

this week

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GPs threaten action over contract

NHS England has imposed a contract on GPs that will start in April, prompting GPs' leaders to renew their promise to discuss the possibility of industrial action.

In a letter sent to GPs on 6 March, NHS England outlined changes to the contract for 2023-24 that had not been agreed with the BMA's General Practitioners Committee England. The deal includes requirements on improving access but has no extra funding.

Last month GPC England voted to reject the contract update and said it would "be forced to consider all options, including the potential for industrial or collective action" if a better deal was not negotiated. A meeting with Steve Barclay, the health secretary, on 2 March failed to break the deadlock.

Kieran Sharrock, acting chair of GPC England, said the contract did "absolutely nothing to improve what is fast becoming an irreparable situation for practices and their patients" and would lead to more GPs leaving the profession. "This contract is the result of a failure to listen to what GPs actually need and totally ignores the calls for any extra support to help meet the rising costs of keeping their doors open," he said.

Sharrock added, "The committee's recent rejection of the contract offer still stands. We will now look to enter serious discussions

with our membership and the wider profession on what action we take next."

Key changes include a contract update "to make it clear that patients should be offered an assessment of need, or signposted to an appropriate service, at first contact."

In addition, the number of indicators in the Investment and Impact Fund (IIF) will be reduced from 36 to five to support a "small number of key national priorities," namely, flu jabs, learning disability health checks, early cancer diagnosis, and a two week access indicator. The value of these indicators will be £59m. The majority and remainder of the IIF, worth £246m, will be entirely focused on improving patients' experience of contacting their practice and being assessed or seen within the appropriate timeframe.

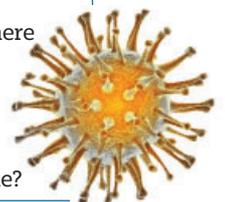
The letter, signed by NHS England's national director of primary care, Amanda Doyle, also sets out changes to the additional roles reimbursement scheme, including increasing the cap on advanced practitioners from two to three per primary care network, removing all existing recruitment caps on mental health practitioners, and introducing apprentice physician associates as a reimbursable role.

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2023;380:p549

Amanda Doyle, NHS England's primary care national director, signed the letter informing GPs of the imposed contract

LATEST ONLINE

- GP who pursued a sexual relationship with a girl while he was a student is struck off
- US studies show racial and ethnic disparities in long covid
- H5N1: Has there been human-to-human transmission, and do we have a vaccine?



SEVEN DAYS IN

Consultants in England are “ready to strike,” as 86% vote in favour of action



BMA NEWS

Consultants in England could soon formally vote on industrial action over pay and pensions, after the BMA's consultative ballot showed 86% in favour of strike action. More than 17 000 senior hospital doctors said they were ready to strike, on a 61% turnout for the ballot launched at the beginning of February.

Unless the government outlines serious proposals before 3 April for how it intends to “fix pay, pensions, and the broken pay review process,” the BMA has said it will proceed to a statutory ballot around 17 April. If that ballot is successful, consultants could take strike action this spring, running a “bank holiday” service on weekdays.

The chair of the BMA Consultants Committee, Vishal Sharma (left), said he had “never seen consultants more demoralised, frustrated, and in despair over this government's refusal to support the NHS workforce and the patients they serve.” He added, “It is within the government's gift to pay doctors fairly for the crucial, lifesaving work they do, and there are clear, straightforward solutions to fix the punitive pensions tax rules.”

The average consultant in England has had a real terms cut of nearly 35% in take home pay since 2008-09, the BMA said.

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2023;380:p539

Mental health

NICE recommends online therapies for adults

Draft guidance from NICE proposes rolling out eight digital therapies to treat depression and anxiety disorders in adults, including post-traumatic stress disorder and body dysmorphia. Each of the digital technologies uses cognitive behavioural therapy techniques and can be delivered only with NHS Talking Therapies practitioner support, including regular monitoring and management of patient safety and progress. The therapies could help more than 40 000 people. A consultation on the recommendations is live at www.nice.org.uk.

Service relaunches for lonely, isolated patients

A service for lonely and isolated people that was set up at the start of the pandemic has been relaunched in England with more than 1000 volunteers. Health professionals, including GPs and pharmacists, can request the Check in and Chat service, which can be a one-off call or a series of calls. Volunteers will provide a listening ear and where appropriate will help patients to connect with others, become more physically active, or learn

new skills. Nine in 10 healthcare workers who used the service during the pandemic said it would help to meet current patient needs.

Norovirus

Cases in UK care homes reach seasonal high

Reports of norovirus are more than double the five season average from before the pandemic, data from the UK Health Security Agency showed, with increases in all age groups but most notably in over 65s. Outbreaks reported in care home settings rose from 47 in the week commencing 6 February to 54 the following week, the highest number of outbreaks reported in a week so far this season.

Industrial action

Unions call off ambulance strikes in England

The GMB, Unite, and Unison unions called off strikes by ambulance staff planned for 6 and 7 March after the government agreed to talks about its pay offer for 2022-23, saying that ministers had said new money would be made available to try to solve the stalemate. Julian Hartley (left), chief executive of NHS Providers, said that trust leaders would be

relieved by the move but that “the prospect of a three day walkout by junior doctors continues to loom large” and that he hoped similar negotiations could take place with other unions.

Regulation

Surgeon who failed to ask for help is struck off

A former locum consultant general surgeon has been struck off after he twice failed to call for help during botched emergency



laparoscopic appendectomies (above), prompting theatre staff to take emergency measures. On one occasion a theatre scrub nurse refused to give the surgeon, Luigi Angelini, any more instruments until another doctor took over. In the other case an anaesthetist left the theatre to fetch a senior surgeon after Angelini insisted that they remove tissue even as they disagreed on whether it was actually the appendix. Patients had been placed at risk, the tribunal chair said, and Angelini had expressed no remorse.

Fake psychiatrist is jailed for seven years

A bogus doctor who practised for more than 20 years as a psychiatrist in the UK has been jailed for seven years after being convicted of fraud. Zholia Alemi joined the medical register in 1995 and practised in hospitals in England, Wales, and Northern Ireland until 2017 after sending the GMC a forged certificate and verification letter purporting to be from the University of Auckland in New Zealand. She received more than £1m in earnings and benefits, Manchester Crown Court heard.

Advertising for blood test was “misleading”

A blood testing panel marketed to the public as “FREE if we don't find anything” breached advertising standards. The Advertising Standards Authority ruled that the drug company Numan, which advertised on its website a blood test checking 17 or 21 biomarkers, had misleadingly implied something was medically wrong if a biomarker was outside the normal reference range.

Margaret McCartney, a Glasgow GP who filed the complaint, said the test also took resources from the NHS because GPs would have to see patients who had been led to believe something was wrong.



MEDICINE

Smoking

Use budget to end tobacco use, says charity

Cancer Research UK is calling on the chancellor, Jeremy Hunt, to take action on tobacco control in the budget on 15 March after an analysis showed 75 000 GP appointments a month in England could be freed up if the government put an end to smoking. Measures to achieve this should include a consultation on raising the age for buying tobacco and more funding to help people quit, with a “polluter pays” style charge on the industry if no government money is available, said the charity. Last year smoking cost public finances an estimated £20.6bn, with £2.2bn spent on the NHS.

