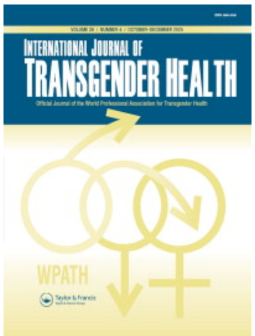

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The Cass Review: Cis-supremacy in the UK's approach to healthcare for trans children

Cal Horton

Centre for Diversity, Research, Policy and Practice, Oxford Brookes University, Oxford, UK

ABSTRACT

***Background*:** Since 2016 trans people in the UK, and particularly trans children, have experienced a sustained and escalating campaign to roll back trans freedoms, rights and access to healthcare. A series of legislative, politicized and media-driven campaigns have resulted in the year-by-year worsening of access to affirmative healthcare for trans children in the UK.

***Aim*:** This study examines publications from the NHS-commissioned 'Cass Review' into children's gender services, seeking to better understand what is happening in trans children's healthcare in the UK.

***Methods*:** Inductive and deductive reflexive thematic analysis was applied to a collection of Cass Review publications related to trans children's healthcare published between January 2020 and May 2023.

***Results*:** Four concerns are presented and explored: (1) prejudice; (2) cisnormative bias; (3) pathologization; and (4) inconsistent standards of evidence. Each of these concerns impacts the Cass Review's approach to trans children's healthcare, with negative repercussions for trans children's healthcare rights and well-being.

***Discussion*:** The Cass Review itself can be understood as an example of cis-supremacy, within a cis-dominant healthcare system lacking accountability to trans communities. These findings draw attention to systemic barriers to effective healthcare policy, with relevance for trans healthcare across and beyond the UK.

KEYWORDS
Children; discrimination; gender identity; healthcare; policy; transgender; youth

Introduction

The UK is considered a hostile country for trans people especially for trans children (Madrigal-Borloz, 2023). Trans healthcare under the UK's National Health Service (NHS) has long been criticized for causing harm to trans people, with reports of pathologization, coercion and harm in NHS healthcare services (Horton, 2022d, 2022a; Pearce, 2018). Since 2016 the UK media has engaged in a sustained culture war related to trans rights, with a significant focus on trans children's healthcare (Amery, 2023; Faye, 2021; Pearce et al., 2020). Trans children's healthcare has become a topic of political interest, with politicians including the Prime Minister, the Secretary of State for Health and various Ministers for Equality questioning the validity of, or calling for the removal of access to, trans children's healthcare (Milton, 2022; Parsons, 2020; Raza-Sheikh, 2022). A 2020 legal judgment (Bell vs Tavistock, 2020), that was later overturned at appeal, called into doubt trans children's ability to consent to puberty-blocking medication. Legislative barriers to healthcare have been exacerbated by institutional responses, with NHS England responding to the original Bell court judgment by immediately suspending access to trans children's healthcare (NHS England, 2020). As a result of NHS England restrictions, no new adolescents were able to access puberty blockers from the NHS for nearly a year (Andersson, 2021), with barriers to care not removed even after the Bell judgment was overturned at appeal (Bell vs Tavistock, 2021). Within this politicized and challenging context, NHS England commissioned the 'Cass Review' into children's gender services, led by NHS pediatrician Dr Hilary Cass.

CONTACT Cal Horton chorton@brookes.ac.uk Centre for Diversity, Research, Policy and Practice, Oxford Brookes University, Oxford, UK
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Since the launch of the Cass Review in 2020, the situation for trans children in the UK has continued to decline (Madrigal-Borloz, 2023). In 2022 the UK Minister for Health called for clinicians to look for evidence of "*what has caused children to be trans*," citing the Cass Review to claim that "*identifying as trans*" is likely to be a response to "*child sex abuse*" (Milton, 2022). The Cass Review was cited by the British government to justify plans to exclude trans people from legislation to ban conversion therapy (British Psychological Society, 2022). The Cass Review was also cited to justify the closure of existing children's gender services for England and Wales, with services ceasing to see any new referrals 18 months before replacement services are expected to be operational (Ali, 2023). Trans healthcare professionals outside of the UK have critiqued the Cass review (Pang et al., 2022) as well as critiquing healthcare policies inspired by the Cass Review such as the NHS' 2023 draft service specification (WPATH et al., 2023).

This article offers an evidence-based analysis of key Cass Review documents, seeking to understand the positionality and approach of the Cass Review. A critical analysis of Cass Review documents is undertaken to better understand approaches to trans children's healthcare policy-making in the UK's National Health Service (NHS), with broader relevance to trans healthcare policy-making in other contexts. This effort builds from and complements a body of work analyzing trans related policy-making in different domains including in education (Horton, 2020; Omercajic & Martino, 2020) and healthcare (Linander et al., 2021; Pearce, 2018). This article is also informed by an interest in understanding the challenges trans people, and especially trans children face in the UK. The article looks to the concept of cis-supremacy to better understand how policy-making occurs in cis-dominant institutions and policy-scapes (Horton, 2023a). Cis-supremacy calls attention to the axes and forces of cis-power that actively dominate and oppress trans people, producing and perpetuating systemic and sustained injustices (Horton, 2023a). This article seeks to understand the factors that influence policy-making in one such cis-dominant institution, the UK's NHS, through examination of one discrete policy-influencing initiative, the Cass Review.

Methods

Secondary data

This article analyses a secondary dataset of NHS reports related to trans children's healthcare published since 2020. Four Cass Review reports are included: the Cass Review Terms of Reference (report 1), two Cass Review-authored stakeholder reports (reports 3–4) and the Cass Interim report (report 5). Two Cass chaired NICE reviews of evidence are also included (reports 2a and 2b). These reports are summarized in Table 1, with each report allocated a number that will be utilized for citations in the results section. Selection criteria for secondary data from the Cass Review prioritized published reports related to trans children's health care (January 2020–April 2023) and excluded letters, submissions to inquiries, submissions to draft service specifications, and blog posts. This collection of NHS documents published since 2020 constitutes an important source of information and insight on how NHS establishment stakeholders and policy-makers engage with trans children's healthcare.

Qualitative analysis

The dataset was uploaded into NVivo software and analyzed utilizing broad and unstructured inductive coding, combining qualitative document analysis (Bowen, 2009; Mackieson et al., 2019) with a critical review methodology. A critical review is inherently and intentionally subjective (Grant & Booth, 2009), bringing a reviewer's

Table 1. Summary of secondary data.

Report no.	report type	Abridged citation
Report 1	Cass Review Terms of Reference	(Cass Review, 2021b)
Report 2a and 2b	NICE evidence Review into puberty blockers (a) and hormones (b)	(National Institute for Health and Care Excellence – NICE, 2021b, 2021a)
Report 3	Online panel with primary and secondary care professionals	(Cass Review, 2021a)
Report 4	Gender specialists' questionnaire	(Cass Review, 2022a)
Report 5	Interim Report	(Cass Review, 2022b)

perspective and positionality into analysis and reflection on a body of work (Paré et al., 2015; Temple Newhook et al., 2018). I approached this analysis as a non-binary researcher, as a parent of a trans child, and with experience as a parent-service user of children's gender services in the UK. My approach to this topic is informed by a commitment to trans emancipatory research (Noel, 2016), acknowledging that trans lives are equal to cis lives, and being attentive to cisnormativity or pathologization of gender diversity. In the initial inductive coding content was reviewed and categorized into themes, drawing upon my theoretical and personal knowledge of trans healthcare, highlighting content that provided insight into the Cass Review's approach to trans children's healthcare. Initial categories were distilled into four broad themes (see Table 2), that correspond to the four key themes of the results section. For each broad theme, a thematic research question (see Table 2) was selected, with the data then taken through a second round of qualitative analysis framed by those research questions, looking for evidence and insight from the dataset to enrich and expand understanding of Cass Review approaches. This second-round of analysis applied deductive reflexive thematic analysis (Braun & Clarke, 2019), seeking data-driven answers to the four research questions, utilizing Cass Review data to enrich and expand understanding of the Cass Review's approach to trans children's healthcare.

Results

Results are presented in four broad themes: (1) prejudice; (2) cisnormative bias; (3) pathologization; and (4) inconsistent standards of evidence.

Table 2. Broad themes and research questions.

