SEGM
SOCIETY FOR EVIDENCE BASED GENDER MEDICINE

From: Society for Evidence-Based Gender Medicine (SEGM)

To: Allsherjar- og Menntamálanefnd , Alþingi.

Regarding: "Conversion Practices Prohibition Bill." Frumvarp til laga er varðar breytingu á almennum hegningarlögum nr. 19/1940, með síðari breytingum (bælingarmeðferð), Þingskjal 45-45.mál.

Date: November 8, 2022

Dear Members of the Parliament,

The Society for Evidence-Based Gender Medicine (SEGM) is a non-partisan, non-profit, scientific organization comprised of medical specialists in endocrinology, pediatrics, psychiatry, obstetrics, family medicine, as well as scientists, clinicians, psychologists, researchers, and medical educators. Over 150 professionals hailing from the U.S., Europe (including Iceland), and Australia supply SEGM's expertise. Our mission is to promote safe, compassionate, ethical, and evidence-informed healthcare for children, adolescents, and young adults with gender dysphoria.

As you may know, it the last 24 months, following systematic reviews of evidence, three European countries (Finland, Sweden, England) have explicitly named *psychosocial interventions* as the first line of treatment for youth gender dysphoria (COHERE, 2020; Socialstyrelsen, 2022; NHS England, 2022). Two different types of interventions are recommended: general, holistic mental health care to address co-occurring mental health problems, as well as a specialized *gender-exploratory* psychotherapy that specifically deals with the distress related to "gender incongruence" – the mismatch a young person feels between their biological sex, and their internally experienced sense of "gender." The outcomes of both types of interventions can range from amelioration of the distress while continuing to experience gender incongruence, to gaining insight into what may have contributed to the sense of "gender incongruence" and resolving it. Although psychotherapy does not aim to change an individual's inner sense of "gendered self," it does promote identity exploration and development, and a subsequent change in gender identity can be a *natural outcome* of such ethical psychotherapeutic work.

The "psychotherapy first" recommendation from the leaders in youth gender transition in Europe arose from the new recognition that the evidence for gender dysphoria medical treatments in youth is very low quality; that the benefits of "early medical intervention" are of very low certainty; and that these uncertain benefits must be balanced with the real risks of such treatments, which include harms to bone, brain, cardiovascular health and other physical functions, including infertility and sterility (NICE 2021a, 2021b; Pasternack et al., 2019; SBU, 2021). Another key risk is that of regret, voiced by growing numbers of youth worldwide (Entwistle, 2020; Littman, 2021; Vandenbussche, 2022).

The low certainty of benefit of hormone treatments of youth was also reached by a recent "overview of systematic reviews" commissioned by the U.S. State of Florida (Brignardello-Peterson & Wiercioch, 2022). In November 2022, Florida's Medical Board determined that hormones and surgeries for gender dysphoric youth are experimental, and banned this practice in general medical settings (Ghorayshi, 2022). The Board encouraged clinicians to treat gender dysphoric youth under the well-established "community standard of care" for distress, which is psychotherapy.

In young people, gender dysphoria arises from a wide range of causes, often in complex developmental and family contexts (Bewley et al., 2019; Churcher Clarke & Spiliadis, 2019; D'Angelo, 2020; Kozlowska et al., 2021; Schwartz, 2021). Claims by U.S. clinician activists that therapy for gender dysphoria leads to harms have been decisively refuted (D'Angelo et al., 2021). There is a small but growing body of evidence that psychotherapy for gender dysphoria not only can be performed ethically, but also can lead to resolution of gender-related distress (Churcher Clarke & Spiliadis, 2019; Lemma, 2018; Spiliadis, 2019; Schwartz, 2021). Should the Conversion Practices Prohibition Bill pass as written, it will effectively make it impossible to consider the roles of developmental, family, and mental health issues in generating or contributing to gender dysphoria.

Nearly a dozen studies have concluded that the majority (61-98%) of children who struggle with gender-related issues will identify with their biological sex before reaching mature adulthood, either spontaneously, or with the help of ethical, supportive psychotherapy (Hembree et al., 2017; Ristori & Steensma, 2016; Singh, 2021). The analysis of psychosexual outcomes of these youth clearly indicates that most gender-dysphoric children and adolescents grow up to be lesbian, gay, or bisexual adults when they are not gender-transitioned as minors (Cantor, 2022).