International news

MSF issues funding plea for Rohingya refugees



Médecins Sans Frontières has called for donors to reaffirm their commitment to support around a million Rohingya refugees in the Cox's Bazar district in Bangladesh, after the World Food Programme cut rations by 17% to below the accepted minimum standard of 2100 calories a person a day, which will increase the risk of malnutrition and affect refugees' health. MSF's Claudio Miglietta said, “Funding has gone down, and the number of aid organisations working in Cox's Bazar has declined by almost 80%. Donors must reprioritise the Rohingya and reaffirm their funding commitments.”

UN is urged to act on abortion in US

Five international charities have called on the UN to intervene in a



Ending smoking in England would free up 75 000 GP appointments, says Cancer Research UK

“human rights crisis” in the US in the wake of the Supreme Court's 2022 abortion ruling that restricts access to services for millions of women. The charities are pleading for UN officials to ask US politicians to comply with their obligations as a UN member state to protect and uphold the rights to life, health, privacy, liberty, and security. They said that the restrictions on abortion deny “women's decisional and bodily autonomy in a way that rejects the agency, dignity, and equality of people who can become pregnant.”

Fertility

Thirty year old law needs updating, says HFEA

The Human Fertilisation and Embryology Authority has proposed changes to the UK's 30 year old fertility law, saying that it does not reflect modern fertility practice and is inflexible in responding to scientific innovation. The changes propose increasing the authority's regulatory powers so that it can more rapidly impose conditions, suspend services, or enforce financial penalties after serious non-compliance. The HFEA has also said that it needs “broader powers to address fertility services outside licensed fertility clinics” and the ability to authorise trials for low risk new practices, to encourage innovation. A consultation is due to close on 14 April.

Cite this as: *BMJ* 2023;380:p538

OBESITY

More than half—**51%**—of the world's population will be overweight or obese by 2023, at a cost of **\$4.32tn** a year unless treatment and support improve [*World Obesity Federation*]



Mun-Keat Looi, *The BMJ*

Cite this as: *BMJ* 2023;380:p526

SIXTY SECONDS ON ... FISHBONE DOCTORS



OH MY COD, WHAT'S THIS?

Doctors in China are adept at removing fish bones lodged in throats, the *Wall Street Journal* has reported. And there is a growing network of at least 11 fishbone clinics, many located south of the Yangtze river, a region sometimes called the “land of fish and rice.”

SOUNDS SO-FISH-TICATED

The newspaper reported from an overnight clinic that opened in response to a large number of night time cases, some of which required laryngoscopy. The clinic estimates that it has more than 100 cases a week.

FIRST TIME I'M HERRING ABOUT THIS

It's less of a problem in cuisines that tend to use easy-to-eat fish fillets. But many east Asian communities serve whole fish as a communal dish. The Chinese words for “fish” and “surplus” are homophones in several dialects, making it a symbol of good luck. On the messaging app WeChat, searches for and mentions of “fish bone” increased sixfold this New Year's Day (22 January) from the previous day.

CALL THE STURGEON

A 2017 paper in *BMJ Case Reports* said that fish bones can get stuck in the base of the tongue, tonsils, posterior pharyngeal wall, aryepiglottic fold, and upper oesophagus, causing sharp pain. Occasionally they can cause gastrointestinal tract perforations. In 2018 the Chinese state run *Global Times* reported that a doctor had to remove more than 100 fish bones from a man's rectum after he feasted on fish.

A HARD PLAICE TO EAT

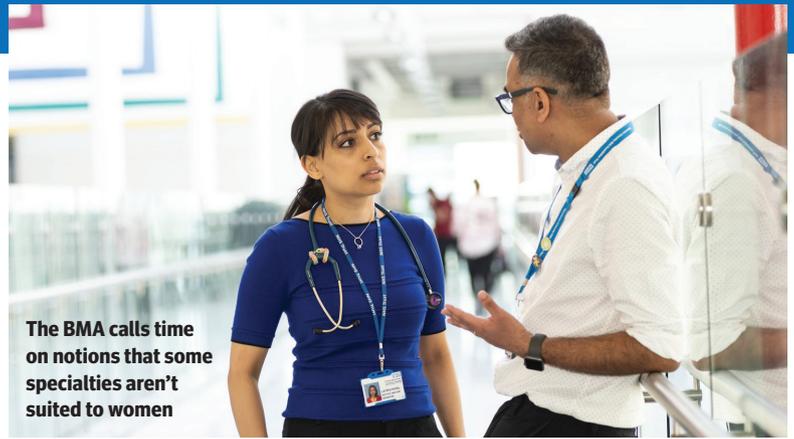
The main problem is home remedies. In Japan, unchewed rice is the method of choice. China has a folk remedy of water imbued with bone dissolving properties by an incantation taken from the ancient spell book of Lu Ban, a legendary carpenter. Any of these methods could force the bone deeper, exacerbating the situation.

YOU'RE KRILLING ME

That's what Chinese expats often say about doctors abroad, who they complain have no idea how to treat stuck fish bones, leading to long waits in A&E, repeated scans, or x rays and huge bills for general anaesthesia.

EXCLUSIVE

BMA pledges to end sexism and tackle gender discrimination



The BMA calls time on notions that some specialties aren't suited to women

Sexism harms us all, not just holding back individuals but affecting the care they can offer to patients

Latifa Patel

The BMA is appealing to organisations across the healthcare sector to stamp out sexism in the medical profession with a 10 goal pledge and a call for senior doctors to “call out sexism” and be responsible and accountable for tackling their own bias.

The “ending sexism in medicine” declaration asks all healthcare organisations to implement “robust sexual harassment policies” along with codes of conduct to protect doctors and medical students from sexual harassment by colleagues and patients. It also calls time on the assumption that being a doctor is a

male role or that certain specialties are less suited to women. Signatories to the pledge include NHS Employers, NHS Providers, the Medical Women’s Federation, and numerous royal medical colleges and other representative organisations.

A survey of thousands of UK doctors in 2021 found that 91% of female doctors had experienced sexism at work, with 42% saying they were unable to report it. The findings, brought together by the BMA and the campaign organisation Surviving in Scrubs, which publishes anonymous reports of sexual harassment and assault in the medical workforce, resulted in a BMA report that

concluded that sexism was “impacting women’s long-term career progression and causing problems in their day-to-day working lives.”

The pledge is about turning those findings into a roadmap to a profession free of gender discrimination, said

A SURVEY of thousands of UK doctors in 2021 found that **91%** of female doctors in the UK had experienced sexism at work, with **42%** saying they were unable to report it

NHS staff’s mental health “hasn’t recovered from pandemic”

The NHS should be systematically measuring the mental health of its staff and making wellbeing a “strategic priority” in response to high levels of burnout since the covid pandemic, a leading consultant anaesthetist has urged.

Kevin Fong, chair of public engagement and innovation in the department of science, technology, engineering and public policy at University College London, was speaking at the Nuffield Trust’s 2023 summit during a session on solving the

NHS workforce burnout crisis.