Broad theme	Research question number	Research question
Prejudice	RQ1	"How does the Cass Review engage with anti-trans prejudice?"
Cisnormative bias	RQ2	"Is there evidence of cisnormative bias within the Cass Review?"
Pathologization	RQ3	"Is there evidence of pathologization within the Cass Review"s approach?'
Inconsistent standards of evidence	RQ4	"How does the Cass Review engage with standards of evidence and decision making under uncertainty"

1/Prejudice

This section responds to the broad research question (RQ1) "How does the Cass Review engage with anti-trans prejudice?" More specifically, it seeks to examine (i) Does the Cass Review define and recognize anti-trans prejudice? (ii) Is there evidence of anti-trans or ill-informed professional views within Cass reports and how does Cass engage with such views? (iii) Does the Cass Review take steps to proactively protect trans children from anti-trans prejudice in healthcare?

Cass Review reports do not explicitly engage with the topic of anti-trans prejudice in healthcare. Reports do not cite or engage with an existing body of literature on anti-trans prejudice amongst healthcare professionals (Brown et al., 2018; Stroumsa et al., 2019). Within Cass Review reports however, quotations from interviewed healthcare professionals do display indications of potential ignorance, bias or anti-trans prejudice (see Table 3). These include healthcare professional quotes that express concern about trans children being created by peer pressure or social media, or the dismissal and belittling of trans children's identities (Table 3). All healthcare professional views, including those demonstrating ignorance, dismissiveness or hostility to trans children are presented as valid and valuable inputs to the Cass Review, with no discussion of the potential for anti-trans prejudice or ignorance amongst healthcare professionals.

One Cass Review report conducted a survey on the beliefs of a sample of healthcare professionals (Report 3). In this survey a third of interviewed healthcare professionals identified with the view that "*there is no such thing as a trans child*" (Table 3), a view that may indicate significant ignorance or anti-trans prejudice. The sample of interviewed healthcare professionals are described as "self-selecting," with the Cass Review taking no steps to exclude anti-trans professionals, despite working in a UK context of growing anti-trans prejudice (Amery, 2023; Pearce et al., 2020).

Table 3. Evidence of professional ignorance, bias or prejudice.

Category	Examples from professionals who are quoted within cass reports
Ignorance or conspiracies about transness as an externally imposed identity	"I have a concern some young people may feel pressured to believe they are gender discongruent by a powerful peer group." [Report 3, p. 37] "influence from external sources such as peer groups, social media, or online media such as YouTube" [Report 3, p. 37].
Belittling or dismissing trans identities	"Adult issues are being "thought about" with children who simply do not have the emotional development to be able to really think about it all." [Report 4, p. 27] "sometimes we get referrals for 3, 4, 5 year-olds. Young children that have no true comprehension of gender identity at all." [Report 4, p. 25]
Denying the existence of trans children	"There is no such thing as a trans child. Gender dysphoria is always an indicator of another underlying problem and assessment should focus on understanding the causes of their distress." [Report 3, p. 35]. This statement, provided by the Cass Review as one of three options to describe professional views, was self-selected by 32% of interviewed healthcare professionals.

Table 4. Evidence of professional support for the non-affirmation of trans children.

Category	Examples from professionals who are quoted within Cass Reports
Challenging children on their identities	"I think it is important for a GP to gently challenge a child who presents like this" [Report 3, p. 21].
Seeking support for non-affirmative therapies	"creating a climate in which different therapeutic approaches can be discussed and developed without fear of vilification, legal action or complaints being brought. I believe the Cass Review has a role to play here." [Report 4, p. 31]

The Cass Review accepts this opinion that trans children do not exist as a valid professional viewpoint. At no point is this position or any other view recognized by the Cass Review as an indication of ignorance or prejudice. Instead, the Cass Review adopts a position where all views are welcomed and valued. The view that "there is no such thing as a trans child" is not deemed disqualifying from a professional seat at the table in designing healthcare for trans children. This approach has been noticed and critiqued by professionals from world leading healthcare services for trans children including from Australia. Professionals from Australian children's gender services wrote in the British Medical Journal that "*Cass seems keen to find a way forward that ensures 'conceptual agreement' and 'shared understanding' across all interested parties, including those who view gender diversity as inherently pathological*" (Pang et al., 2022, p. 2).

Cass Review reports include several quotations from interviewed healthcare professionals who advocate for approaches that do not accept or affirm a child's identity (see Table 4). In one quote a healthcare professional calls for trans children to be challenged on their identity (Table 4). Such professional views are presented without the Cass Review examining how a trans child would experience being probed or challenged on their identity when seeking healthcare support, with the professional's perspective centered. In another quote (Table 4) a healthcare professional expresses hope that the Cass Review will enable the practice of non-affirmative therapies "*without vilification or legal action*" (see Table 4). The exact type of non-affirmative therapy that might be subject to vilification or legal action is not defined, though the reference to legal action may relate to a long-proposed national ban on conversion therapy (Perry, 2023).

When considering references to non-affirmative or conversive clinical practice, it is important to note three points. Firstly, affirmative clinical approaches are characterized by listening to and respecting a child's individual identity, and supporting them without pre-defined expectations, whilst valuing all identities and expressions as equally valid (Hidalgo et al., 2013; Telfer et al., 2018). Secondly, conversion therapy encompasses any approaches that deny, delay or problematize a person's identity (UN Human Rights Council, 2020). Thirdly, non-affirmative practices are rarely openly labeled as conversion therapy (Ashley, 2022b). Instead conversive practices, or approaches grounded upon the rejection, pathologization or problematisation of gender diversity are commonly veiled under language of "exploratory" therapy (Ashley, 2022c). In the UK affirmative therapists have emphasized the space for gender exploration within an affirmative approach, and have highlighted the dangers of so-called "exploratory therapy" offered by non-affirmative practitioners who do not regard trans identities as valid (TACTT, 2023). Trans healthcare policy reviews need to be aware of the potential dangers of conversive approaches, including approaches that are not openly identified as conversion therapy. Cass Review reports reference non-affirmative practice without acknowledging, defining or critiquing therapeutic practices that problematize or pathologize trans identities. Cass Review reports draw attention to the concerns of non-affirmative professionals, without recognizing the NHS' duty of care to trans children, including a responsibility to protect trans children from being harmed by conversive or pathologizing professional practice.

The Cass Review summarizes the concerns of professionals who want to provide non-affirmative therapy for trans and gender diverse children. There are many occasions where professionals seeking support for non-affirmative therapy are framed positively in Cass Review commentary.

> Participants who expressed concerns about the lack of non-affirmative or 'neutral' treatment tend to refer the child/young person to private providers. [Report 3, p. 19]

> Professionals feel unsupported to provide care that maintains a neutral approach in the face of what some participants described as an otherwise ideologically driven pathway. [Report 3, p .29]

These statements provide insight into the Cass Review's positionality. Cass Review commentary positions non-affirmative approaches as "neutral," contrasting them to affirmative approaches that are framed as "ideological." There is no recognition of the ideology underpinning approaches that deny the existence or validity of trans children. Cass Review reports do not consider the harms of approaches that deny or reject a trans child's identity (Horton, 2022c). Instead, Cass Review reports provide a sympathetic description of non-affirming professionals, centering the pressure they feel under to adopt an affirmative approach:

> Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach. [Report 5, p. 17]

Cass reports frame an expectation of trans positivity as an infringement on professional freedom, centering professional fears of being labeled transphobic.

> A perceived lack of freedom for professionals to take an exploratory approach or challenging approach due to perceived pressures from what some participants described as organisations taking an 'ideological stance'. [Report 3, p. 25]

> This can lead to a fear of being labelled transphobic if the professional suggests that it may be worthwhile trying to understand the possible meaning or origin of gender non-conformity in the child. [Report 3, p. 25]

Cass Review reports emphasize the concerns that some healthcare professionals hold that they might be sanctioned for their approach, presumably referencing a proposed national ban on conversion therapy:

> Fear of reprisals for professionals who take a more exploratory approach to supporting children and young people. [Report 3, p. 17]

> Some participants said they were concerned about being sanctioned by regulatory bodies if they were reported by a client who was seeking affirmation. [Report 3, p. 25]

In this last example, Cass Review commentary is referencing a hypothetical client who "*was seeking affirmation*," who might complain. The report centers a healthcare professional's concern of potential professional consequences. The Cass Review commentary does not reference the rights or well-being of the client, in this case presumably a child, who might seek redress for the harms of non-affirmative therapy. The Cass Review presents commentary on the fears of non-affirming professionals without any comment on the harms of conversion therapy, the negative impacts of transphobic professionals, or trans children's right to healthcare that is free from prejudice. Indeed, the voices of trans children harmed by interactions with transphobic healthcare professionals are noticeably absent across Cass Review publications to date. Literature outlining service user perspectives is not cited by the Cass Review (Horton, 2022d, 2022b).

