

## Misleading information in Dr de Bres' article on 19 April

A Spinoff article “[What access to puberty blockers means for trans young people and their whānau](#)” by Julia de Bres, published on 20 April contains errors of fact that should be corrected. The article is not described as an opinion piece. There is also a failure in the Spinoff to provide balance over time. Dr de Bres cited the Cass report recently released in the UK.

As noted in our other email exchange, the opinion label was added shortly after publishing but dropped off after a minor spelling correction was made later that day. This was a genuine technical error and was not noticed until the complainant's email was received. After responding and checking again, the opinion tag was re-added.

My complaint is made against the Spinoff in respect of the Media Council principles. These are

- 1 Accuracy, Fairness and Balance
- 4 Comment and Fact
- 10 Conflicts of interest

### Principle 4 Comment and Fact

The problems I identify are as follows.

1. Dr de Bres wrote “Community concerns are based on the report's approach to evidence, **for example dismissing almost 100 studies because they were not randomised** controlled trials, even though such trials would be *unethical* in this field.”

This assessment is not true. See The Times [I can't travel on public transport anymore](#) (archived here <https://archive.ph/m1mfc>) and the BBC's More or less Programme ([More or less](#)). 60 out of 103 studies were rated high or medium quality and included in the results synthesis. 43 studies were dismissed but not because they were not RCT, because they were unreliable and it would be unscientific to base an overall evidence assessment on studies that are likely to be biased. In the BBC interview Dr Cass states that “This particular

body of evidence is uniquely poor compared to almost any other body of evidence that the University of York has looked at”.

In writing this piece, the author explicitly chose to portray the perspectives of young trans people and their parents, which had been missing from discussion in the media. The mention of “community concerns” is accurate, as those concerns have been reported on elsewhere.

The author's aim when writing the piece was not to debate every detail of the Cass Report but to share experiences of trans whānau with puberty blockers. The concerns were included from trans organisations to give context.

The key point was that rainbow organisations have roundly criticised the report (linking to PATHA statement, and there are many other egs, e.g. from InsideOUT, trans orgs in Australia and the UK...)

Regarding the bolded sentence about the dismissing of 100 studies, this point – and the report's methods in general – have been disputed internationally.

The number has been linked to an article regarding the review by British Medical Journal. (<https://www.bmj.com/company/newsroom/evidence-for-puberty-blockers-and-hormone-treat>

ment-for-gender-transition-wholly-inadequate/) where it reads "of the 50 [...] only one was of

high quality" and "of the 53 [...] only 1 was sufficiently high quality, with little or only inconsistent evidence on key outcomes, such as body satisfaction, psychosocial and cognitive outcomes, fertility, bone health and cardiometabolic effects." This framing – in a journal article that includes quotes from Dr Cass – suggests the studies findings were not considered "sufficient" in the review. This is what the author (and others) are referring to when they say that studies were dismissed.

In certain areas of medicine, such as Paediatrics and Child and Adolescent Psychiatry, it is

common for routinely used medications to lack "high" quality evidence. For example, the 2018 NICE ADHD Guidelines recommend Methylphenidate (aka Ritalin) as first-line treatment for young people with ADHD despite no relevant studies being rated as "high" quality (all are moderate, low, or very low). This medication is recommended firstline in clinical guidance worldwide, inclusive of New Zealand and Australia.

The PROSPERO record for the Cass Evidence reviews shows that the review diverted from their original protocols. They had originally stated their intention to use the NMAT to assess

quality of evidence, but later seem to have switched to using the NOS instead. There is no rationale given for this, but given the review protocol was updated during the review process

and this was not changed, it is evident that this was done late into the process. This is

deviation from systematic review protocol and - in the absence of explanation - may indicate bias.

Critically, the difference between the NMAT and the NOS is that guidance around the use of

the NMAT recommends that no studies are excluded from consideration regardless of the strength they are graded due to the subjective nature of evidence grading and the bias which

can arise as a result. There have been some concerns - particularly given the late timing of

the change of tool and the lack of explanation for this - this represents a way in which evidence was included in order for the review to be more in keeping with a desired conclusion.

The concern about dismissed studies due to not being "high quality" is what was being expressed by the author, and is a valid concern when viewed in the context of other reviews

of other medications and the weighting placed on "high quality" studies (which is a lower threshold than was applied in the Cass Review in regards to puberty blockers).