Fong cited the results from a study he coauthored last year, which found that almost two thirds (64%) of 6080 intensive care staff surveyed may have experienced a mental health disorder during the peak of the pandemic.

Fong told the audience that 46.5% of the staff who were surveyed for the study met the criteria for post-traumatic stress disorder in January 2021, which compared with 17% among UK military veterans who were

deployed in a combat role in Afghanistan.

“It’s clear from the data that my colleagues have been injured in a substantial fraction and significantly,” he said. “They have not recovered.”

Although the pandemic exacerbated burnout, Fong described its high level as an “enduring problem” that the NHS had not done enough to tackle over many years, given its impact on staff, patients, and services. “The only operational strategy for us over time immemorial has been to stretch the staff into the gap between supply and demand,” he said. “The lie we tell ourselves as an organisation is that it can have no cost. Of course it has a cost, and the cost is borne by the staff.”

He added, “If you see those rates of injury in any workforce, it impacts their functional status.”

Fong said that although it wasn’t possible to solve high levels of burnout instantly some things could be done that could start to make a difference. “We haven’t measured the mental health of our workforce in any useful longitudinal way that’s operationally valuable to the people who manage this workforce,” he said. “If we start measuring, we will start managing. Wellbeing needs to be a strategic priority, and that needs to be more than just something we say.

“It needs to be wired through our operational tiers from top to bottom. And every change that we make, we shouldn’t just be thinking about the performance advantage, we need to think about what will happen to staff. We have not done that.”

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2023;380:p548



Wellbeing needs to be a strategic priority, and that needs to be more than just something we say

Kevin Fong

Latifa Patel, the BMA's lead on equality. She said, "From the moment they enter medicine, medical students and doctors face gender based discrimination, from structural barriers that impact their career progression to sexist comments from their colleagues and patients. Sexism harms us all, not just holding back individuals but affecting the care those individuals can offer to patients."

Chelcie Jewitt, cofounder of Surviving in Scrubs, said, "We have

been overwhelmed with the stories submitted by women facing every kind of sexism, misogyny, sexual harassment, and even sexual assault in the NHS. Every story is heart breaking; not only does this kind of endless demeaning of female doctors make their working days so much less bearable but it is holding back careers, reducing confidence, and wasting so much potential."

Adele Waters, *The BMJ*

Cite this as: *BMJ* 2023;380:p527

THE NHS'S 10 GOAL PLEDGE TO END SEXISM

- 1 Eliminate sexism from career progression opportunities
- 2 End sexual harassment in medicine
- 3 Ensure that there are multiple channels for reporting sexual harassment and sexism
- 4 Promote the benefits of gender diversity in medicine
- 5 Guarantee safe and supportive environments for pregnant doctors and medical students
- 6 Remove the detrimental impact that having children and other caring responsibilities can have on career progression and work-life balance
- 7 Actively challenge gender stereotypes in medicine
- 8 Increase the visibility and voices of women
- 9 Employees in more senior roles to recognise gender bias in the workplace
- 10 Support women's health

Northern Ireland's health sector embraces Windsor framework

After years of post-Brexit precariousness the Windsor framework has more or less "solved" the question of how medicines will continue to flow into Northern Ireland from Great Britain, health experts have said.

Until last week pharmaceutical suppliers in Great Britain faced increased costs for relabelling medicines destined for Northern Ireland under the Northern Ireland protocol, which forms part of the withdrawal deal signed by the UK and the EU in 2020. Under the existing protocol Northern Ireland remains within the EU's regulatory system for medicines despite most products coming from Great Britain. Without the changes in the framework such drugs would eventually have to be packaged differently in Northern Ireland from the rest of the UK.

However, Rishi Sunak, the prime minister, introducing the framework on 27 February, said, "From now on, drugs approved for use by the UK's medicines regulator will be automatically available in every pharmacy and hospital in Northern Ireland."

"It's a massive relief," said Alan Stout, chair of the BMA's Northern Ireland General Practitioners Committee. In January he and other experts gave evidence to the House of Lords Ireland/Northern Ireland subcommittee regarding the pharmaceutical problems created by the protocol. The solutions proposed in the Windsor framework, which has yet to be ratified, were "almost exactly" what he and others had suggested, said Stout.

The danger of disrupted drug supplies was very real, Stout added. Suppliers had already indicated that the cost of relabelling drugs for sale in Northern Ireland would have been unacceptable, he said.

Chris Baraniuk, Belfast Cite this as: *BMJ* 2023;380:p501

Career progression is still worse for ethnic minority doctors

UK graduates of black heritage have lower pass rates in specialty exams (62%) than UK white (79%), Asian (68%), and mixed heritage trainees (74%), a review of postgraduate medical education outcomes by the GMC has found.

In 2021 almost half (46%) of all trainees in the UK were from an ethnic minority. The proportion of trainees who had graduated in European Economic Area countries was 4%, while 19% were "international medical graduates" from other countries.

The review, the first time the GMC has published data on postgraduate medical education outcomes broken down by specific ethnic groups, included findings from medical royal college and faculty exam data, ARCP (annual review of competence and progression) data from postgraduate training bodies, and the outcomes of recruitment of foundation year 2 trainees into specialty training.

UK black trainees from areas with a high level of deprivation had an even lower exam pass rate than UK white trainees from an equivalent socioeconomic background (59% versus 76%). A greater proportion of black British trainees (5.3%) had their training programme extended than UK white trainees (2.6%), the GMC found, while a smaller proportion of UK black or black British trainees received an offer when applying to specialty training than other UK qualified groups (an offer rate of 75%, versus 82% for UK white trainees).

Analysis of pass rates by sexual orientation and gender showed that female trainees identifying as lesbian had a slightly higher pass rate (on average 77%) than those who identified as heterosexual (70%), as did gay men (on average 72%) when compared with heterosexual men (68%).

The report said that the GMC was collaborating with partners such as Health Education England and the Royal College of Psychiatrists to evaluate a range of promising initiatives designed to improve trainees' access to support and educational resources.

Colin Melville, medical director and director of education and standards at the GMC, said the council had set a target to eliminate disadvantage and discrimination in medical education and training by 2031.

Katherine Woolf, professor of medical education research at UCL Medical School, told *The BMJ*, "I think it's still quite shocking, upsetting, and disappointing that the gap hasn't really changed very much.

"Although it's horrible to see these findings, if we didn't have the data we would be in a much weaker position to be able to do anything about it. These are big problems that are across a number of areas, and I commend the GMC for publishing these data.

"I think it's important to join efforts so nobody can think, 'This isn't my problem.' This is everybody's problem, and we all need to work together and focus on it."

Adrian O'Dowd, London Cite this as: *BMJ* 2023;380:p542



COVID-19 Leaked messages reveal casual policy making—and love for Chris Whitty

The 100 000 WhatsApp messages sent during Matt Hancock's time as England's health secretary give an insight into the UK government's operations at the height of the pandemic, reports **Jacqui Wise**

? Where do the messages come from?

The cache of messages between government ministers, cabinet officials, aides, and advisers, including Chris Whitty, chief medical officer, and Patrick Vallance, chief scientific adviser, was passed to the *Daily Telegraph* by Isabel Oakeshott, a journalist who was given copies of the texts while working with England's former health and social care secretary, Matt Hancock, on his book *Pandemic Diaries*.