The Cass Review does recognize that individual attitudes toward transness can impact on professional behavior and approach:

> Professionals' experience and position on this spectrum may determine their clinical approach. [Report 5, p. 16]

However, the review takes no steps to specifically recognize or discuss anti-trans prejudice. It does not define anti-trans prejudice, and does not recognize the scope for interviewed professionals to hold views that are impacted by prejudice or ignorance. In failing to acknowledge or understand anti-trans prejudice, it also fails to recognize that prejudice can present as good intentions, particularly framed around a rhetoric of "protecting children" (Amery, 2023; Oakley, 2023). In one report the Cass Review describes how every person on a stakeholder panel is there with the best intentions:

> There is strong professional commitment, everyone participating on the panel wants to be able to do the best for these children and young people. [Report 3, p. 41]

The Cass Review focuses on what it regards as good intentions, whilst ignoring a reality that 32% of that specific sample of healthcare professionals self-identified as denying the existence of trans children (Table 3). Denying the existence of trans children is arguably a highly ideological and prejudiced position, with the impossibility of a trans child a core tenet of "gender critical" ideology (Amery, 2023). According to Amery (2023, p. 13) "*'gender critical' activism around childhood portrays trans identity as a pernicious ideology or false belief to which children are vulnerable*." The movement against trans equality seeks to limit trans possibilities through targeting and curtailing the supports that allow trans people to exist as trans people (Owen, 2022). Denying the existence of trans children pushes trans children into a position of precarity, making it harder for trans children to be recognized and find social and institutional support as trans children (Amery, 2023). In the Cass Review, individuals who deny the existence of trans children are retained and valued as professional experts, with all healthcare professional views welcomed, included those grounded in the erasure, rejection, and problematisation of trans children.

The Cass Review emphasizes the polarization that characterizes trans children's healthcare in the UK.

> Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus. [Report 5, p. 26]

Here the Cass Review takes a stance that polarization is in itself a key problem in trans children's healthcare. The Cass Review discusses polarization without acknowledging the existence of anti-trans prejudice. Framing all (cis) views as equally valid and equally welcome, enables that Cass Review to frame neutrality as an appropriate starting position. Amidst a field characterized by stark polarization, the review chooses to place significant emphasis on a search for consensus:

> Recommendations of the Review and will be captured through our participative and consensus development approach. [Report 1, p. 2]

In several places in Cass Review reports, an absence of consensus is itself regarded as a significant cause for concern. The Cass Review raises concerns about puberty blockers, emphasizing a lack of consensus on "the primary purpose of puberty blockers" [Report 4, p. 11]. It references differing views on whether their aim is "*to pause puberty to allow further time to explore options (30.3%) or to alleviate or reduce distress associated with pubertal changes (21.2%)*" [Report 4, p. 27]. The Cass Review here presents different articulations on their primary purpose as a significant cause for concern, even when the presented options are overlapping and mutually compatible. Similarly, a lack of consensus on the purpose or comparator groups for evaluating affirmative healthcare is raised as a concern for both puberty blockers and gender affirming hormones.

> The first step of this involves defining the PICO (the Population being treated, the Intervention, a Comparator treatment, and the intended Outcomes).

> This of itself was challenging, with a particular difficulty being definition of the intended outcomes of puberty blockers, and suitable comparators for both hormone interventions. [Report 5, p. 35]

Here the Cass Review frames a lack of consensus on purpose or comparator groups as inherently a concern in the use of affirmative healthcare. The Cass Review fails to acknowledge the significant barriers to consensus in defining purpose, comparison group, or intended outcomes in a politicized and prejudice affected field of medicine. There is not likely to be consensus on who the target population is, or what the goal of medical intervention is, when some actors are seeking to treat, prevent or eradicate a disease, confusion or disorder, while others are seeking to maximize well-being outcomes in a minority population. There is no room for consensus between those seeking to maximize health and happiness in trans and gender diverse children, and those seeking to prevent or minimize the existence of trans children. Across Cass Review reports there are multiple indications that the Cass Review has failed to recognize, to take steps to protect trans children from the influence of anti-trans prejudice.

2/Cisnormative bias

This section addresses the research question "Is there evidence of cisnormative bias within the Cass Review?" (RQ2 see Table 2). Cisnormativity is the presumption that everyone is cisgender or should be (Keo-Meier & Ehrensaft, 2018). Serano (2016) has described cisnormativity as a societal double standard that advantages cis people. Cisnormativity permeates societies and institutions, invisible to most cis people, yet exacting harm on trans people in structures and systems that were not designed to include trans lives (Newbury, 2013). Within a cisnormative world, individuals and groups are highly likely to be influenced by cisnormative biases, which can often be unconscious or unintentional. Cisnormative bias can lead to a trans child being viewed as inherently a problem or deviation, with transness regarded as suspicious, problematic or pathological (Horton, 2022a). Cisnormative bias can lead to trans lives not being valued as equal to cis lives, with trans children's rights disregarded. This section explores the positionality of the Cass Review, examining Cass Review reports for indications of potential cisnormative bias.

In order to understand the positionality of the Cass Review, it is helpful to first examine how the Cass Review was designed and established. Dr Cass was selected to lead the process that became known as the Cass Review explicitly because she was a clinician without any knowledge or professional experience in trans children's healthcare.

> Given the increasingly evident polarisation among clinical professionals, Dr Cass was asked to chair the group as a senior clinician with no prior involvement or fixed views in this area. [Report 5, p. 35]

Wider stakeholders around Cass were likewise selected for an absence of trans specific knowledge or experience, including exclusion of those with lived experience of being trans. The original published Terms of Reference (ToR) for the Cass Review's assurance group explicitly excluded trans expertise, stating that it "*deliberately does not contain subject matter experts or people with lived experience of gender services*" [Report 1, version 1]. The current (updated) assurance group ToR is worded less clearly, yet still conveys exclusion of those with expertise or lived experience, as such individuals would naturally be expected to have an interest in the outcome of the review:

> Members are independent of NHS England and NHS Improvement and of providers of gender dysphoria services, and of any organisation or association that could reasonably be regarded as having a significant interest in the outcome of the Review. [Report 1, p. 2]

The Cass Review, by design, prioritized cis professionals with no experience in trans healthcare. Within this design there was no obvious consideration of the risk of cisnormative bias in such a leadership structure. Nevertheless, upon establishment, the Cass Review could have taken steps to actively and explicitly tackle cisnormative bias within the delivery of the Review. Indeed, such an approach could be justified as essential in a cis-led team working in trans children's healthcare (Ashley & Domínguez, 2021). However, there is no indication that this has been done, and several indications of embedded cisnormativity.

Indications of cisnormative bias can be seen in the terms the Cass Review uses to describe trans and gender diverse children. There are multiple occasions where trans children are explicitly delegitimised and mis-gendered within Cass Review reports. In several places, trans children are defined by their assigned gender:

> The largest group currently comprises birth-registered females first presenting in adolescence. [Report 5, p. 16]
>
> birth-registered males presenting in early childhood. [Report 5, p. 19]

Here we see that trans children are mis-gendered and delegitimised as "*birth registered females/males*," a description that actively disregards a trans child's identity and self-knowledge. Such language is an act of disrespect and potential harm to current NHS service users including trans boys, trans girls and non-binary children. This language choice calls into question whether the Cass Review prioritizes a duty of care to trans children, including their right to have their identity respected and valued in Cass Review reports. Within the interim report the Cass Review chooses to categorize all trans boys and trans masculine adolescents under the label "*F*" and places all trans girls and trans feminine children under the label "*M*" [Report 5, p. 33]. Many current GIDS service users are trans, yet here all GIDS service users are categorized by the Cass Review as though they are cis. Categorizing all current GIDS service users as though cis can be interpreted as an indication of cisnormative bias, and arguably an exertion of cis power in a report on trans and gender diverse children. It's worth noting that this type of practice, the systemic erasure and delegitimization of trans people, falls under a definition of transphobia commonly used by trans communities in the UK (TransActual, n.d.).

Delegitimization of trans identities is not only applied to trans children. In the Cass Review's stakeholder report, interviewed professionals are listed by identity, with the report choosing to exclude adult trans professionals from the categories of "male" and "female." Instead, all trans professionals are segregated to an "other" category described as encompassing "*Other = Trans female, trans male, no gender, non-binary*" [Report 3, p. 11]. Excluding all trans people from the categories of male and female is a cisnormative approach, indicating trans people's identities are not regarded as equal to cis people's. In reports written by cis stakeholders, with no trans accountability, it can be viewed as an exercise in cis-supremacy (see discussion section), with even trans adults' genders othered and excluded.