Again the whole report's approach to evidence is highly disputed and assessing each detail

of the report was not the point of this particular article.

2. Dr de Bres starts her article quoting PATHA's *Briefing to the incoming minister* to say that "people's autonomy over their own bodies" is mandated by a Māori health framework *Te Pae Mahutonga* devised by Professor Sir Mason Durie.

This is false. Dr Durie describes autonomy in the context of health promotion initiatives directed at *Māori communities*, not individual's rights to determine their own health pathways. This is a flagrant misuse of a Māori health framework to make the case for a low

bar to informed consent for gender medicine.

*Te Pae Mahutonga*, as a health framework, is not applicable only to Māori communities.

This is a concerning approach to viewing *mātauranga Māori*. *Te Pae Mahutonga* is used in PATHA's framing of trans healthcare, and it is the framework used by Gender Minorities

Aotearoa to frame their entire approach to their work: 'We operate within the kaupapa Māori public health framework Te Pae Māhutonga, and The Ottawa Charter (1986). Our aim is to facilitate health and well-being for transgender populations, as defined by The World Health Organisation. This includes complete physical, mental, emotional, spiritual, and social well-being.' This framework is totally relevant to this topic.

2. Dr de Bres stated "another fundamental concern is the lack of inclusion of any trans people or clinicians with expertise in gender-affirming care in the final decision-making related to the review."

This is false. On page 75 of the Cass Report there is a description of the NHS England Policy Working group chaired by Dr Cass. The groups includes "2 senior members of the [Gender Identity Development Service] team" and "3 representatives with lived experience". Also p. 62 states that "*A Clinical Expert Group was established to consider the strength of the evidence and findings from the Review's research programme, and assist the Review in achieving clinical consensus where evidence is not available or limited. Membership included **clinical experts on children and adolescents in relation to gender, development, physical and mental health, safeguarding and endocrinology.***

While she consulted with trans people and clinicians, ie spoke to them, they were not involved in the recommendations specifically. The report doesn't list membership of this group, nor lay out what its role was beyond "consider the strengths and evidence of the findings... and achieve clinical consensus where evidence is not available or limited".

Neither

of these are "final decision-making relating to the review".

The PWG who are named on page 75 appear to have defined the PICO (the Population being treated, the Intervention, a Comparator treatment, and the intended Outcomes) but the review was actually carried out by the NICE National Institute for Health and Care Excellence

3. Dr de Bres states that when puberty blockers are stopped puberty starts again.

This is not true. Puberty is one of a number of critical windows in human development. If

brain development is left without the correct input or stimulation during puberty, the functions

served will be [permanently compromised](#). Recent evidence also shows that in males pubertal suppression causes an [inability to orgasm](#). PATHA's own information shows that there are negative effects on the pubertal increase in [bone density and penises remain small](#)

if puberty is fully suppressed. A recent paper awaiting peer-review argues there are serious

[effects on male sexual development](#),.

The concerns listed here do not dispute that *puberty starts again*. There are known effects of

puberty blockers, which are discussed with parents and those taking them before prescribing. None of those effects are that puberty is permanently stopped.

4. Dr de Bres wrote that puberty blockers provide 'Time to Reflect'

This is not true. The Cass report says "*these data suggest that puberty blockers are not buying time to think, given that the vast majority of those who start puberty suppression continue to masculinising/feminising hormones, particularly if they start earlier in puberty*".

More over the report said "*Prior to the introduction of puberty blockers, the clinical experience of [sex confused children] suggested that although in the vast majority the gender incongruence resolved by puberty*" See [Cass report page 176](#) and the recent paper on the impacts of suppressing puberty by [Baxendale](#).

There are two possible interpretations of the finding that the majority of young people who take puberty blockers go on to take masculinising/feminising hormones.

- 1) They are trans and they have decided they want to continue their medical transition
- 2) They are somehow locked into this path by taking puberty blockers.

Anti-trans groups prefer the latter interpretation, but the first is equally likely at face value.

Given that people who choose to take puberty blockers are much more likely to be trans than not, and no one is forcing these young people to take hormones – it remains their choice – the former would be the more likely reason.

