

when the authors were asked to address significant methodological limitations and reanalyse including a comparator group, any purported benefit disappeared.<sup>13</sup> The journal editor stated that the original conclusion of the benefits of surgeries 'was too strong', and that the data 'demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts'.<sup>14</sup> The published correction garnered much less media interest than the initial flawed research.

We agree with Ashley that scientific literature must meet the highest standard for publication and that competent care depends on the integrity of the scientific process. We would add that gender healthcare deserves the same rigorous scientific underpinning as all other areas of medicine. However, in the absence of double-blind randomised controlled trials, there can be no analysis of metadata. The often cited 'What we Know' project does not meet even the minimum standard of a systematic review.<sup>15</sup> Poor-quality publications are then recycled as 'evidence' and can form the basis of poor-quality guidelines,<sup>16</sup> which in turn are cited as further evidence that this 'treatment' works.

Ashley calls for love, but this quality resides outside the consultation room and is not a medical intervention. We support the highest-quality compassionate and evidence-based care for all individuals, based on their own values and circumstances, and are only opposed to bad science<sup>17,18</sup> which supports, promotes or sells medical interventions without reliably quantifying the outcomes. Present and future patients deserve better, unbiased, sound evidence. Higher-quality collaborative research and independent adjudication of the evidence<sup>19</sup> are required to find out exactly what works, for whom, when and for how long.

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## Declaration of interest

None

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## Extreme 'gender critical' views will alienate many gender dysphoric patients

The authors provide a welcome update of evidence and reasoning for the 'gender critical' position, and the problems with the 'gender affirming' position that the Royal College of Psychiatrists adopted in 2018. Their argument might have been even stronger if it had included an account of recent complaints about pressures against free enquiry and expression in this area.<sup>1</sup> Such pressures may partly account for the paucity of published gender critical clinical and scientific research. Neither did the authors mention the professional misconduct of a 'gender affirming' consultant psychiatrist in a London teaching hospital, which was brought to the public's attention in 2007 by the campaigning journalist Julie Bindel.<sup>2</sup> Or, specifically, the influence of the pharmaceutical industry, although that was implied in at least one of the references they cited.<sup>3</sup> However, some of their reasoning appears to lean towards an extreme gender critical position, which is inconsistent with mainstream psychiatric practice. They write that 'there is little to no

convincing evidence to support fundamental differences between the brains of females and males'. But a lack of reliable neurobiological pathology is true of most psychiatric disorders, for which psychiatrists routinely prescribe drugs and other physical treatments, quite often coercively. Again, 'As a pure subjective experience, [gender identity] may be overwhelming and powerful but is also unverifiable and unfalsifiable'. Psychiatric disorders are mainly diagnosed on the basis of what patients report about their 'subjective experience', so the requirement that transgender patients must provide substantial additional 'verification' of their experiences also suggests that the authors have adopted a double standard. Do they propose that patients with depression or post-traumatic stress disorder demonstrate that their problems are 'falsifiable' before they can receive treatment? The authors attempt to distance themselves from 'conversion therapy', but many gender dysphoric patients will not find their arguments convincing. They claim 'there is little evidence' that transgender conversion therapy 'is taking place in the UK', but the 2018 National LGBT Survey found that 13% of UK trans respondents 'had been offered' conversion therapy, compared with 7% of 'cisgender' respondents.<sup>4</sup> Conversion therapy for homosexuality is closely associated with psychoanalysis.<sup>5</sup> The American Psychiatric Association removed homosexuality from its list of disorders in 1973, with strong opposition from psychoanalysts. It took nearly three decades for the London-based International Psychoanalytical Association (IPA) to act similarly, in 2002. It seems likely that the IPA continues to tolerate the view that homosexuality is a disorder, treatable by psychoanalysis.<sup>6,7</sup> The authors allude to 'complex intrapsychic conflicts' but fail to explain what they mean by this or provide a reference. This suggests an undeclared allegiance to psychoanalysis. Some British psychoanalysts appear to see transgender patients as a growth opportunity.<sup>8</sup> The gender critical views of the ex-Tavistock London psychoanalyst Marcus Evans have been quoted by the BBC<sup>9</sup> and the *BMJ*,<sup>10</sup> while journalists have failed to scrutinise his implied claim that psychoanalysis can provide valid clinical opinion. Such scrutiny is especially necessary given the problematic relation of psychoanalysis to homosexuality and its wider history of evading scrutiny of its claims to therapeutic efficacy, validity<sup>11</sup> and safety.<sup>12</sup> Psychiatry should retain its gatekeeping role for transgender patients seeking physical treatments or legal gender change, but extreme gender critical views, which at present appear to include special pleading for psychoanalysis, would undermine the consent necessary for that role to be effective.

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## Authors' reply

We thank Dr MacFarlane for his response<sup>1</sup> and welcome his comments about various providers and pharmaceutical agencies as well as freedom of speech.

We did not review the neuroscience of brain sex differences but draw interested readers' attention to a recent review<sup>2</sup> and accessible analyses of available research.<sup>3,4</sup> We agree that the art of psychiatric diagnosis depends on the clinician accepting the truth of the patient's own experience. In the absence of objective diagnostic tests, believing and trusting the patient's own subjective narrative is central to the doctor-patient relationship. However, this starts to lose coherence when the doctor must readjust their own understanding of material reality in order to accommodate another's subjective belief. Declaring that 'Despite having the body of a man, I am in all other respects a woman' supposes some inherent essence of gender that many would reject. Reorganising psychiatry to give primacy of gender identity over sex risks breaching the necessary boundaries that exist to maintain the safety and dignity of individuals, groups of people and society more generally.

Without a clear definition of conversion therapy, it is not possible to know the extent of the practice in the UK. Proponents of affirmative care have argued that conversion therapy is anything that might act as a barrier to medical transition.<sup>5,6</sup> It would follow that attempts to assess and treat coexistent mental illness, or even the process of making an accurate initial diagnosis of gender dysphoria, could be described as conversion therapy