A significant indication of cisnormative bias can be seen in the absence of recognition of the existence of trans children across all Cass Review reports. A review expected to define best practices for trans children's healthcare chooses to entirely avoid the word trans when referring to the children or adolescents who access UK Children's Gender Services. Whilst including seven references to "transgender adults," the interim report does not include even one reference to a trans child, adolescent or young person. Trans children are instead reduced to definition as "*gender questioning children and young people*" (Report 5, p. 11) or "*children and young people needing support around their gender*" (Report 5, p. 7). This framing conflates trans children, including those who have socially transitioned and are settled and confident in their affirmed identity, with children who are questioning their gender. This conflation erases the existence of trans children. The decision to erase trans children across all Cass Review reports is an indication of cisnormative bias, framing trans children's very existence as up for debate. This position can also be regarded as an act of cis-supremacy, rendering trans children invisible in a report that will determine their access to healthcare.

Cisnormative bias can also be seen in Cass Review discussions on different approaches to trans healthcare. In a Cass Review survey, healthcare professionals are asked to position themselves along a spectrum from "*cautious*" to "*affirmative*" [Report 3, p. 13]. This can be recognized as biased framing. It avoids acknowledging the existence of anti-trans and conversive approaches within the spectrum, framing "cautious" as the alternative to affirmative care. This choice to frame trans-hostile and pro-conversion therapy views as “cautious” or “careful” is seen elsewhere in Cass Review commentary:

> some clinicians taking a more gender-affirmative approach and others emphasising the need for caution and for careful exploration of broader issues. [Report 5, p. 48]

> There is no precedent in terms of where professionals would place themselves on an ideological spectrum when it comes to their approach to the management of gender questioning children and young people… whilst a higher proportion of participants would consider themselves ‘cautious’, the research team was able to recruit professionals with a broad mix of views. [Report 3, p. 10]

Cass Review commentary does not include any recognition of clinical practices that are coercive or abusive. Nor does it acknowledge that anti-trans prejudice, or indeed conversion therapy, can be veiled under a banner of caution (Ashley, 2019b). The Cass Review does not examine the role of cisnormativity in making professionals uncomfortable with affirmative approaches that respect and value trans lives. The scale utilized to assess professional views seems to have been created by the Cass Review, rather than utilizing an existing tool in trans healthcare. The Cass Review scale runs from “cautious” to “affirmative,” in order to assess professional viewpoints on appropriate care for trans children. The fact that this scale was deemed appropriate is an indicator of cisnormative bias. The scale enables trans-hostile professionals to list themselves under the positive banner “cautious,” implying that an affirmative approach is incautious or reckless, whilst obscuring the risk inherent in denial of affirmative healthcare.

The Cass Review presents an interpretation of what it sees as the key differences between non-affirmative and affirmative approaches to trans children’s healthcare:

> At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual, or a more fluid and temporal response to a range of developmental, social, and psychological factors. [Report 5, p. 16]

This long sentence combines several different concepts and issues. It references the nature of gender identity, factors that could influence identity, and whether identity is fixed or can be fluid or dynamic. The sentence combines these references to the concept of gender identity with discussion of discrete policy agendas. The sentence conflates specific claims (identity as inherent and rigid) with specific policy recommendations (transition may be beneficial), presupposing that transition may not be beneficial if identities are in any way socially influenced or can be evolving or fluid. These simplistic statements and assertions are provided without evidence. This interpretation arguably mischaracterizes much current trans healthcare scholarship and affirmative practice (Ashley, 2019a; Hidalgo et al., 2013; TACTT, 2023). In affirmative practice it is commonplace, for example, for gender fluidity to be respected alongside recognition of the importance of individual self-determination and support for autonomous social transition at any age (Telfer et al., 2018).

Yet here, according to the interpretation of the Cass Review, belief that identity can be socially shaped, evolving or fluid is presented as a justification for non-affirmative practice. Within Cass Review commentary, nuanced and complex questions on the nature of identity are combined and conflated with policy agendas in a way that veils more significant differences between affirmative and non-affirmative healthcare. Differences in healthcare approach are characterized as built on philosophical and metaphysical differences in understanding of gender identity. The Cass Review centers a focus on the meaning of gender, decentering acknowledgement that trans people, including trans children, exist, and have a right to equity in healthcare. This focus on the meaning of gender rather than healthcare policy and practice appears in other sections of Cass Review reports.

> At one end are those who believe that gender identity can fluctuate over time and be highly mutable… gender related distress may be a response to many psychosocial factors, the distress may resolve in later adolescence or early adulthood…. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a

> clear indicator of that child or young person being transgender. [Report 5, p. 56]

Here the Cass Review frames disagreement between affirmative and non-affirmative approaches as one centered around "belief" on the nature of gender identity. Disagreement is presented as conceptual or philosophical, eluding more important distinctions in action and policy. Notably, the Cass Review does not examine core distinctions between affirmative and non-affirmative approaches that relate to the pathologization or celebration of gender diversity, that relate to child rights, that relate to agency or bodily autonomy, and that relate to institutional accountability to or control over marginalized communities. This framing, and its emphasis on the philosophical and conceptual draws focus away from analysis of pathologization, persecution or oppression. Approaches that control, pathologize or deny trans existence are framed through a focus on philosophical curiosities on the meaning of identity. Here the Cass Review strays from the remit of a review of effective healthcare for a minoritized population, moving from medicine into the philosophy or theory of gender. This shift from healthcare design for a minority group to philosophizing on the meaning of gender itself reveals the cis bias of the Cass team. Trans existence is not accepted as a starting point for this review into trans healthcare, instead the very meaning of gender is elevated as a clinical curiosity.

The Cass review references the polarization in trans children's healthcare (as discussed in the earlier section on prejudice), with the Cass Review presenting itself as neutral amidst this polarization, capable of building consensus. There are a number of concerns with the Cass Review seeing itself a suitable leader in the development of consensus in this polarized field. The Cass Review is a cis-led team selected for being unfamiliar with trans lives and inexperienced in trans healthcare. This inexperience and outsider status brings with it significant scope for cisnormative bias. The Cass Review has adopted a stance where all views are welcome and where anti-trans prejudice is not acknowledged or isolated, meaning a search for consensus includes stakeholders who are actively opposed to, or deny the existence of trans children. The Cass Review has adopted an approach where trans children are not explicitly recognized, with no acknowledgement of their existence let alone their right to equality in healthcare. These elements create a situation where a search for consensus holds risks for trans children. In several sections the Cass Review references the risk of ideology shaping the work of others, but without self-reflection on the likely bias of a cis outsider engaging with trans healthcare:

> there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint. [Report 5, p. 19]

The lack of consideration of the potential for cisnormative bias amongst the Cass Review team is a significant limitation of the Cass Review. Trans healthcare is a field long impacted by the ignorance or fears of professionals who problematize trans lives (Pearce, 2018). Professionals need to take pro-active steps to overcome entrenched cisnormativity, to recognize and challenge systemic anti trans bias or fears, to welcome and respect trans people of all ages as equals.

3/Pathologization

Across Cass Review reports there are numerous examples of the problematisation of the existence of trans children. The Cass Review interim report references "*aetiology*" [Report 5, p. 56], or research into the factors that cause a trans identity. The Cass Review referencing research on etiology problematizes gender diversity. Research into the causation of trans identities has a pathologized history, running parallel to efforts to prevent or cure transness (Winters, 2011, 2022). Reference to etiology has no place in a modern depathologized healthcare system that values trans lives as equal to cis lives (Turban, 2020). This reference to seeking evidence on the causation of gender diversity contrasts strikingly with recent publications related to trans children's healthcare from countries with a more trans positive approach. The Australian Standards of Care for trans children's healthcare for example states that "*being trans or gender diverse is now largely viewed as being part of the natural spectrum of human diversity*" (Telfer et al., 2018, p. 2). The World

Professional Association for Transgender Health (WPATH)'s latest Standards of Care (version 8) chapter on children states "*childhood gender diversity is an expected aspect of general human development*" and "*childhood gender diversity is not a pathology or mental health disorder*" (Coleman et al., 2022, p. 67). Recognition of the existence and value of trans children's lives provides, in other healthcare systems, an important foundation of respect from which other data and clinical priorities are drawn. The Cass Review avoiding any such trans positive statements about the value of trans children's lives, while referencing research into 'etiology', is an indication of the pathologization of trans identities.

Research on identity fluidity at different ages is upheld as a significant research priority for a national health service.