The *BMJ*, like other media outlets, has not seen or independently verified the messages. The *Daily Telegraph* is publishing many stories derived from the messages under the banner the Lockdown Files. Its choice of which messages to include is likely to be selective, not least

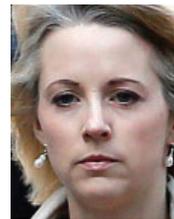
because Oakeshott has said she chose the newspaper because of its anti-lockdown stance.

? Why has Oakeshott released the messages?

Oakeshott, Talk TV's international editor, has been a vocal lockdown sceptic. Although she signed a nondisclosure agreement when writing the *Pandemic Diaries*, she told the *Today* programme she had leaked the messages as it was in the "overwhelming national interest."

She would not say how much she has been paid by the *Daily Telegraph* but said, "Anyone who thinks I did this for money must be utterly insane."

"This is about the millions of people who were adversely affected by the catastrophic decisions to lock down this country, often on the flimsiest of evidence, for political reasons."



This is about the catastrophic decisions to lock down this country, often on the flimsiest of evidence, for political reasons

Isabel Oakeshott

In a statement Hancock said Oakeshott's actions were a "massive betrayal and breach of trust." He said there was no public interest case for the breach, because all the material used for his book was given to the covid inquiry headed by Heather Hallett. But Oakeshott said that she released the messages to avoid a "colossal whitewash" and that the inquiry "will drag on forever."

? What did government advisers say?

The messages released so far seem to shine a good light on Whitty and Vallance. In one message Hancock even writes, "I love Chris Whitty." At times the advisers patiently explain the science of covid while at others they seem to be carrying out a maths tutorial. For example, Boris Johnson, then prime minister, said he had



? What are the key revelations so far?

Care homes

The messages show that on 14 April 2020, the day before the government's action plan on managing covid in adult social care settings was released, Chris Whitty, England's chief medical officer, told Hancock there should be "testing of all going into care homes" and "segregation whilst awaiting results."

Hancock initially said the advice "is obviously a good positive step and we must put it into the doc." However, a later message to a special adviser said, "I do not think the community commitment

adds anything and it muddies the waters." Testing was made mandatory for people entering care homes from hospital but not from the community. Guidance that tests should be carried out for everyone entering care homes was not introduced for four months.

Despite Hancock's claim he put a "protective ring around care homes," in those four months thousands of people in care homes died from covid-19.

Responding to the leaked messages, a spokesman for Hancock said the testing policy followed an operational meeting where the advice was that it was not possible to test everyone entering care homes. On 1 March Helen Whately, the social care minister, responded

to an urgent question from Labour in the Commons, saying, "Selective snippets of WhatsApp conversations give a limited and at times misleading insight."

School closures

In December 2020, as covid cases rose rapidly, Hancock sought to have schools closed for most pupils, but England's education secretary, Gavin Williamson, disagreed, the messages seem to show.

A WhatsApp exchange on 28 December between Hancock and an aide, Emma Dean, taking place at the same time as Hancock was in a video meeting with the prime minister, described Williamson as "going absolutely gangbusters" over



read in the *Financial Times* that the mortality rate for covid-19 had fallen to 0.04. “How can we possibly justify the continuing paralysis to control a disease that has a death rate of one in 2000,” he wrote on 26 August 2020. Whitty, Vallance, and the special adviser Dominic Cummings then all attempted to explain that this was the case fatality rate and that 0.04 as a probability meant 4%. The prime minister replied “Eh” and then sent another message reading “?”

? What have we learnt about how the government works?

The exchanges, amounting to 2.3 million words, show the extent of government decision making on WhatsApp. Messaging groups have names such as “Top Teams,” “covid-19 senior group,” and “crisis management”—this last one set up to

deal with the fallout of the revelation of Hancock’s relationship with his aide Gina Coladangelo in 2021.

Hancock has said the messages give just a snapshot of what was going on in government at that time and that there will also have been numerous emails, policy papers, and meetings.

However, the sheer volume of messages reveal what at times seems to be casual decision making or policy made on the basis of gut feeling. Aides and ministers often discuss what they have read that day in the media or the latest polls. The messages also reveal exchanges that are often childish, unprofessional, and insulting. For example, Hancock described the teaching unions as a “bunch of

Hancock’s messages imply he was more driven by publicity and what would make him look good

Devi Sridhar

absolute arses,” with then education secretary Gavin Williamson replying, “I know they really do just hate work.”

Devi Sridhar, Edinburgh University chair of global health, wrote in the *Guardian*, “The messages we’ve seen show there was a huge gulf between what public health experts and scientific advisers were recommending and what the UK actually did—even as ministers claimed to be ‘following the science.’” She said Hancock’s messages on care home testing “imply he was more driven by publicity and what would make him look good—the phrase ‘muddies the waters’ seems to refer to the perception of a policy, rather than how it would work.”

Azeem Majeed, professor of primary care at Imperial College London, tweeted, “Politicians and everyone else in professional roles need to be careful what they put in written messages. I work on the basis that everything I write may one day be made public, and aim to be polite and respectful in all my written communications.”

Jacqui Wise, Kent
Cite this as: *BMJ* 2023;380:p522

The **EXCHANGES**, amounting to **2.3** million words, show the extent of government decision making on WhatsApp

the issue. When it appeared that Williamson had won the argument, Hancock said “we must now fight a rear-guard action.” He contacted Dan Rosenfield, chief of staff to the prime minister Boris Johnson, to try to get schools to stay shut after the Christmas break. On 5 January, a day after some younger children had returned to classes for a day, schools were closed and did not reopen until 8 March.

Facemasks in schools

The *Daily Telegraph* said that masks were introduced in schools for the first time to avoid an argument with Scotland’s first minister, Nicola Sturgeon, over the issue. She

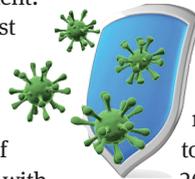
had announced the compulsory wearing of masks in corridors and communal areas in Scottish secondary schools, and Johnson asked for advice on whether they were needed in England.

The messages seem to show that Whitty was ambivalent. “No strong reason against in corridors etc, and no very strong reasons for. The downsides are in the classroom because of the potential to interfere with teaching. So agree not worth an argument.”

Speaking on BBC Radio 4’s *Today* programme last week, the children’s commissioner, Anne Longfield, said, “It was political expediency that won the argument.” She said the messages showed that schools

and children always seemed to be down the pecking order. “We got a series of pinball decisions often made on the hoof and often in contradictory ways.”

Shielding



The *Daily Telegraph* highlighted discussions on the merits of shielding that took place on 9 August 2020, a week after the government lifted national shielding guidance.

Johnson asked whether there was any merit offering over 65s a choice over whether to shield. “If you are over 65 your risk of dying from covid is probably as big as your risk of falling down stairs. And we

don’t stop older people from using stairs.” Whitty replied, “Agree this is entirely reasonable at an individual level,” adding, “Outside a situation where the NHS risks being overwhelmed it has to be a personal choice.”