The novel cohort of youth that developed gender dysphoria only around or after the onset of puberty, and often in the context of significant pre-existing mental illness and neurocognitive conditions such as attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) (Becerra-Culqui et al., 2018; Kaltiala-Heino et al., 2015; Kozlowska et al., 2021), is not well-understood. However, every youth gender clinic in the world now reports that this cohort has become the predominant clinical presentation (de Graaf & Carmichael, 2019; Kaltiala-Heino et al., 2018; Zhang et al., 2021; Zucker, 2019).

The rate of discontinuation of hormones among recently transitioning youth is now between 10% and 30% within just a few years after initiating the treatment (Boyd et al., 2022; Hall et al. 2021; Roberts et al., 2022). Since "gender-affirming" hormone treatment is anticipated to be lifelong, this high rate of discontinuation suggests that a number of erroneously undertaken transitions are currently taking place.

Not all those who discontinue "gender-affirming" interventions are voicing regret, but growing numbers of them are. (Vandenbussche, 2021; Littman, 2021). Since the average time to regret has been documented as 10 years or more (Dhejne et al., 2014; Wiepjes et al., 2018), and the practice of gender transitioning of young people only become widespread in the last few years, it is likely that we will see many other youth who will consider themselves harmed by the medical profession in the years to come. As currently written, the Bill is likely to discourage therapists from offering

psychotherapy for gender-dysphoric youth, leaving them with only one choice of treatment to alleviate their distress—effectively forcing them into medical transition.

Further, we would like to emphasize that using the term "conversion practices" in the context of gender dysphoria is not only misleading but also inaccurate. "Conversion practices" refer to an ideological and, historically, religiously motivated effort to forcefully "convert" lesbian, gay, and bisexual individuals to become heterosexual. To suggest that this practice is being applied to gender-questioning youth is erroneous and only serves to further inflame the already highly politicized field of transgender medicine. The fear of being accused of practicing "conversion therapy" will scare ethical psychotherapists from working with this vulnerable population, which in turn will lead to reduced access to quality healthcare for the very population this Bill aims to protect: young people suffering from gender dysphoria.

The principle of "first, do no harm" dictates that noninvasive treatments should be attempted before invasive, risky, and irreversible interventions, based on low-quality evidence, are considered (D'Angelo et al., 2020). Rather than banning "conversion therapy" for gender dysphoria, Iceland should consider passing laws that *protect* ethical psychotherapists and sacred therapist-patient relationships from such accusations. Even the principal author of the "Dutch study," which is used as the primary justification for gender transition of minors (de Vries et al., 2014), acknowledged that for the novel cohort of youth that began to dominate gender clinics in the last few years, psychotherapy may be more appropriate than hormones and surgery (de Vries, 2020).

The Icelandic government should pay close attention to international developments, as a growing number of countries and states begin to regulate access to irreversible hormones and surgeries, and prioritize psychotherapy. Iceland's current medical practice appears to be out of step with the leading European nations' direction. For example, while Iceland appears to endorse the practice of social gender transition of youth, England's NHS recently concluded that social transition is a form of psychosocial intervention that carries significant risks, and it explicitly discouraged social transition in youth (NHS England, 2022). If social gender transition is pursued, there must be an explicit diagnosis of gender dysphoria, and the benefits of social transition must be deemed sufficient to outweigh the risks in each particular case. Further, explicit informed consent should be granted for this practice (NHS England, 2022). This NHS recommendation was made in response to emerging evidence that social transition of minors tends to "lock" them into a medicalized treatment pathway (Olson, 2022; SEGM, 2022).

In Iceland, no diagnosis appears to be required to initiate social transition of minors, and clinicians are advised to refer for puberty blocking medication. To the best of our knowledge, many health practitioner codes of practice already follow this rubric. According to the Bill, should clinicians in Iceland follow international developments and the conventional standard of pursuing noninvasive interventions before attempting medication and surgery, making a referral to psychotherapy would in effect be considered practicing "conversion." As written, the Bill would further accelerate the medicalization of vulnerable youth with hormones and surgery with known and serious lifelong impacts, including likely *infertility and sterility* (Laidlaw et al., 2019), when adhering to the WPATH's recommendations to block puberty at the earliest sign (Tanner stage II) and follow with cross-sex hormones (Coleman et al., 2022). The health risks associated with puberty blocking, cross-sex-

hormones, and surgery are significant (Levine et al., 2022a) and it is not certain whether minors can ethically consent to these interventions, especially when they are denied the choice of noninvasive interventions first (Levine et al., 2022b).