> The more contentious and important question is how fixed or fluid gender incongruence is at different ages and stages of development, and whether, regardless of aetiology, can be an inherent characteristic of the individual concerned. [Report 5, p. 56]

Here the Cass Review presents as accepted fact that identity fluidity is an important research priority. No evidence is provided to support this presumption. There is no discussion of why this is deemed a top research priority, nor is there stipulation on who holds this view. The reader is presumed to agree with this unsupported statement. There is no consideration of whether trans communities or indeed trans children hold identity rigidity as a top research priority for their healthcare service. Presenting this as a top research priority can be seen as an indication of the problematisation of identity fluidity, with gender stability upheld as an important research question. No justification is provided on why this topic is prioritized by a National Health Service, rather than for example, research into how to improve mental and physical health in trans and gender diverse children, or efforts to enhance healthcare access and equity. Research on identity fluidity at different ages is upheld as an important research priority with no discussion or evidence on how this is relevant to healthcare outcomes. This can be seen as a pathologising research priority, with the Cass Review focusing on studying, measuring and defining trans identities, whilst disregarding priorities that ensure trans and gender diverse children receive their right to equal and respectful healthcare.

Analysis of the words used by the Cass Review can reveal underlying assumptions. In several sections the Cass Review utilizes the language of disease when referring to trans children and associated research priorities. The Cass Review references "*a rapid change in epidemiology*" [Report 5, p. 16]. The word epidemiology, with its associations with disease, presents as problematic a phenomenon (increased awareness and confidence of trans children) that could in a trans-positive report be celebrated. Framing increased confidence of trans children in the language of disease is pathologizing, inherently problematizing trans lives. Cass Review reports demonstrate no awareness of the harms of treating transness as a disease, nor any commitment to the depathologization that the NHS is meant to be adapting to under the World Health Organization's ICD-11 (as discussed further below). Cass Review usage of such language is at odds with a depathologized approach that values trans lives (Horton, 2022a).

Further evidence of a lack of commitment to depathologization can be seen in the Cass Review's approach to diagnosis. A depathologized approach would recognize trans people, including trans children, as a minoritized group who sometimes have discrete healthcare needs (Suess Schwend, 2020). Instead, the Cass Review utilizes the existence of discrete healthcare needs as justification for applying a disease diagnosis and treatment model to a minority population. In one sentence the Cass Review acknowledges that trans young people do not recognize being trans as a medical condition. However, the Cass Review immediately disregards this stance by pointing to the existence of a psychiatric diagnosis.

> Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and receive a medical diagnosis of gender dysphoria. [Report 5, p. 45]

Trans communities have historically been pathologized as holding an identity "disorder" that requires psychiatric diagnosis (Winters, 2011). This pathologization has continued, even whilst the diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM) has shifted from "Gender Identity Disorder" in 1994s DSM IV (*Diagnostic and statistical manual of mental disorders, 4th ed*, 1994) to "Gender Dysphoria" in 2013s DSM V (American Psychiatric Association, 2013). The continued existence of a 2013 DSM-V psychiatric diagnosis for transness does not justify continued NHS adherence to pathologization. Indeed, global commitment to depathologization of trans identities led to the World Health Organization's reclassification of trans health in ICD-11, moving the diagnosis out from the chapter on mental and behavioral disorders (World Health Organisation, 2021). This reclassification was specifically intended to help combat a legacy of pathologization of trans identities by the medical and psychiatric establishment, with the World Health Organization recognizing that pathologization "*can cause enormous stigma*" (World Health Organization, n.d., para. 3).

There are times when the Cass Review steps close to recognizing the need to adopt a different approach to trans healthcare than a pathologized disease diagnosis, treatment and prevention paradigm. Yet, each time the Cass Review steps close to this recognition, the review turns the other way. In one paragraph the Cass Review recognizes that presenting trans identities as a clinical condition "*feels wrong*":

> We recognise that for some of those reading this report it may feel wrong to compare gender incongruence or dysphoria to clinical conditions, and indeed this approach would not be justified if individuals presenting with these conditions did not require clinician intervention. However, where a clinical intervention is given, the same ethical, professional and scientific standards have to be applied as to any other clinical condition. [Report 5, p. 54]

The fact that some trans people sometimes require specific medical interventions is deemed sufficient to justify treating transness as a clinical condition. There is no reflection on the pathologization inherent in this approach. There is also no discussion of trans children's right to equal access to healthcare, or their right not to be pathologized and problematized by their healthcare providers. In other areas of the report the Cass Review maintains that a diagnosis approach to engaging with trans children is essential, even while recognizing that gender identity is personal and cannot be externally diagnosed.

> For children and young people with gender-related distress, many people would dispute the notion that 'making a diagnosis' is a meaningful concept, arguing that gender identity is a personal, internal perception of oneself. However, there are several reasons to why a diagnostic framework is used. [Report 5, p. 59]

The concept of diagnosis is referenced in multiple areas, with a particular emphasis on clinician perspectives. In one section the Cass Review presents commentary on concerns raised by interviewed healthcare professionals:

> The majority of participants have experienced this trend where…children and young people presenting with concerns about their gender identity have self-diagnosed. [Report 3, p. 32]

Using the word "trend" in a UK NHS report to describe trans children can be considered problematic or pathologizing, resonating with a discourse (trans as a "trend") that delegitimises and harms trans children (Amery, 2023). The Cass Review then reflects on diagnosis being impeded by a lack of a blood test for being trans:

> When it comes to gender dysphoria, there are no blood tests or other laboratory tests, so assessment and diagnosis in children and young people with gender related distress is reliant on the judgements of experienced clinicians. [Report 5, p. 60]

In the above quotation, the Cass Review steps from a factual statement (there not being a blood test), to a pathologising assumption that it is therefore a clinician's responsibility to use their judgment to diagnose trans-ness. This assumption, that is not analyzed or justified, disregards affirmative approaches that recognize and respect trans people's self-knowledge. The assumption that a clinician should and can diagnose whether a child is trans, potentially contradicting and over-ruling an individual's self-understanding, feeds into a belief that a clinician ought to first rule out other possible diagnoses before respecting a child's identity. This issue is referenced in Cass Review report discussions on the topic of "differential diagnosis."

> It is standard clinical practice to undertake a process called differential diagnosis… (establishing) the most likely diagnosis, other possible diagnoses and the reasons for including or excluding them… These considerations need to be applied to the assessment of children and young people presenting with gender-related distress. [Report 5, p. 60]

Within Cass Review reports, multiple healthcare professionals are quoted expressing concern at applying what they see as a non-clinical approach to healthcare for individuals with the disease or condition of gender distress:

> How as mental health professional do we differentiate between a child who wants to change their body, or is mentally ill and needs help, or child that has trauma and abuse? We can use detailed assessment, but we can still misdiagnose. [Report 3, p. 39]

Cis professional concerns over accepting a child's self-knowledge of their own identity are presented by the Cass Review as reasonable and appropriate clinical concerns. Cass Review reports do not consider the need to educate under-informed healthcare professionals or advocate for a depathologized understanding of trans identities. There is no examination of the potential harms and risks of a medical diagnosis approach to validating and respecting trans children's identities. The Cass Review also makes no effort to reflect upon the risks of "differential diagnosis" in a world where many medical professionals ideologically deny the existence of trans children. Instead, the Cass Review reinforces the need for applying a standard disease diagnosis and treatment approach to trans or gender diverse children. Indeed, the Cass Review shows sympathy to healthcare professionals who report feeling "under pressure" to treat trans children with respect, implicitly presenting an affirmative approach as inappropriate.

> Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters. [Report 5, p. 17]

Across Cass Review reports and analysis, commitment to a trans as disease paradigm is visible yet unacknowledged. Instead of acknowledging a minority population with discrete healthcare needs, the Cass Review prioritizes a disease treatment model intended to "*resolve gender related distress*" [Report 5, p. 8]. This failure to understand the purpose of trans healthcare, framing it as diagnosis, prevention and treatment of a disease, rather than supporting well-being in a minority population, flows directly into problems in the Cass Review's approach to evidence, the focus of the final theme.

4/Inconsistent standards of evidence

This section explores the Cass Review's approach to evidence and uncertainty. It examines the quality of evidence required to justify affirmative policy and practice, the level of evidence required to justify non-affirmative approaches, and how evidence informs Cass Review policy recommendations.

When reviewing existing practices in gender affirming healthcare, the Cass Review relies on two National Institute for Health and Care Excellence (NICE) evidence reviews, both chaired by Dr Cass. Dr Cass chaired reviews into the use of puberty blockers and sex hormones for trans adolescents [Report 2a and 2b]. These NICE evidence reviews, their approach to evidence, and their recommendations directly inform the wider Cass Review. Two concerns relating to these NICE evidence reviews will be outlined here. These two concerns relate to the NICE review approach to evidence, and the public communication of NICE evidence review conclusions.