Patrick Vallance, the UK chief scientific adviser, wrote, “In reality we haven’t found shielding easy or very effective first time round and I don’t think anyone else has either. It is a particular problem with multigenerational households. The challenge is how you could make all this work in practice if the disease is spreading widely amongst the younger population.”

Despite the misgivings, shielding was reintroduced during later national lockdowns.

THE BIG PICTURE

Art that shares the pain of migraine

Between 1980 and 1987 the British Migraine Association ran four art competitions to share impressions from across the world of people's experience of migraine.

Competitors were asked to express the pain created by the condition, using any material and any medium, including crayon, charcoal, oils, and watercolour. Most of the participants had no artistic background.

The competition attracted 545 unique, often striking works of art that are now being curated before being displayed by the Wellcome Collection later this year. As a prelude to a full exhibition, Wellcome has published a selection online at bit.ly/WellcomeMigraine, with notes from Rada Vlatkovic, the information officer, who explains the history of the competition and reflects on her own experience of migraine.

Alison Shepherd, *The BMJ* Cite this as: *BMJ* 2023;380:p544

1



2



3



4



1. Onset of Migraine in a Peaceful Landscape, 1987
2. Pencil outline of face with red, black and yellow visual disturbance, 1980s
3. Splitting Skull Attacked by Monsters, 1985
4. Blue Face with Red and Yellow Lightning
5. Skull with Right Eye Zigzag Aura, 1980

5



Healthy masculinities

Encouraging equality starts at school

Andrew Tate, the British-American social media personality and self-proclaimed misogynist, recently made headlines for his arrest on charges of rape and human trafficking. Alongside much global condemnation, Tate has received a massive wave of support—millions of young men and boys look up to him as a model of masculinity and a positive force for men.

Tate's rise as a major influencer across online spaces—particularly the “manosphere,” a network of communities within which male supremacist and antiwomen discourses flourish—has revived global attention for the need to engender progressive, healthy forms of masculinity, especially among young men and boys.

Masculinity related norms that define the socially accepted ways of “being a man” place value on behaviours and attitudes that are characterised by control, stoicism, emotional rigidity and inhibition, risk taking, hypersexuality, and aggression.^{1,2} Research and evidence clearly suggest that such norms have long been prevalent worldwide and that adherence is harmful for men's health and wellbeing.²⁻⁸

Young men and boys are particularly at risk, and exhibit health and service engagement profiles that differ from those of adult men and young women.⁹ As they grow from adolescence into adulthood, boys are faced with heightened pressures to prove their manhood. They are also more likely than girls to endorse inequitable gender norms such as the belief that women are primarily homemakers and men are primarily breadwinners.⁹⁻¹¹

At this stage of life, boys also begin to disengage from healthcare services and face additional barriers to care, with stigma and



DAVID BAGNALL/ALAMY

Schools provide the opportunity to engage with and garner the support of parents, staff, and alumni

shame making them reluctant to seek help, particularly for mental health problems.¹²

Gender transformative approaches

International evidence shows that approaches combining strategies at the individual, social, and structural levels are key to promoting gender equitable attitudes and behaviours during adolescence. These include group education, campaigns, and changes in institutional practices and policies to promote gender equality.²⁻¹³ Gender transformative approaches aim to examine, question, and transform unequal gender norms and their attendant behaviours and attitudes through the creation of safe spaces for critical thinking and reflection.¹⁴ This helps young men and boys to recognise and question the power and privileges afforded to them, while acknowledging and dealing with the pressures associated with masculine norms and the stigma arising from deviation from these norms. At the same time, interventions must also address the intersections of men's gender identities with other social diversities and hierarchies (such as race, class, sexual orientation) that shape the health practices of young men and boys.

Some of the most encouraging examples of transforming gender norms and practices come from interventions with adolescents in schools. At a life stage when

masculine identity is forming, schools are ideal environments for interventions promoting healthy and equitable notions of gender relations, particularly in group settings where students experience connections and imbibe social values. Small group sessions using participatory methods and incorporating media and sport are likely to improve engagement and create safe spaces for critical reflection.^{10,15} Schools also provide the opportunity to engage with and garner the support of a wider interconnected system including parents, staff, and alumni.^{2,9} Building the knowledge, capacity, and gender perspective of school staff and others engaged in delivering interventions is also critical for the efficacy and sustainability of such a programme.⁹

Given young men and boys' unique and gendered health vulnerabilities, researchers and implementers have long advocated for promoting positive conceptions of masculinity to engage men in reconstructing “healthier” definitions of manhood.³ Still, many have called into question the language of “toxic” and “healthy” masculinity as limiting or even deceptive. They continue to position men as victims of a broader vague and predisposed entity, rather than highlighting their agency in shaping masculinity.¹⁶ Additionally, reconstructing “healthy” traits into a new type of masculinity reinforces masculinity as the only expression of gender available to men and boys, devaluing femininity (and androgyny) as well as other forms of female and non-binary masculinities.¹⁶ In the long term, gender and health interventions must engage with masculinity as a relational, contested, and changeable concept and engage with men's agency and power for transformation.

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WHO keeps covid-19 a public health emergency

A sensible decision—the defining criteria still apply

On 30 January the director general of the World Health Organization, Tedros Adhanom Ghebreyesus, announced his decision that covid-19 remains a public health emergency of international concern (PHEIC),¹ three years after the emergency was first declared.² In doing so, Tedros acknowledged the advice of the covid-19 emergency committee that “the covid-19 pandemic is probably at a transition point.” There is considerable speculation about when the PHEIC will be terminated.³

PHEICs are events that are deemed to be extraordinary, constitute a public health risk to other states through international spread of disease, and potentially require a coordinated international response.⁴

PHEICs are the highest and only alarm under the International Health Regulations.⁵ Whether they function effectively as such an alarm remains debatable.⁶ They also activate certain powers, including the ability of the WHO director general to issue “temporary recommendations.”

While not legally binding, temporary recommendations are intended to guide state practice—both in measures that should be taken and in measures that should not be exceeded without adequate justification, particularly restrictions on international travel and trade.

Continuing risk

The director general’s recent determination that covid-19 still meets the PHEIC criteria is correct. Globally, SARS-CoV-2 remains an “extraordinary” risk to health based on reported rates of infection and disease.⁷ Moreover, transmission from humans to multiple mammalian species



DENIS BALIBOUSE/REUTERS/ALAMY STOCK PHOTO

It remains highly likely that variants of concern will emerge that are more transmissible, more pathogenic

has been observed with minimal adaptation,⁸ and the size of these reservoirs is unknown. Against this backdrop, it remains highly likely that variants of concern will emerge that are more transmissible, more pathogenic, or otherwise able to evade public health and medical countermeasures.⁹

Determining the risk of variants to settings other than their source requires efforts to understand transmission and pathogenicity in populations with different infection and vaccination histories.¹¹ Global vaccine inequity contributes to ongoing disparity of health outcomes¹² and perpetuates the risk of further variants of concern.¹³ Understanding of the effectiveness of covid-19 vaccines against transmission and severity of disease has shifted substantially over the past two years, but longer term data are needed to help assess the likely effect of new variants in different countries and to inform immunisation programmes to support resilience.¹⁴

Finally, a coordinated international response clearly remains essential to identify and mitigate ongoing risks from covid-19 and to support effective, evidence based communication. Development of improved countermeasures¹⁶ agnostic to variant characteristics remains an important, internationally shared research and development priority.

