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Trans Health Care Must Also Meet Medical-Scientific Standards

The demand for transgender care is increasing rapidly. The originally Dutch treatment using puberty blockers is coming under increasing international fire. Jan Kuitenbrouwer and Peter Vasterman argue for independent research.

"Waiting lists for transgender care too long: 'It will destroy you'", RTL News headlined at the beginning of this year. Dutch gender clinics are overwhelmed by an almost exponentially growing demand for gender care. The previous cabinet installed a 'quartermaster' to initiate a drastic expansion of capacity. But: what kind of care should that actually be?

Until 2010, an average of about 200 patients per year reported to a gender clinic in the Netherlands, including about 60 children and young people. Around 2013, the number of registrations suddenly doubles and from that moment the line goes up steeply. In 2022, there will be almost 6,000 people on the waiting list and more than 5,000 in treatment, including about 1,600 minors. The growth rate is also enormous in that group, with another 1,800 on the waiting list. They “do not feel at home in their own gender” and want to “transition”. This growth trend is international. Underage patients at the British gender clinic Tavistock went from 51 in 2009 to 3,585 in 2022. Thousands of children were also on the waiting list there this year.

Feeling out of place in one's own gender is called 'gender dysphoria' and nowadays often also 'gender incongruity'. The treatment is largely based on the administration of 'cross-sex hormones', women receive testosterone to become 'more masculine', men receive estrogen to become 'more feminine'. Teenage patients also use 'puberty blockers', substances that stop the physical process of puberty. Normally boys develop a low voice, beard growth and Adam's apple, girls develop breasts, wider hips and 'curves'. That process is stopped. The 'secondary sex characteristics' do not form, time is gained for the child to explore their 'gender identity'. puberty blockers are a 'pause button'. Should the need for transition disappear, the treatment will be stopped and puberty will still start, without adverse consequences, is the promise. If the transition is continued, then no secondary sex characteristics need to be 'removed'.

This approach was developed in the 1990s in the gender clinic of the VU (Vrije University) Hospital (nowadays the Knowledge and Care Center for Gender Dysphoria of the Amsterdam University Medical Centre). In 2006, strict criteria were formulated in a study sponsored by hormone producer Ferring: there had to be gender dysphoria from an early age, which also worsens at the start of puberty; the patient is psychologically stable and receives sufficient emotional support. Possible side effects were not taken lightly, they were outweighed by the major benefits: relief from the torment called gender dysphoria. The approach took off and in a few years the 'Dutch Protocol' became the international standard of care in this area. It is believed that many tens of thousands of children have been treated in this way all over the world. It is estimated - there are no official figures - that there are about 500 to 1,000 in the Netherlands every year..

Being Different

This is a new type of patient. Before this boom, the typical 'transsexual' was an adult man, but the major growth is now among young people, especially girls (75 percent). They often do not present until puberty has already started, and they often have no history of gender dysphoria. In fact, even when they report this is often not really the case, they claim gender incongruity, they don't suffer so much from it, they want to be something else. It is not a disorder, but an 'identity'. What is striking

is that many of these young people have additional psychological complaints, there are unprocessed traumas or they are struggling with their sexuality. One in four has an autism spectrum disorder. Are these complaints the result of their dysphoria or the cause? What should you treat?

This boom is explained by trans organizations as the result of increased societal acceptance of gender diversity; doubters come out of the closet more easily. Critics point out that social acceptance of deviant behavior changes only slowly, while this is a very abrupt, exponential growth, which started around 2013. What happened then? Is it a coincidence that this explosion coincided with the spectacular growth of social media around the same time? The statistics show a striking resemblance. And if this has to do with social acceptance, why then mainly girls, while girls traditionally have more room for gender nonconformity than boys?

In the Netherlands, more and more people with regrets are manifesting. They believe that they have been wrongly subjected to irreversible treatment. They feel they were pushed and insufficiently protected against themselves.

This is why the Dutch protocol is being viewed more and more critically worldwide. Is it the right approach for this new group? Is it as safe and effective as is assumed?

The answers are disturbing. Following extensive scientific evaluations of the treatment, health authorities in Sweden, Finland and the United Kingdom have recently decided to emphasize psychological treatment in children and to prescribe puberty blockers only in very severe cases or, as in Florida to completely stop prescribing them.

According to the Swedish review (2021), the available data do not form a sufficient basis to properly assess the effects on gender dysphoria, psychosocial conditions, cognitive functioning, and physical health. “The risks currently do not outweigh the possible benefits,” says the Swedish health authority. The Finnish report (2020) comes to a similar conclusion, as does the British 'Cass Review' (2022). The leading British pediatrician Hilary Cass condemned the British application of the Dutch protocol and, based on her report, the Tavistock gender clinic, the largest in the world, was immediately closed.

Puberty Blockers

Another major concern is that puberty blockers are not a "pause button" but rather a self-fulfilling prophecy. Almost all treated children switch from the puberty blockers to the cross-sex hormones at the age of 16. In practice, puberty blockers do not appear to be a pause button for reflection, but the start button for transition. Cass's investigation was partly the result of the controversial case of Keira Bell, a young woman who regrets her transition and claims to have been talked into it by Tavistock.

More and more is also becoming known about the long-term side effects of puberty blockers. These GNrHs (Gonadotropin Releasing Hormone) disrupt physical sexual development, hinder the development of the bone system (osteoporosis), can cause anorgasmia, infertility and interfere with the ability to make rational decisions.

The scientific substantiation of the Dutch protocol also appears to be rather shaky. Almost all publications that the Knowledge and Care Center for Gender Dysphoria relies on originate from its own practitioners, and is therefore just experts giving advice in line with their own best interests. Where is the confirmation from outside researchers? The research that is always cited is that of child psychiatrist Annelou de Vries and the Amsterdam gender team, published in 2011 and 2014. The results would show that the 55 children who were first treated with puberty blockers and then

with hormones had positive results eighteen months after the operation reported. This study has since been criticized in numerous publications, not only because of the lack of a control group and a random sample (out of a total of 196 children treated), but also because of the use of incomparable questionnaires. Conclusion: this is not a sound evidence base.

To date, De Vries' results have therefore not been replicated. An attempt by a research team at the Tavistock clinic failed, with the results disappearing in a desk drawer. Only recently were they released by order of the British court.

Head In The Sand

It is remarkable that the media in neighboring countries report extensively on this reconsideration of the Dutch protocol, but the Dutch hardly ever do. Does the KZcG have so much prestige and goodwill that it is respectfully kept out of the wind? If the Tavistock clinic worked intensively with the Dutch protocol and was finally closed after an evaluation, what would it be like in the Dutch clinic where this protocol was invented? And if this treatment has such a solid scientific basis, why did De Vries recently receive an NWO grant for a five-year study into the "missing evidence base"? Has irreversible, life-changing treatment been carried out on De Boelelaan in Amsterdam for more than twenty years without an 'evidence base'?

The Dutch transclinicians stick their heads in the sand. At her installation recently as professor of Gender and Sex Variations at the Amsterdam UMC, Baudewijntje Kreukels accused critics of being 'opponents of [...] transgender care' and that opinions are more important than scientific findings… It is the existing transgender care that would benefit from less wishful thinking and more science. The undersigned are writing this because they are in favor of transgender care. Responsible, proven care.

The Netherlands has long been a guiding country in this respect. That status creates obligations. Before the capacity of Dutch trans health care is drastically expanded, the existing health care must be critically and independently evaluated. These are all reasons for the Health and Youth Care Inspectorate to take action.

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Both signed the manifesto of the Gender Doubt foundation.