The two NICE evidence reviews have been critiqued on a number of fronts. The European and World Professional Associations for Transgender Health raised written concerns about these two NICE reviews, critiquing their approach to evidence appraisal, for example critiquing their exclusion of a body of studies that combine puberty blockers with HRT (EPATH & WPATH, 2023). Parents of trans children have questioned the exclusion from evidence review of data demonstrating the safety and effectiveness of puberty blockers when used by cis children for precocious puberty (Horton, 2023c). Other commentators have questioned the appropriateness of the critical outcomes in the NICE studies, with puberty blockers, for example, assessed by NICE on whether they lead to improvements in dysphoria or mental health rather than whether they are safe and effective in blocking puberty (Eckert, 2021). A particularly concern about the NICE evidence reviews concerns their approach to evidence quality, and their narrow focus on evidence of a specific type.

The NICE reviews adopted the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) approach to appraisal of evidence (Guyatt et al., 2008). In the GRADE approach, evidence is designated high, moderate, low or very low quality, depending on the nature or source of the evidence (Balshem et al., 2011). "High quality" designations are reserved for evidence drawn from sources such as Randomized Control Trials (RCTs), whilst observational studies are typically considered "low" or "very low" quality evidence. The two NICE reviews, by design, prioritized a search for "high quality" evidence. They found no such "high quality" evidence, utilizing a lack of RCTs to inform their conclusion "*evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive*" [Report 5, p. 18].

There are several significant limitations of this approach to evidence appraisal. RCTs are widely recognized as inappropriate for trans children's healthcare, with a wide range of experienced healthcare researchers, ethicists and clinicians recognizing RCTs as both infeasible and unethical in this field (Brik et al., 2020; Giordano & Holm, 2020; Horton, 2023c). Brik et al. (2020, p. 2616) notes that "*many would consider a trial where the control group is withheld treatment unethical, as the treatment has been used since the nineties and outcome studies although limited have been positive.*" Parents of trans children "*felt a randomised trial in which some trans adolescents would be offered psychological therapy with an incongruent puberty instead of affirmative healthcare, was an approach that would amount to 'conversion therapy'*" (Horton, 2023c, p. 508). For reasons of feasibility and ethics no RCTs have been conducted, nor are any currently planned. Even for precocious puberty, a planned RCT into puberty blockers was unsuccessful when participants in the non-treatment arm noticed their puberty had not been blocked, and dropped out of the study in order to access puberty blockers from a different source (Mul et al., 2001). A recent article has criticized the methodological and clinical inappropriateness of RCTs in trans children's healthcare, whilst highlighting the value of observational studies in guiding clinical practice (Ashley et al., 2023). The NICE evidence reviews adopted a search strategy that centered a standard of evidence considered by many practitioners, researchers and ethicists to be inappropriate for evaluating puberty blockers and affirmative HRT.

The NICE reviews also deviated from standard GRADE guidance in their treatment of "low quality" evidence. GRADE guidance explicitly separates the appraisal of evidence quality from the development of recommendations, stating that "*low or very low quality evidence can lead to a strong recommendation*" (Balshem et al., 2011, pt. 4). GRADE guidance also clearly states that, when forming clinical recommendations, any alternative clinical approaches need to be based on "*systematic review of the impact of alternative management strategies on all patient-important outcomes*" (Balshem et al., 2011, pt. 5), drawing recommendations from appraisal of all available evidence. Lower quality studies are considered particularly valuable to inform clinical policy where multiple lower quality studies indicate the same conclusion (Balshem et al., 2011, pt. 4). In these two NICE evidence reviews, evidence from "low quality" studies, including qualitative studies or observational studies without a control arm, did not inform evidence review recommendations.

Instead of drawing policy recommendations from an appraisal of the best available evidence, the two NICE reviews prioritized only a standard of evidence that does not, and likely cannot exist in trans healthcare, resulting in the conclusion that the evidence for affirmative healthcare is "*inconclusive.*" This conclusion ignores the high degree of consistency in evidence from a significant body of "low quality" studies that attest to the important benefits of affirmative healthcare (Ashley et al., 2023). The NICE review into gender affirming hormones partially acknowledged ethical concerns associated with RCTs, proposing a route to overcome ethical barriers. The NICE report recommended that trans adolescents who are seeking affirmative healthcare, yet allocated to a study's control arm, be provided with "*close psychological support*" (Report 2b, p. 47) in place of access to affirmative hormones. No evidence is provided that psychological support whilst denied access to affirmative healthcare is an effective and ethical medical intervention for trans adolescents seeking medical transition. No evidence is provided that this is likely to result in safe or enhanced outcomes, and existing literature outlining the harms of denial of affirmative healthcare (e.g., Fisher et al., 2014) is not discussed. This indicates a double standard in the NICE Review approach to evidence-based policy in trans children's healthcare. Non-affirmative healthcare approaches such as provision of "close psychological support" are endorsed with no evidence of benefits. Affirmative healthcare, the globally recognized standard of care as endorsed by WPATH (Coleman et al., 2022), is not supported unless it can provide a standard of evidence (RCTs) that is neither feasible nor ethical.

The second major concern with the two NICE evidence reviews relates to how they are communicated to a non-specialist audience, including by the Cass Review. In healthcare communication, nuance is important when communicating about the quality of evidence (Ashley et al., 2023). A significant proportion of clinical recommendations in pediatric healthcare are unsupported by RCT standard evidence, instead relying on "lower quality" evidence (Meng et al., 2022). A review of World Health Organization recommendations found that 55% of strong recommendations relied on low or very low quality evidence (Alexander et al., 2014). "Low quality" evidence holds a specific and nuanced meaning under a GRADE approach, that can be easily misrepresented and misunderstood when used in general communication (Balshem et al., 2011). The NICE evidence review's finding of a lack of "high quality" evidence has been communicated in a way that undermines confidence in trans healthcare. The Cass Review describes evidence for trans healthcare as "*inconclusive*" across analysis and public commentary. This is presented as fact, without reference to the unsuitability of Randomized Control Trials (RCTs), and without reference to the consensus of positive impacts of affirmative healthcare found in a large body of non-RCT evidence. Multiple studies reporting benefits (Achille et al., 2020; Brik et al., 2020; Horton, 2022b; McGregor et al., 2023; Miesen et al., 2020), and no studies reporting significant harms is ignored when the Cass Review references the evidence base for trans children's healthcare:

> The disagreement and polarisation is heightened when potentially irreversible treatments are given to children and young people, when the evidence base underlying the treatments is inconclusive, and when there is uncertainty about whether, for any particular child or young person, medical intervention is the best way of resolving gender-related distress. [Report 5, p. 28]

The above paragraph does not install any confidence that trans healthcare is supported by any evidence of effectiveness. This is powerful framing in a report expected to be widely read by audiences who are not medical professionals. In the above sentence, the Cass Review utilizes language ("uncertainty," "inconclusive") to communicate risk, danger and even recklessness in the existing approach. This approach to criticizing and raising concern over established healthcare practices neglects any consideration of the risk and danger inherent in denial of healthcare that has been used for decades with significant non-RCT evidence of benefits. No evidence of harm from affirmative healthcare is provided to justify denial of such care. Instead, it is the 'polarization' and lack of consensus that justifies a shift away from the healthcare approach endorsed by global medical establishment bodies like WPATH.

The Cass Review fails to recognize the ubiquity of "controversy" in the healthcare of a highly marginalized and harassed minority group. Trans children's healthcare will always be controversial when some individuals do not recognize the validity of trans lives, when a portion of interested stakeholders believe trans children do not or should not exist. The Cass Review does not recognize the responsibilities of healthcare professionals to center their service users, especially in the face of politicized controversy. In other countries like Australia, healthcare professionals have taken strong steps to ensure they are standing by their trans communities, including advocating for trans children's right to healthcare (Telfer et al., 2018). In the UK, the Cass Review seems to agree that controversy is itself a reason to increase barriers to healthcare. The Cass Review defines puberty blockers as a particularly controversial medication:

> The administration of puberty blockers is arguably more controversial…, because there are more uncertainties associated with their use. [Report 5, p. 37]

The Cass Review presents puberty blockers as controversial, without providing scientific evidence to justify any controversy. The global Endocrine Society recognizes their safe and effective use to temporarily block puberty in trans adolescents (Hembree et al., 2017), and they are not deemed controversial when used by cis children (Kim, 2015). No evidence is provided by the Cass Review to demonstrate that puberty blockers are ineffective or unsafe. In justifying concern over puberty blockers, the Cass Review instead asserts a series of fringe theories that are unevidenced, or outright contradicted by modern literature.