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These ongoing risks and uncertainties are challenging for decision making. The WHO emergency committee and the director general are clearly grappling with the potential risks of terminating the PHEIC designation and aiming for a careful transition when the time comes.¹ These deliberations are occurring in parallel with substantial changes to global emergency governance arrangements. WHO member states are negotiating amendments to the International Health Regulations as well as a new legally binding agreement (most likely a treaty) on pandemic prevention, preparedness, and response.¹⁷

Proposals include the possibility of issuing intermediate public health alerts (short of PHEICs) and determining public health emergencies of regional concern.¹⁸ Notably, although covid-19 is routinely referred to as a pandemic, this word is not used in the International Health Regulations.

The first draft of the pandemic treaty contemplates a much broader agreement than the current International Health Regulations, including integrated human and animal surveillance systems for pathogens and variants with pandemic potential and equitable access to diagnostics, therapeutics, and vaccines.¹⁹ The definition of “pandemic” in the treaty, and the declaration or termination of such an event, will have far wider ramifications than those related to a PHEIC.

It remains to be seen whether member states will be prepared to give WHO’s director general the authority to determine and terminate future pandemic events, and, if so, the criteria they will set for such decisions.

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Gender dysphoria in young people is rising—and so is professional disagreement

More children and adolescents are identifying as transgender and are being offered medical treatment, especially in the US—but some providers and European authorities are urging caution because of a lack of strong evidence. **Jennifer Block** reports

Last October the American Academy of Pediatrics (AAP) gathered inside the Anaheim Convention Center in California for its annual conference. Outside, several dozen people rallied to hear speakers including Abigail Martinez, a mother whose child began hormone treatment at age 16 and died by suicide at age 19. Supporters chanted the teen’s given name, Yaeli; counter protesters chanted, “Protect trans youth!” For viewers on a livestream, the feed was interrupted as the two groups fought for the camera.

The AAP conference is one of many flashpoints in the contentious debate in the US over if, when, and how children and adolescents with gender dysphoria should be medically or surgically treated.

US medical professional groups are aligned in support of “gender affirming care” for gender dysphoria, which may include gonadotrophin releasing hormone analogues (GnRHa) to suppress puberty; oestrogen or testosterone to promote secondary sex characteristics; and surgical removal or augmentation of breasts, genitals, or other physical features. At the same time, however, several European countries have issued guidance to limit medical intervention in minors, prioritising psychological care.

The discourse is polarised in the US. Conservative politicians, pundits, and social media influencers accuse providers of pushing “gender ideology” and even “child abuse,” lobbying for laws banning medical

transition for minors. Progressives argue that denying access to care is a transphobic violation of human rights. There’s little dispute within the medical community that children in distress need care, but concerns about the rapid widespread adoption of interventions and calls for rigorous scientific review are coming from across the ideological spectrum.

The surge in treatment of minors

More adolescents with no history of gender dysphoria—predominantly birth registered females—are presenting at gender clinics. A recent analysis of insurance claims by Komodo Health found that nearly 18 000 US minors began taking puberty blockers or hormones from 2017 to 2021, the number rising each year. Surveys aiming to measure prevalence have found that about 2% of high school aged teens identify as “transgender.”

These young people are also more likely than their cisgender peers to have concurrent mental health and neurodiverse conditions including depression, anxiety, attention deficit disorders, and autism. In the US, although Medicaid coverage varies by state and by treatment, the Biden administration has warned

A recent analysis found that nearly 18 000 US minors began taking puberty blockers or hormones from 2017 to 2021



states that not covering care is in violation of federal law prohibiting discrimination. Meanwhile, the number of private clinics that focus on providing hormones and surgeries has grown from just a few a decade ago to more than 100 today.

As the number of young people receiving medical transition treatments rises, so have the voices of those who call themselves “detransitioners” or “retransitioners,” some of whom claim that early treatment caused preventable harm. Large scale, long term research is lacking, and researchers disagree about how to measure the phenomenon, but two recent studies suggest that as many as 20-30% of patients may discontinue hormone treatment within a few years. The World Professional Association for Transgender Health (WPATH) asserts that detransition is “rare.”

Same evidence, divergent recommendations

Three organisations have had a major role in shaping the US’s approach to gender dysphoria care: WPATH, the AAP, and the Endocrine Society. On 15 September 2022 WPATH published the eighth edition of its Standards of Care for the Health of Transgender and Gender Diverse People, with new chapters on children and adolescents and no minimum age requirements for hormonal and surgical treatments. GnRHa treatment, says WPATH, can be initiated to arrest puberty at its earliest stage, known as Tanner stage 2.



Protesters, from both sides of the debate, gather outside the American Academy of Pediatrics' annual conference in Anaheim, California last October

The Endocrine Society also supports hormonal and surgical intervention in adolescents who meet criteria in clinical practice guidelines published in 2009 and updated in 2017. And the AAP's 2018 policy statement says that "various interventions may be considered to better align" a young person's "gender expression with their underlying identity." Among the components of "gender affirmation" the AAP names social transition, puberty blockers, sex hormones, and surgeries. Other prominent professional organisations, such as the American Medical Association, have issued policy statements in opposition to legislation that would curtail access to medical treatment for minors.

These documents are often cited to suggest that medical treatment is both uncontroversial and backed by rigorous science. "All of those medical societies find such care to be evidence-based and medically necessary," stated a recent article on transgender healthcare for children published in *Scientific American*.

Two physicians and an attorney from Yale recently opined in the *Los Angeles Times* that "gender-affirming care is standard medical care, supported by major medical

organizations . . . Years of study and scientific scrutiny have established safe, evidence-based guidelines for delivery of lifesaving, gender-affirming care." Rachel Levine, the US assistant secretary for health, told National Public Radio last year regarding such treatment, "There is no argument among medical professionals."

Internationally, however, governing bodies have come to different conclusions. Sweden's National Board of Health and Welfare, which sets guidelines for care, determined last year that the risks of puberty blockers and treatment with hormones "currently outweigh the possible benefits" for minors. Finland's Council for Choices in Health Care issued similar guidelines, calling for psychosocial support as first line treatment. (Both countries restrict surgery to adults.)

Medical societies in France, Australia, and New Zealand have also leant away from early medicalisation. And NHS England, which is in the midst of an independent review of gender identity services, recently said that there was "scarce and inconclusive evidence to support clinical decision making" for minors with gender dysphoria and that for most who present before puberty it will be a "transient phase," requiring clinicians to focus on psychological support and to be "mindful" even of the risks of social transition.

"Don't call them evidence based"

"The brief history of guidelines is that, going back more than 30 years ago, experts would write articles and so on about what people should do. But formal guidelines as we think of them now were seldom or non-existent," says Gordon Guyatt, distinguished professor in the Department of Health Research Methods, Evidence, and Impact at McMaster University, Ontario.