Mental health practitioners play a unique role in the lives of young people because of their understanding of the complexity of childhood and adolescent psychosexual and identity development. We recommend that the Icelandic government make explicit its support for developmentally informed psychological approaches for the management of gender dysphoria in young people, and protect the rights of gender dysphoric patients to access noninvasive solutions for their distress.

Therefore, SEGM urges the Parliament to reject the Conversion Practices Prohibition Bill in its current form.

Roberto D'Angelo, PsyD, MMed, MBBS, FRANZCP, SEGM President

On behalf of the Board of Directors of the Society for Evidence-based Gender Medicine (SEGM)

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Frá Society for Evidence-Based Gender Medicine (SEGM)

Til: Allsherjar- og Menntamálanefnd , Alþingi.

Varðandi: Frumvarp til laga er varðar breytingu á almennum hegningarlögum nr. 19/1940, með síðari breytingum (bælingarmeðferð), Þingskjal 45-45.mál.

Dagsetning: 8. nóvember, 2022

Kæru alþingismenn,

"The Society for Evidence-Based Gender Medicine (SEGM)" eru pólitískt óháð vísindasamtök sem eru ekki rekin í hagnaðarskyni. Að samtökunum standa sérfræðingar í meðal annars innkirtlalækningum, barnalækningum, geðlækningum, fæðingalækningum og heimilislækningum sem og vísindamenn, sálfræðingar og kennarar innan heilbrigðisvísinda. Það eru þannig meira en 150 læknar og sérfræðingar frá Bandaríkjunum, Evrópu (þar með talið Íslandi) og Ástralíu sem byggja upp sérþekkingu SEGM. Markmið okkar er að stuðla að öruggri, heildrænni, siðrænni sem og vísindalega gagnreyndri heilbrigðisþjónustu fyrir börn, unglinga og unga fullorðna með kynama.

Ykkur er kannski ljóst að á síðastliðnum 24 mánuðum hafa þrjár Evrópuþjóðir (Finland, Svíþjóð, England), í kjölfar kerfisbundinnar yfirferðar á rannsóknabakgrunni meðferða barna og ungmenna með kynama, gert sálfélagslegar meðferðir að fyrstu meðferð fyrir þennan hóp. (COHERE, 2020; Socialstyrelsen, 2022; NHS England, 2022). Þannig er nú mælt með tveimur mismunandi meðferðarformum fyrir þennan hóp þ.e. annarsvegar almennri heildrænni geðheilbrigðisþjónustu sem miðar að því að vinna með önnur samhliða geðræn og félagsleg vandamál og hinsvegar sértækri sálrænni meðferð[1] sem tekur sérstaklega á þeirri vanlíðan sem kemur upp í tengslum við kynama og kynmisræmi þ.e. þegar einstaklingur upplifir að líffræðilegt kyn hans samræmist ekki innri kynvitund.

Áhrif ofangreindra meðferða geta verið allt frá því að minnka vanlíðan, þó kynmiræmi sé enn til staðar, til þess að með auknum skilningi og innsæi í hvaða þættir gætu hafa stuðlað að þróun kynmisræmis gert það að verkum að kynmisræmi gangi til baka. Jafnvel þó sálræn meðferð sé ekki veitt með það að markmiði að reyna að breyta kynvitund einstaklinga þá getur slík meðferð samhliða áframhaldandi þroska og sjálfsmyndaruppbyggingu orðið til þess að það sé niðurstaðan.