> The most difficult question is whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway which culminates in progression to feminising/masculinising hormones by impeding the usual process of sexual orientation and gender identity development. [Report 5, p. 36]

The Cass Review provides no evidence to support the proposal that puberty blockers, medication routinely used by cis children with precocious puberty, cause the "locking in" of a trans identity. The Cass Review provides no evidence that forcing a trans child through an unwanted and incongruent puberty will result in deviation from a trans identity. Yet this entirely unevidenced theory is taken as sufficient evidence to elevate it to what the Cass Review calls "*the most difficult question*." This is an example of the Cass Review citing theories or views, in support of non-affirmative approaches, without evidence to substantiate these theories or approaches.

Whilst established trans-positive healthcare practices are rejected by the Cass Review without RCT standard evidence, there are a range of concepts and approaches that are accepted by Cass with little or no evidence at all. A Cass Review graphic includes the outcome "*settled sexuality resolves gender dysphoria*" [Report 5, p. 57]. The Cass Review is here presenting a fringe view, that settling sexuality is a root to resolving or curing gender dysphoria. This fringe view is presented as fact without any evidence at all for this claim.

In several other areas the Cass Review presents contested or outdated concepts as though they are established knowledge. This is particularly noticeable when the Cass Review references the highly disputed concept of "desistance":

> This stage of pubertal development was chosen because it was felt that although many younger children experienced gender incongruence as a transient developmental phenomenon, those who expressed early gender incongruence which continued into puberty were unlikely to desist at that stage. [Report 5, p. 31]

Here the Cass Review dismisses trans children's identities by presenting the theory of "desistance." This concept, a term drawn from criminology, has been extensively critiqued in peer reviewed literature, and is not considered a useful concept in modern healthcare (Ashley, 2022; Temple Newhook et al., 2018). The concept has also been contradicted by a body of modern research (De Castro et al., 2024; Olson et al., 2022). Nevertheless, the Cass Review is content with reference to a highly disputed theory, referring to it in several sections:

> Previous literature has indicated that if gender incongruence continues into puberty, desistance is unlikely. However, it should be noted that these older studies were not based on the current changed case-mix or the different sociocultural climate of recent years,

> which may have led to different outcomes. Having an open discussion about these questions is essential if a shared understanding of how to provide appropriate assessment and treatment is to be reached. [Report 5, p. 56]

This paragraph provides an interesting case in point on how the Cass Review approaches evidence. First the Cass Review presents, under the authority of reference to "*previous literature*" a discredited theory that puberty is relevant to "*desistance*." In this first sentence the Cass Review distorts the actual literature, inserting reference to a modern cohort and diagnosis of "gender incongruence" on studies that focused instead on gender identity disorder. The distinction is an important one, as the diagnosis of gender incongruence is intended to focus on trans children, whilst the broader category of gender identity disorder pathologized a wider range of children including those who were non-conforming cis children. Next, the Cass Review acknowledges a sub-set of the criticisms of desistance literature, avoiding reference to peer reviewed literature that has critiqued the application of desistance literature to trans children. Finally, the paragraph ends with assertion of the importance of "open discussion" of such matters. Trans healthcare scholars who have critiqued and debunked flawed and pathologizing concepts like desistance for decades are called to again debate and challenge concepts and literature that has multiple times been discredited in peer reviewed research.

The same contested research on desistance informs the Cass approach to social transition, with the professional panel report recommending denial of social transition until "*after puberty… If the Gender Dysphoria is unresolved…*" [Report 3, p. 33]. This policy position, and its suggestion of dysphoria being "resolved by puberty" relies on the same older desistance studies, predominantly on cis children, from the 1950s-2000s. A majority of this pathologizing older research was undertaken with a focus on preventing or curing gender non-conformity (Temple Newhook et al., 2018). Nonetheless this weak and discredited evidence influences significant policy recommendations, directly cited as justification for NHS England's revised service specification:

> Dr Cass has recommended that social transition be viewed as an 'active intervention'… In line with this advice, the interim service specification sets out more clearly that the clinical approach in regard to pre-pubertal children will reflect evidence that in most cases gender incongruence does not persist into adolescence… (NHS England, 2022, p. 11)

Historical studies (from the 1950s-2000s) that focused on a different cohort, that have been critiqued multiple times in peer reviewed literature, provide an extremely weak body of evidence for guiding modern healthcare (Ashley, 2022; Temple Newhook et al., 2018). Yet these low-quality historic studies, none of which focused specifically on trans children, are deemed sufficient evidence to justify denial of support for social transition. In the Cass Review approach affirmative healthcare is held to an unachievable standard of RCT evidence. Non-affirmative approaches are presented as the default position or as accepted knowledge either without citation, or with reliance on older (pre-2013) non-RCT evidence that has been critiqued multiple times in peer reviewed publications. This highlights a significant double standard that impacts on the Cass Review's approach to evidence-based policy. There is also a noticeable bias in what approaches are prioritized where evidence is limited. The Cass Review's approach, with its direct impact on NHS England policy, assumes that treating a trans child with respect and affirmation is an active intervention, requiring a high degree of evidence. The Cass Review notes:

> Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. [Report 5, p. 62].

Support for affirmation of a trans child's identity is upheld as a medical "intervention" requiring high quality evidence. Rejection or non-affirmation of a child's identity is presumed the natural default position, requiring no evidence at all. Arguably, denying and rejecting a child's self-knowledge is a far greater intervention in that child's life, requiring a greater burden of clinical proof, than simply letting each child assert and affirm their own identity. Yet the Cass Review considers acceptance of a child's identity as trans as a significant "intervention." The Cass Review's position frames rejection of a trans child's identity as neutral and benign, requiring no evidence for such a policy proposal. Accepting and embracing a trans child is viewed as more extreme and in need of "high quality" evidence. This position demonstrates extreme cisnormativity, with only cis children viewed as natural or inherently worthy of respect and acceptance. This position is also pathologizing, with acceptance of a trans identity considered a medical intervention. It is also noteworthy that the Cass Review develops recommendations cautioning against social transition without analyzing existing literature on social transition. This includes the Cass Review failing to cite or reflect upon a growing body of evidence on the known benefits of social transition for trans children (Durwood et al., 2017; Horton, 2023b, 2023d; Olson et al., 2016).

In several sections the Cass Review emphasizes the risk or significance of any affirmative medical or social interventions, whilst negating or ignoring the potential harms of nonintervention or denial of social or medical transition. Trans healthcare is referred to as comprising "challenging decisions about life-changing interventions" [Report 5, p. 18], whilst the denial of trans healthcare is not weighed as a significant or life-changing intervention. This is another example of the Cass Review centering a cisnormative perspective to evidence or decision-making. A trans person being denied affirmative healthcare and being forced through incongruent puberty is not considered "life-changing." Healthcare policies that deny access to affirmative healthcare can be justified by the Cass Review without any burden of proof that they lead to improved health or well-being outcomes. There is significant evidence of a double standard in evidence-informed policy making within the Cass Review, with affirmative approaches held to a higher standard of evidence than non-affirmative approaches.

Discussion

Within the Cass Review anti-trans prejudice is not acknowledged as a problem or a threat to trans children. Across several reports the Cass Review centers the concerns of non-affirmative professionals, including those who do not believe in the existence of trans children. The existence of anti-trans prejudice amongst healthcare professionals is well-documented in existing literature (Brown et al., 2018; Stroumsa et al., 2019) and Cass Review reports indeed provide clear indication of professional ignorance or prejudice. However, across Cass Review reports, there is no instance where professional views on trans children are identified as ill-informed or prejudiced or are rejected from inclusion in the review. Instead, the views of ignorant or pathologizing professionals seeking support for non-affirming practice with trans children are presented with sympathy. There is no parallel consideration of the rights or welfare of trans children, nor discussion of an NHS duty of care to protect trans children from being harmed by professionals who reject the validity or existence of trans lives. The Cass approach welcomes all views, including those grounded in ignorance, pathologization or denial of the existence of trans children. The Cass Review also seeks consensus in a field characterized by polarization. Those of us with expertise in this field can recognize that it is not possible, nor indeed desirable, to find consensus between advocates for trans children's equal rights, who celebrate trans children's value in this world, and individuals who deny the existence of trans children, for whom transness is a disorder or confusion in need of conversion, prevention or eradication. Policy and evidence processes in trans healthcare need to recognize the existence of anti-trans prejudice or ignorance, even amongst healthcare professionals, and take steps to protect trans healthcare users from approaches that are driven by prejudice.