Moreover, this interpretation is supported by the stories of young people and parents. The

author presented a selection of lived experiences in their piece to illustrate this. Other stories

in the info sheets linked in the piece refer to young people who chose to come off blockers and not proceed to hormones - they too said they appreciated the time to reflect.

Additionally the Cass report shows all kinds of claims are made for the reason puberty blockers are deployed. *“The synthesis of international guidelines by the University of York found that there is no clarity about the treatment aims of puberty suppression, with options*

*including reducing gender dysphoria, improving quality of life, allowing time to make decisions, supporting gender exploration, extending the diagnostic phase and ‘passing’ better in adult life. Cass report page 174*

A variety of aims does not lessen their validity. The author reiterates that it is great that puberty blockers have so many benefits for those who need them - as shown in their article.

5. Dr de Bres writes that the Cass review finds that *“there is less evidence of harm from blockers than benefit”*.

This claim does not appear to have been made in these terms in either the Cass Report itself nor in the systematic review *“Interventions to suppress puberty”*. Even if some wording in the report has led Dr de Bres to report this as her assessment in the context of

the whole report it is a highly misleading claim. In the BBC programme *More or Less* Dr Cass said “this particular body of evidence is uniquely poor compared with any other body of

evidence the University of York has looked at.” (*More or less at 5.30*) The report itself said

● in relation to medical treatment *“clinicians who the Review has spoken to nationally and internationally have stated that they are unable to reliably predict which children/young people will transition successfully and which might regret or detransition at a later date”*

Not evidence of harm, just something some doctors have said. Unsurprising that doctors can't ‘predict’ who is trans. Even if we were to accept that regret about treatment is a harm, the review found less than 10 of over 3,000 people detransitioned, finding that this type of harm is incredibly rare.

● *There is insufficient and/or inconsistent evidence about the effects of puberty*

*suppression on psychological or psychosocial health.”*

This is not evidence of harm

● *“Only very modest and inconsistent results were seen in relation to improvements in mental health [and] there is a lack of long-term outcome data for children and young people in adult life.”*

This suggest a weak evidence of benefit, not evidence of harm

● *“Blocking the release of … sex hormones could have a range of unintended and as yet unidentified consequences.”*

This is speculation, not evidence of harm

● *“Brain maturation may be temporarily or permanently disrupted by the use of puberty blockers, which could have a significant impact on the young person’s ability to make complex risk-laden decisions.”*

This is speculation, not evidence of harm

● *“The University of York systematic review found no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes, which without a control group could be due to placebo effect or concomitant psychological support.” Cass report page 172-180*

That is not what the systematic review says:

*“Three studies assessed internalising and externalising symptoms with one reporting improvements in both (pre-post24), one improvement in internalising but not externalising symptoms when compared with adolescents under assessment by a gender service (cross-sectional37)”*

*“For those receiving GnRH-a, further improvements were observed at 12 and 18 months. At 18 months, psychosocial functioning in this group was considerably higher than in those still waiting for puberty suppression, and similar to adolescents not experiencing gender dysphoria/incongruence. However, there were considerably fewer participants included at final follow-up.”*

6. Dr de Bres says *“Parents, clinicians and researchers would all welcome more research into the effects of puberty blockers, to continue to identify and deliver best practice care.”* This claim ignores facts which cast doubt on whether gender clinicians and researchers both in the UK and in New Zealand are really interested in understanding more about puberty blockers and their harms and benefits.

This is nothing here to respond to as it is simply a disagreement.

In England the opportunity to carry out research to understand that longer term trajectories

of children at the GIDS clinic was not taken by clinicians. The CASS report says that “*six of*

*the seven adult clinics declined to support the study*” See Cass Report Appendix 4 page 6)

This is because doing so would mean breaking the law - they were asked to share info without patient consent or knowledge and rightfully declined

In New Zealand the very people (like Dr de Bres) who opine the lack of research are the very

same people who have money for transgender research but do not carry out this research.

Dr de Bres argues strongly for medicines that she argues are life-saving and entirely positive in use. She does not seek to assure they are safe.

● Dr Bres’ own research promotes the use of [puberty blockers](#) while not drawing attention to the older evidence based reviews, like the Cass report, that argue for caution. Dr de Bres’ current project [advocates the use of puberty blockers](#) based on low quality studies [many of which have strong rebuttals](#).