Þessar leiðbeiningar "Sálræn meðferð fyrst" eru unnar af þeim þjóðum sem teljast leiðandi í Evrópu er varðar meðferð barna og unglinga með kynama. Sérhver þjóðanna sem um ræðir hefur þannig framkvæmt sína eigin opinberu og óháðu kerfisbundnu yfirferð á rannsóknunum sem fyrir liggja um þetta efni (NICE 2021a, 2021b; Pasternack et al., 2019; SBU, 2021) og allar komist að þeirri niðurstöðu að meðferðarmódelið sem áður var stuðst við og byggir á snemmbærum

[1] Með sálrænni meðferð er í þessari umfjöllun átt við "psychotherapy" sem vísar til samtalsmeðferðar sem er veitt innan ramma heilbrigðiskerfisins af viðurkenndum fagaðilum í geðheilbrigðisþjónustu eins og til dæmis geðlæknum eða sálfræðingum.

læknisfræðilegum inngripum styðst við rannsóknir sem eru af vísindalega lágum gæðum sem þýðir að gagnsemi þessarar meðferðar er óljós og hún stendur á mjög veikum grunni vísindalega.

Það verður þannig að vega þessa óljósu gagnsemi mjög vandlega á móti þeim áhættum sem vitað er að þessi meðferð felur í sér. Má þar nefna neikvæð áhrif á beinþroska sem valdið getur beinþynningu, aukna áhættu á hjarta og æðasjúkdómum og tímabundna eða varanlega ófrjósemi. Einnig eru í vaxandi mæli að stíga fram einstaklingar sem upplifa eftirsjá eftir að hafa gengist undir slíka meðferð á unglingárum eða snemma á fullorðinsárum (Entwistle, 2020; Littman, 2021; Vandenbussche, 2022).

Nýlega birt samantektaryfirlit á kerfisbundnum yfirferðum (e. overview of systematic reviews) er varða þetta efni, og gerð var á vegum Flórída ríkis í Bandaríkjunum (Brignardello-Peterson & Wiercioch, 2022), leiddi til sömu niðurstöðu er varðar óvissu í gagnsemi inngripa með hormónum fyrir ungmenni með kynama. Læknaráð Flóridaríkis hefur nýlega ákvarðað að meðferð barna og unglinga með kynama sem byggir á hormónum og/eða skurðaðgerðum sé í raun tilraunakennd meðferð og er slík meðferð frá og með nóvember mánuði í ár (2022) bönnuð í ríkinu sem leiðir til að fyrsta meðferð fyrir þennan hóp verður sálræn meðferð.

Það er í vaxandi mæli að koma í ljós að sálræn meðferð eingöngu getur gagnast við að minnka vanlíðan í tengslum við kynmiræmi (Churcher Clarke & Spiliadis, 2019; Lemma, 2018; Spiliadis, 2019; Schwartz, 2021). Verði frumvarpið sem um ræðir samþykkt að óbreyttu mun það gera það að verkum að það verður nú ómögulegt beita sálrænum meðferðum og taka inn í myndina þætti eins og þroska, fjölskyldubakgrunn og geðræn vandamál og skoða hvernig þeir hugsanlega stuðla að eða hafa áhrif á kynama hjá ungum einstaklingi.

Rannsóknir hafa sýnt að meirihluti (61-98%) einstaklinga sem upplifa kynmisræmi í barnæsku munu síðar samsama sig að fæðingarkyni sínu áður en þeir ná fullorðinsaldri. Þetta gerist annað hvort af sjálfu sér án inngripa eða með stuðningi í formi sálrænna meðferða sem byggja á læknisfræðilega siðfræðilegum grunni. (Ristori & Steensma, 2016; Singh, 2021). Flest börn og unglingar með kynama vaxa úr grasi sem samkynhneigðir eða tvíkynhneigðir einstaklingar (Cantor, 2022).

Á síðastliðnum áratug hefur orðið gríðarleg aukning á tilfellum ungmenna sem þjást vegna kynama og á sama tíma hefur faraldsfræðilegur bakgrunnur hópsins gjörbreyst. Flestir þeirra sem leita sér meðferðar í dag eru einstaklingar sem upplifa kynama fyrst á unglingsárum, nokkuð sem var sjaldséð áður, og í þessum hópi er einnig, gagnstætt því sem áður þekktist, mjög aukin tíðni annarra geð- og taugaröskunagreininga eins og þunglyndis, kvíða, sjálfskaðahegðunar, ADHD og einhverfu með meiru (Becerra-Culqui et al., 2018; Kaltiala-Heino et al., 2015; Kozlowska et al., 2021). Ekki er enn vitað hvað veldur þessari aukningu á tilfellum og breytingu á faraldsfræðilegum bakgrunni hópsins en viðlíkra breytinga hefur orðið vart nánast samtímis um heim allan(de Graaf & Carmichael, 2019; Kaltiala-Heino et al., 2018; Zhang et al., 2021; Zucker, 2019).