That led to the movement towards developing criteria for what makes a "trustworthy guideline," of which Guyatt was a part. One pillar of this, he told *The BMJ*, is that they "are based on systematic review of the relevant evidence," for which there are also now standards, as opposed to a traditional narrative literature review in which "a bunch of experts write whatever they felt like using no particular standards and no particular structure."

Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University, says, "An evidence based recommendation requires two steps." First, "an unbiased, thorough, critical systematic review of all the relevant evidence." Second, "some commitment to link the strength of the recommendations to the quality of the evidence."

The Endocrine Society commissioned two systematic reviews for its clinical practice guideline, *Endocrine Treatment*



There is no argument among medical professionals
Rachel Levine



Gordon Guyatt: Found "serious problems" with the Endocrine Society guidelines

Medical societies in France, Australia, and New Zealand have leant away from early medicalisation

of Gender-Dysphoric/Gender-Incongruent Persons: one on the effects of sex steroids on lipids and cardiovascular outcomes, the other on their effects on bone health. To indicate the quality of evidence underpinning its various guidelines, the Endocrine Society employed the GRADE system (grading of recommendations assessment, development, and evaluation) and judged the quality of evidence for all recommendations on adolescents as “low” or “very low.”

Guyatt, who co-developed GRADE, found “serious problems” with the Endocrine Society guidelines, noting that the systematic reviews didn’t look at the effect of the interventions on gender dysphoria itself, arguably “the most important outcome.” He also noted that the Endocrine Society had at times paired strong recommendations—phrased as “we recommend”—with weak evidence. In the adolescent section, the weaker phrasing “we suggest” is used for pubertal hormone suppression when children “first exhibit physical changes of puberty”; however, the stronger phrasing is used to “recommend” GnRHa treatment.

“GRADE discourages strong recommendations with low or very low quality evidence except under very specific circumstances,” Guyatt told *The BMJ*. Those exceptions are “very few and far between,” and when used in guidance, their rationale should be made explicit, Guyatt said. In an emailed response, the Endocrine Society referenced the GRADE system’s five exceptions, but did not specify which it was applying.

Helfand examined the recently updated WPATH Standards of Care and noted that it “incorporated elements of an evidence based guideline.” For one, WPATH commissioned a team at Johns Hopkins University in Maryland to conduct systematic reviews. However, WPATH’s recommendations lack a grading system to indicate the quality of the evidence—one of several deficiencies. Both Guyatt and Helfand noted that a trustworthy guideline would be transparent about all commissioned systematic reviews: how many were done and



Endocrine Society judged the quality of evidence for all recommendations on adolescents as low or very low

what the results were. But Helfand remarked that neither was made clear in the WPATH guidelines and also noted several instances in which the strength of evidence presented to justify a recommendation was “at odds with what their own systematic reviewers found.”

For example, one of the commissioned systematic reviews found that the strength of evidence for the conclusions that hormonal treatment “may improve” quality of life, depression, and anxiety among transgender people was “low,” and it emphasised the need for more research, “especially among adolescents.” The reviewers also concluded that “it was impossible to draw conclusions about the effects of hormone therapy” on death by suicide.

Despite this, WPATH recommends that young people have access to treatments after comprehensive assessment, stating that the “emerging evidence base indicates a general improvement in the lives of transgender adolescents.”

Yet WPATH contends that the evidence is so limited that “a systematic review regarding outcomes of treatment in adolescents is not possible.” But Guyatt counters that “systematic reviews are always possible,” even if few or no studies

meet the eligibility criteria. If an entity has made a recommendation without one, he says, “they’d be violating standards of trustworthy guidelines.” Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and lead author of the AAP’s statement, says that the AAP’s process “doesn’t quite fit the definition of systematic review, but it is very comprehensive.”

Sweden conducted systematic reviews in 2015 and 2022 and found the evidence on hormonal treatment in adolescents “insufficient and inconclusive.” Its new guidelines note the importance of factoring the possibility that young people will detransition, in which case “gender confirming treatment thus may lead to a deteriorating of health and quality of life (i.e., harm).”

Calling a treatment recommendation “evidence based” should mean that a treatment has not just been systematically studied, says Helfand, but that there was also a finding of high quality evidence supporting its use. Weak evidence “doesn’t just mean something esoteric about study design, it means there’s uncertainty about whether the long term benefits outweigh the harms,” Helfand adds.

“Evidence itself never tells you what to do,” says Guyatt. That’s why guidelines must make explicit the values and preferences that underlie the recommendation.

The Endocrine Society acknowledges in its recommendations on early puberty suppression that it is placing “a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm.”

WPATH acknowledges that, while its latest guidelines are “based upon a more rigorous and methodological evidence-based approach than previous versions,” the evidence “is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion.” In the absence of high quality evidence



Weak evidence means there’s uncertainty about whether the long term benefits outweigh the harms
Mark Helfand

Sweden conducted systematic reviews in 2015 and 2022 and found the evidence on hormonal treatment in adolescents insufficient and inconclusive

and the presence of a patient population in need—who are willing to take on more personal risk—consensus based guidelines are not unwarranted, says Helfand. “But don’t call them evidence based.”

An evidence base under construction

In 2015 the US National Institutes of Health awarded a \$5.7m (£4.7m) grant to study “the impact of early medical treatment in transgender youth.” The abstract submitted by applicants said that the study was “the first in the US to evaluate longitudinal outcomes of medical treatment for transgender youth and will provide essential evidence-based data on the physiological and psychosocial effects and safety” of current treatments. Researchers are following two groups, one of participants who began receiving GnRHa in early puberty and another group who began cross sex hormone treatment in adolescence. The study doesn’t include a concurrent no-treatment control group.

Robert Garofalo, chief of adolescent medicine at the Lurie Children’s Hospital in Chicago and one of four principal investigators, told a podcast interviewer in May 2022 that the evidence base remained “a challenge . . . it is a discipline where the evidence base is now being assembled” and that “it’s truly lagging behind [clinical practice], I think, in some ways.”

That care, he explained, was “being done safely. But only now, I think, are we really beginning to do the type of research where we’re looking at short, medium, and long term outcomes of the care that we are providing in a way that I think hopefully will be either reassuring to institutions and families and patients or also will shed a light on things that we can be doing better.”

While Garofalo was doing the research he served as “contributor” on the AAP’s widely cited 2018 policy statement, which recommends that children and

adolescents “have access to comprehensive, gender-affirming, and developmentally appropriate health care,” including puberty blockers, sex hormones, and, on a case-by-case basis, surgeries.

Garofalo said in the May interview, “There is universal support for gender affirming care from every mainstream US based medical society that I can think of: the AMA, the APA, the AAP. I mean, these organisations never agree with one another.” Garofalo declined an interview and did not respond to *The BMJ*’s requests for comment.

The rush to affirm

Sarah Palmer, a paediatrician in private practice in Indiana, is one of five coauthors of a 2022 resolution submitted to the AAP’s leadership conference asking that it revisit the policy after “a rigorous systematic review of available evidence regarding the safety, efficacy, and risks of childhood social transition, puberty blockers, cross sex hormones and surgery.”

In practice, Palmer told *The BMJ*, clinicians define “gender affirming” care so broadly that “it’s been taken by many people to mean go ahead and do anything that affirms. One of the main things I’ve seen it used for is masculinising chest surgery, also known as mastectomy in teenage patients.”