The author was not promoting or advocating for the use of blockers, she was sharing lived experience. She was definitely promoting/advocating for the right of people to make their own decisions about accessing gender-affirming care rather than having others restrict them

● In her research with a parents group she reports “no-one in the group reported a negative experience with blockers” but since the group champions transition this is not unexpected.

The group not does 'champion transition'. The group supports parents to support their kids. As noted in the piece, the group includes families whose kids have taken blockers, have chosen not to, or did not have the opportunity.

● The Transgender Health Lab, a long established specialist team at Waikato University — is focussed on [barriers to healthcare](#), not whether the healthcare is effective. It does not appear to have produced research about any aspect of puberty blocker medication in any of the more than 100 papers that have been published giving the impression that, as far as they are concerned, that the science is settled.

There is nothing to respond to here as it is outside of the scope of the article.



● Similarly at Otago University Medical School Dr Sue Bagshaw [suggests there is a lack of research](#) but her only contribution to this lack was to fund a 12 week summer scholar who identified the very real ethical issues to providing puberty blockers.

[See above.](#)

● PATHA has, rather than examining the Cass Report to identify whether there are lessons for New Zealand's practice, [denounced the report as harmful](#) within 30 hours of its publication. They said it did not apply to New Zealand.

[PATHA did read the report in detail, but yes they, like many others, recognised its harm and do not consider it to apply to the different healthcare context in NZ](#)

### **Media Council Principle 10 Conflicts of interest**

Finally Dr de Bres does not declare her own interests in this issue. The information sheets she advises are used are a project she is closely associated with, she has received funding to do the research she cites, she is a participant in the group of parents of transgender children whose interviews she cites and is an advocate in that group for transitioning, rather than caution. ( [REDACTED]

[redacted – personal information from the publisher](#)). [Nor do we believe her participating in the group of parents required disclosure as it was immaterial to the experiences presented.](#)

[Yes she has an interest in this issue, that's why she wrote about it.](#)

[That interest is not a conflict.](#)

[I don't see "The author has no lived experience in this space, nor have they published any research on the topic" disclosures under your own articles for other media outlets, so not sure why this is the expected standard. And again, the author is not an "advocate" for transitioning and both her and I find that repeated claim to be quite offensive and diminishing.](#)

### **Media Council Principle 1 Accuracy, Fairness and Balance**

This article is part of a series of one-sided articles about gender theory and transgender issues.

In relation to a previous story editor Madeleine Chapman wrote of the need for balance as follows. *'So I'll reiterate that The Spinoff's editorial position is for equity over equality on matters relating to trans people and non-binary people (as well as other often marginalised groups such as Māori, Pacific, disabled etc).*

*In regards to trans people specifically and this complaint, it is therefore our default editorial*

*position that trans-inclusionary language (if it allows trans men and non-binary people to be*

*included in language around giving birth and midwifery) is not a topic that requires "balance",*

*just as we would not commission an opposing view to, for example, the growth of te reo Māori or the existence of climate change".(By email 19 March 2024)*

These comments make clear that no matter the news value or materiality of other issues raised in a story The Spinoff would not cover an issue fairly if it involved transgender people

or their supposed best interests, or gender theory, because this does not require balance.

For example the complaint that drew these comments from Madeleine Chapman involved a previous Spinoff story that I regarded, on very credible grounds, as [misrepresenting the law](#)

and citing a study in support of a proposed change, that had not even met its own research

criteria. Such an approach demonstrates an editorial desire not to provide balance on individual issues in relations to transgender issues and gender theory or over time.

Providing a free pass to any sector based on "equity" when serious issues are in play does not to justice to the affected group or to readers.

*I stand by my earlier comment to your earlier complaint. The Spinoff is a small publication and will often only publish one or two articles on a topic that is being widely reported elsewhere. For that reason, we seek to add perspectives that we feel are missing. Other outlets reported extensively on the Cass Report and the concerns raised within it. Our single*

*article was offering another perspective. You yourself have had opinion articles published by*

*other, much larger, outlets (NZ Herald, Stuff) so our decision not to also publish your opinions (as submitted in your previous complaint with the ultimatum that we either publish*

*your response or you'd submit a media council complaint) is not grounds for complaint. If anything, The Spinoff is looking to balance the wider conversation by actually speaking to*

trans whānau about a topic that most affects them.

Jan Rivers 22-04-2024