systematic Reviews,
- 2) the development of recommendations and guidelines for the UK healthcare system.

Guidelines developed from evidence can have different recommendations for care. The best practice (the GRADE system developed by Canadian Gordon Guyatt) requires that strong recommendations require strong evidence and that values and preferences shape medical guidelines and are taken into account. Guidelines “should” be transparent about both the quality of the evidence they rely upon and the values and preferences that influence their treatment recommendations.

The Cass guidelines are cautionary given the lack of strong evidence to support the use of puberty blockers and the claims that they result in improved health outcomes. Claims by trans-rights groups that the Cass systematic reviews of evidence were biased and employed a poor methodology are without grounds. The Cass Review [employed a systematic approach to the evidence reviews consistent with other clinical practice areas](#).

A number of things have happened in the UK since the Cass Review recommendations were released. Nancy Waugh points out that the British Medical Association (BMA) released a statement questioning the Cass Review.

The BMA is a union and as such, takes positions that are not necessarily aligned with the rest of the medical profession that prioritizes an evidence-led approach to care. Their position is being called out as “**ludicrous**” and “**irrational**” in light of the rest of the medical profession backing the evidence and recommendations of the Cass Review.

<https://www.theguardian.com/commentisfree/article/2024/aug/04/bma-stance-on-puberty-blockers-defies-first-principle-of-medicine-first-do-no-harm-cass-review>

<https://www.theguardian.com/society/article/2024/sep/07/bma-stance-on-cass-review-of-transgender-care-has-damaged-its-reputation>

In response to the BMA, the actual medical societies in the UK responsible for regulating the profession (The Academy of Medical Royal Colleges, the Royal College of Psychiatrists and the Association of Clinical Psychologists) all released statements supporting the Cass Review.

The AOMRC is the licensing body for all physicians in the UK and issued a statement on August 1 in response to the BMA position stating their commitment and confidence in the Cass Review:

The Academy of Medical Royal Colleges is mindful that some members of the medical profession are questioning the validity of the evidence and consequently the findings of the independent [Cass Review](#) of gender identity services for children and young people. Our view is that further speculative work risks greater polarisation on this matter which is not helpful and our focus should be on implementing the recommendations of the Cass Review by providing the most appropriate treatment for children and young people with gender dysphoria or gender related distress.

<https://www.aomrc.org.uk/publication/academy-statement-implementation-of-the-cass-review/>

Other supportive statements can be found here:

[Royal College of Psychiatrists detailed response to the Cass Review Final Report](#)

[Association of Clinical Psychologists Response to the BMA](#)

Even the new Labour government is supporting the Cass Review. Labour government Health Secretary Wes Streeting said:

"Children's healthcare must be evidence-led," and "Dr Cass's review found there was insufficient evidence that puberty blockers are safe and effective for children with gender dysphoria and gender incongruence. We must therefore act cautiously and with care when it comes to this vulnerable group of young people." -

<https://www.bbc.com/news/articles/c4ng3gz99nwo>

The High Court in the UK has also had the opportunity to weigh in on the Cass controversy. They ruled on July 29th, 2024 that the puberty blocker ban is lawful and concluded that the government is ***"entitled to conclude that the Cass Review is the best and most up-to-date scientific evidence available"***. The decision concluded: ***"In my judgment, the Cass Review's findings about the very substantial risks and very narrow benefits associated with the use of puberty blockers, and the recommendation that in future the NHS prescribing of puberty blockers to children and young people should only take place in a clinical trial, and not routinely, amounted to powerful scientific evidence in support of restrictions on the supply of puberty blockers on the grounds that they were potentially harmful."***

<https://www.judiciary.uk/judgments/transactual-cic-and-another-v-secretary-of-state-for-health-and-social-care-and-another/>

The controversy over the Cass Review that your editor found from the BMA is one of "values" and not evidence. This has no bearing on evaluating the accuracy of the claim being made about puberty blockers.

Conclusion

Our complaint with the CBC is not related to the expression of opinions that puberty blockers should be offered as part of gender affirmation care; it is related to the accuracy of the statement that puberty blockers are reversible. The claim that puberty blockers are reversible has significant implications as this claim is used to establish public trust that treatment with puberty blockers is safe and that the effects can be reversed. The lack of accuracy and resulting misrepresentation of scientific research directly contravene your journalistic standards.

Systematic reviews of evidence have shown that there are serious risks and low evidence of benefits from gender-affirmation medical treatments for young people. The CBC must be more diligent in understanding the scope of the results of medical studies and not dangle unproven claims that may encourage young people to embark on a life-changing course of treatment that has serious risks and consequences.

Media plays an important role in protecting the public interest by evaluating the claims of our public institutions. The CBC must be careful in its reporting to be impartial and evaluate the claims of gender affirmation treatments to ensure they are accurate and based upon evidence (regardless of which esteemed institutions are making such claims).

Puberty blockers are not approved for the treatment of gender distress in young people and the Endocrine Society admits that this treatment on adolescents will lead to irreversible effects. The Canadian Pediatric Society has not provided any evidence to support their claim that puberty blockers are reversible in the context of gender-affirming care, regardless of what they may assert in their position statement now being used by media and practicing physicians.

We would like the CBC to refrain from making claims that puberty blockers are reversible in the context of gender-affirming care and remove such statements from Andrew Lam's video.

Sincerely,

Pam Buffone

Pamela Buffone
www.genderreport.ca

Canadian Gender Report is a non-sectarian group of parents and professionals concerned about the medical gender transition of children and the cultural forces that are promoting gender medicalization of young people. We keep tabs on what is happening in Canada and around the world. We help families of gender-distressed young people raise concerns in order to advocate for the well-being of their children and an evidence-based approach to healthcare and education.