The AAP has told *The BMJ* that all policy statements are reviewed after five years and so a “revision is under way,” based on its experts’ own “robust evidence review.”

Palmer says, “I’ve seen a quick evolution, from kids with a very rare case of gender dysphoria who

were treated with a long course of counselling and exploration before hormones were started,” to treatment progressing “very quickly—even at the first visit to gender clinic—and there’s no psychologist involved any more.”

Laura Edwards-Leeper, a clinical psychologist who worked with the endocrinologist Norman Spack in Boston and coauthored the WPATH guidelines for adolescents, has observed a similar trend. “More providers do not value the mental health component,” she says, so in some clinics families come in and their child is “pretty much fast tracked to medical intervention.” In a study of teens at Seattle Children’s Hospital’s gender clinic, two thirds were taking hormones within 12 months of the initial visit.

The British paediatrician Hilary Cass, in her interim report of a UK review into services for young people with gender identity issues, noted that some NHS staff reported feeling “under pressure to adopt an unquestioning affirmative approach.”

Eli Coleman, lead author of WPATH’s Standards of Care and former director of the Institute for Sexual and Gender Health at the University of Minnesota, told *The BMJ* that the new guidelines emphasised “careful assessment prior to any of these interventions” by clinicians who have appropriate training and competence to assure that minors have “the emotional and cognitive maturity to understand the risks and benefits.” He adds, “What we know and what we don’t know has to be explained to youth and their parents or caregivers in a balanced way.”

Joshua Safer, director of the Center for Transgender Medicine and Surgery at Mount Sinai Hospital in New York and coauthor of the Endocrine Society guidelines, told *The BMJ* that assessment is standard practice at the programme he leads.

“We start with a mental health evaluation for anybody under the age of 18,” he says. “There’s a lot of talking going on—that’s a substantial element of things.”



More providers do not value the mental health component
Laura Edwards-Leeper



What we know and what we don’t know has to be explained in a balanced way
Eli Coleman



AAP’s process doesn’t quite fit the definition of systematic review, but it is very comprehensive
Jason Rafferty



Gender affirming care is defined so broadly some take it to mean do anything that affirms
Sarah Palmer



The majority of kids who get into these programmes go on to other interventions

Joshua Safer

Safer has heard stories of adolescents leaving a first or second appointment with a prescription in hand but says that these are overblown. “We really do screen these kids pretty well, and the overwhelming majority of kids who get into these programmes do go on to other interventions,” he says.

Without an objective diagnostic test, however, others remain concerned. The demand for services has led to a “perfunctory informed consent process,” wrote two clinicians and a researcher in a recent issue of the *Journal of Sex and Marital Therapy*, in spite of two key uncertainties: the long term impacts of treatment and whether a young person will persist in their gender identity.

And the widespread impression of medical consensus doesn’t help. “Unfortunately, gender specialists are frequently unfamiliar with, or discount the significance of, the research in support of these two concepts,” they wrote. “As a result, the informed consent process rarely adequately discloses this information to patients and their families.”

For Guyatt, claims of certainty represent both the success and failure of the evidence based medicine movement. “Everybody now has to claim to be evidence based” in order to be taken seriously, he says—that’s the success. But people “don’t particularly adhere to the standard of what is evidence based medicine—that’s the failure.” When there’s been a rigorous systematic review of the evidence and the bottom line is that “we don’t know,” he says, then “anybody who then claims they do know is not being evidence based.”

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In the UK, services are paused as evidence comes under scrutiny

The care provided to young people with gender incongruence or gender related stress by the NHS is in limbo.

Last July NHS England announced its intention to close its only specialist youth gender clinic by this spring and replace it with two regional services, the first of several. But this timeline looks highly unlikely.

Families under the care of the Gender Identity Development Service (GIDS) at London’s Tavistock and Portman NHS Foundation Trust say clinicians have been leaving the service, making consistency of care difficult. Current GIDS staff said in February that the trust had not received the six month notice of closure from NHS England.

The decision to close GIDS and build a new model of care followed the interim findings of an independent review, chaired by the paediatrician Hilary Cass, and a critical report from England’s healthcare regulator the Care Quality Commission, which rated the service “inadequate” in January 2021.

Both of those reports came after GIDS staff had raised concerns about the safety of the care being provided. Together with Deborah Cohen, former *BMJ* investigations editor and BBC Newsnight colleague, I began reporting on these in 2019. My new book, *Time to Think*, chronicles how many GIDS clinicians voiced their worries repeatedly over several years. Clinicians such as Anna Hutchinson shared them with the GIDS leadership, the Tavistock board, the chief executive and chair, and finally the media.

GIDS was set up initially to provide—for the most part—talking therapies to young people who were questioning their gender identity. In the 1990s the clinic’s founder, the psychiatrist Domenico Di Ceglie, said that only a minority of the young people seen at his clinic would transition as adults. For

those whose trans identification remained and who were 16 or older, gonadotrophin releasing hormone analogues (GnRHa)—often referred to as puberty blockers—could be prescribed by endocrinologists who were linked to the service.

In 2011 GIDS, together with endocrinologists at University College London Hospitals NHS Foundation Trust, agreed to lower the age at which young people could access GnRHa as part of a research study. Promising data had emerged from the Netherlands showing that for a select group of young people earlier blocking of puberty appeared to be beneficial. But these were early and limited data, so the UK team set out to find out more.

Ahead of the study data being ready, puberty blockers became available from mid-2014 for anyone who was eligible as standard clinical practice at GIDS. The service also moved from an “age” to a “stage” approach, whereby medical interventions would be dictated by a child’s stage of puberty, not their age. There were no robust data, and no formal evaluation of the study was presented to NHS England. It allowed the move to go ahead anyway.

This coincided with a radical shift in referrals—not just in absolute numbers, which rose at a rate of 50% a year from 2009 (and doubled in 2015),

but in the underlying demographic of patients: from largely prepubescent boys to mostly adolescent girls, who were often contending with other difficulties.

Some GIDS staff began to worry. The service, they believed, did not adequately consider the evidence base underpinning the medical treatment of young people—the so called Dutch protocol. Not only was it limited in and of itself but it applied to a different group of young people from those largely seeking the help of GIDS.

GIDS’s users were not the young people with lifelong gender congruence and supportive living environments that the protocol was designed for. Rather, they were often teenage girls whose gender related distress had begun in adolescence and who were often experiencing other complex difficulties. They needed more time than the GIDS assessment model could offer them, especially as the number of referrals rocketed.

The Cass review’s interim findings, published in February 2022, noted that a single clinic could not provide care to an entire nation’s young people. Cass identified that “different subgroups may have quite different needs and outcomes,” hormone treatment being just one. She wrote that “there were different views held within the staff group about the appropriate clinical approach” and that the work was not underpinned by a robust evidence base.

Cass’s final report is expected later this year, but in the meantime the waiting list grows ever longer. In July 2022 it stood at more than 7500 young people, many of them waiting for years to be seen, often without any help in the interim.

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Many GIDS clinicians voiced their worries repeatedly for years