The Cass Review demonstrates cisnormative bias in the erasure of trans children, and in the misgendering and delegitimization of both trans children and trans adults in Cass Review reports. The fact the report is willing to directly misgender and disrespect a portion of current service users provides some insights into the audiences that matter to the Cass Review. Erasure and misgendering of trans children is also a demonstration of cisnormativity and adultism, where child rights and child perspectives are unrecognized, with all children defaulted to a presumed cis status. Cisnormative bias can be seen in the exclusion of trans expertise, and the marginalization of trans voices in leadership and oversight of the Cass Review. Exclusion of trans expertise is not a neutral act in a field that where lived experience and community knowledge is absolutely vital to avoiding pathologization, cisnormativity and medical harm. Exclusion of trans expertise is both indicative of the bias within the Cass Review, and explanatory for continued cisnormativity across the review and its outputs. Such exclusion of trans expertise is all too common in the UK. In a 2021 critique of a pathologizing Nuffield Council on Bioethics consultation on trans children's health (a consultation that problematized trans existence and contained no trans community leadership in design or governance) Pearce (2021, para. 10) emphasized that, in excluding trans leadership they "*are reproducing, once again, the power imbalance that has dominated trans medicine for the past two centuries*." Policy processes in trans healthcare need to take steps to reduce the impact of cisnormativity, especially in processes that are cis-led, where the risk of cisnormativity is particularly acute.

Pathologisation of gender diversity can be seen across Cass Review outputs. Entrenched cisnormativity and problematisation of transness leads to the Cass Review prioritizing the research questions about transness that trouble cis people. The Cass Review does not center trans community research priorities such as enhancing depathologized access to safe and effective healthcare for trans children. This leads the Cass Review into research priorities that are more philosophical than medical, questions on epidemiology of transness, etiology or identity persistence. The Cass Review is able to step beyond (and deprioritise) the domains of effective trans healthcare for trans children, by the Review's failure to recognize trans children as a core stakeholder group, enabling the very existence of trans children to be a valid topic of cis curiosity. Whilst the Cass Review decenters and delegitimises its core target population (trans children), their health and welfare needs are secondary to curiosity on how children came to identify as trans and whether or when they will stop.

A review of trans healthcare that excludes trans leadership or trans accountability is likely vulnerable to pathologization. The Cass Review fails to embed depathologization across its outputs, instead adopting a medicalised approach of trans-ness as something to be diagnosed, treated, prevented or cured. Avoidance of the recognition of trans children as a minority group pushes the Cass Review into a disease paradigm, seeking to treat "gender related distress." The Cass Review has two distinct options available on the topic of diagnosis. It could recognize that being trans cannot be meaningfully diagnosed by an external person. It could recognize that being trans is neither a pathology nor a problem. It could endorse affirmative approaches that start by listening to and respecting child self-knowledge of who they are, noting that affirmative approaches do not prevent an individual child from exploring or reflecting upon on their own identity, in their own time. But because the Cass Review does not endorse an affirmative approach that depathologizes transness, it is instead left tying itself in knots on the question of how a professional can diagnose a trans identity. The reality that many trans people require specific medical interventions is given as a justification for squashing transness into a disease treatment model framed in pathology-related terms of condition, diagnosis, treatment and prevention. A disease treatment model is not the only way to provide healthcare. Ashley (2022a) has drawn a comparison between trans healthcare and other healthcare services that relate to bodily autonomy, such as pregnancy and abortion healthcare. Ashley notes how those healthcare services manage to provide healthcare to a specific group, without relying upon a pathologizing and disempowering disease diagnosis and treatment model of care, prioritizing instead minority healthcare rights and bodily autonomy. The Cass Review and other trans healthcare initiatives need to recognize the harms of pathologization, and take proactive steps to embed depathologisation across their approaches and outputs.

The final section of this article examined the Cass Review's approach to evidence and dealing with uncertainty. The NICE evidence reviews chaired by Dr Cass both utilized an approach where only evidence like RCTs are considered high quality evidence. In a field where RCTs are recognized as infeasible and unethical, in a field where "high quality evidence" does not and may never exist, we may be left to wonder, has this evidence review really served to enlighten and inform decision making in trans healthcare? Those interested in maximizing trans children's well-being would look at all available sources of evidence, and use the best quality existing evidence to inform decision making. Instead, the absence of a type of "high quality" evidence is used by the Cass Review to conclude that "*evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive*." Such statements have legitimized the closure of current trans children's healthcare services for England and Wales, with no services currently operational. The Cass approach places so much emphasis on uncertainties, unknowns, areas without consensus and the absence of "high quality evidence" that it can be read as an argument against affirmative healthcare for trans children. A cisnormative double standard can also be seen, where evidence-based affirmative approaches are dismissed with calls for RCT standard evidence, whilst non-affirmative theories and policies are introduced and endorsed with no or limited evidence.

The Cass Review overall can be considered an example of cis-ignorance, a concept recognized in trans healthcare, where "*ignorance is not simply an absence of knowledge, but an epistemic practice in its own right*" (Mikulak, 2021, p. 827). Mikulak recognizes that "*practices of ignorance are often entangled with practices of exclusion and oppression*" (2021, p. 819). Cis-ignorance can be seen in the Cass Review's decision to exclude trans expertise, in the choice to appoint leadership without experience or knowledge, and in the valuing of insights from healthcare professionals who do not even believe in the existence of trans children. Cis-ignorance is apparent in the cisnormative framing of research questions, where research on the meaning of identity or the epidemiology of transness are perceived as important research priorities, and in the erasure of trans children from the Review's stated target group, leaving trans children's existence a topic of debate. Cis-ignorance can be seen in the citation of discredited research, forcing affirmative researchers to continually re-dispute the same literature that has been critiqued so many times, including in peer reviewed literature, preventing the field from moving forwards. Cis-ignorance can be seen in a futile search for consensus in a polarized field, setting out (with time, resources, and establishment credentials) to reach an objective of building consensus that is doomed from the start. Cis-ignorance can be seen in the dismissal of existing knowledge, framing the whole of trans healthcare as "inconclusive," "unknown" or risky, and in calls for infeasible and unethical RCT or blinded control studies. Observers may wonder whether cis-ignorance is intentional and abusive, or careless and ill-informed. Regardless of intent, it manifests as an exertion of cis power over trans communities, in a National Health Service that continues to fail to uphold trans people's rights to equality in healthcare.

The Cass Review overall can also be seen as an example of cis-supremacy in action. Elsewhere (Horton, 2023a) I have written about a theoretical framework of cis-supremacy, combining scholarship on cisnormativity, pathologization and gender minority stress with scholarship on white supremacy, centering the forces of power and cis domination that shape and constrain trans lives. Cis-supremacy calls attention to the axes and forces of cis-power that actively dominate and oppress trans people, with cis-supremacy particularly harmful in cis-dominant institutions or processes that lack trans accountability (Horton, 2023a). The Cass Review is an exemplar of cis-supremacy, and more specifically, of cis institutional dominance. This is seen in its design and leadership, with the Cass Review designed by and for cis stakeholders, led and advised by cis healthcare professionals with no knowledge or experience of trans healthcare, with no mechanisms for accountability to trans communities. This critical analysis of the Cass Review reveals four areas of concern, relating to how the Cass Review deals with prejudice, cisnormative bias, and pathologization, and with double standards in how evidence informs policy and practice. Each of these concerns impacts on the Cass Review's approach to trans children's healthcare, with negative repercussions for trans children's healthcare rights and well-being. Actors engaged in policy development or evidence reviews in trans healthcare need to be aware of these four pitfalls that could arise in other cis-dominant policy processes.

Conclusion

The Cass Review can be understood as an exercise in cis-supremacy, in a healthcare system that lacks trans accountability. Four areas of concern are highlighted, relating to how the Cass Review deals with prejudice, cisnormative bias, and pathologization, and with double standards in how evidence informs policy and practice. Actors in trans healthcare policy and practice need to recognize these areas of concern and take steps to counter them. Initiatives in trans healthcare need to build from trans positivity and respect, including proactive recognition and celebration of trans children's lives. Initiatives like the Cass Review need to have a much greater commitment to acknowledging and upholding trans children's healthcare rights, prioritizing equity and social justice for minoritized healthcare service users.

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ORCID

Cal Horton http://orcid.org/0000-0003-1944-4122

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