Nýlegar rannsóknir sýna að hlutfall ungmenna sem hætta á kynleiðréttandi hormónameðferð aðeins nokkrum árum eftir að hún hófst er nú allt að 10-30%(Boyd et al., 2022; Hall et al. 2021; Roberts et al., 2022). Þar sem hormónameðferðir í kynleiðréttandi tilgangi eru ætlaðar sem ævilöng meðferð er þetta háa hlutfall einstaklinga sem hætta meðferð vísbending um að verið sé að hefja meðferð á röngum forsendum hjá umtalsverðum hluta hópsins.

Af þeim sem hætta hormónameðferð er vaxandi hluti sem upplifir eftirsjá og eru þeir nú að stíga fram og tjá sig um reynslu sína. (Vandenbussche, 2021; Littman, 2021). Eldri rannsóknir hafa sýnt að eftirsjá eftir kynleiðréttingaferli kemur fyrst fram að meðaltali 10 árum eftir að það er hafið (Dhejne et al., 2014; Wiepjes et al., 2018). Í ljósi þess hversu útbreiddar þessar meðferðir hafa orðið á síðastliðnum fáum árum eru allar líkur á því að við munum í náinni framtíð sjá mikla aukning í hópi ungra einstaklinga sem telja sig hafa orðið fyrir beinum skaða af völdum heilbrigðiskerfisins í gegnum þessar meðferðir.

Að nota hugtakið bælingarmeðferð i sambandi við kynama er ekki aðeins ónákvæmt heldur beinlínis villandi. Bælingarmeðferð vísar í sögulegu samhengi til oft á tíðum grimmúðlegra aðferða til að reyna bæla eða breyta kynhneigð samkynhneigðra og tvíkynhneigðra einstaklinga svo þeir yrðu gagnkynhneigðir. Þessar aðferðir voru byggðar á ákveðnum hugmyndafræðilegum og oftar en ekki trúarlegum grunni. Að gefa í skyn að slíkum aðferðum sé nú beitt á ungmenni sem eru hugsandi yfir kyni sínu eða þjást vegna kynama er rangt og einungis til þess fallið að ýfa upp átök á nú þegar óvenjulega umdeildu sviði innan læknisfræðinnar.

Frumvarpið í sinni núverandi mynd er til þess fallið að fæla fagfólk í geðheilbrigðisþjónustu frá því að veita sálræna meðferð til að hjálpa börnum og unglingum með kynama af ótta við að vera ásakað um að beita bælingarmeðferðum og þar með eiga yfir höfði sér fangelsisvist. Lögin munum þannig skaða hópin sem þeim er ætlað að vernda með því að hefta aðgengi barna og unglinga með kynama að ákveðnum hluta viðurkenndrar heilbrigðisþjónustu og þannig óbeint beina þeim inn á braut meðferða sem byggja á inngripum í formi hormóna og aðgerða.

Í stað þess að leggja á bann við óljóst skilgreindri "bælingarmeðferð" fyrir börn og unglinga með kynama ætti löggjafinn frekar að setja inn lagaákvæði sem verndar fagfólk í heilbrigðisþjónustu sérstakleg gegn ásökunum um slíkt og þannig gefa því svigrúm til að beita þeim meðferðarúrræðum sem eru metin viðeigandi fyrir hvern og einn skjólstæðing. Ein av meginreglum læknisfræðinnar " Primum non nocere " , "framar öllu ekki skaða" kveður á um að að fyrst skuli alltaf beita ekki ífarandi (e. non-invasive) meðferðum áður en ífarandi (e. invasive), áhættusömum og óafturkræfum inngripum sé beitt sérstaklega þegar þau síðarnefndu standa á vísindalega veikum grunni (D'Angelo et al., 2020). Hér er vert að nefna að meira segja hefur einn að höfundum "Hollenska módelsins sem er það meðferðarmódel som byggir grunnin að læknisfræðilegum inngripum fyrir börn og unglinga með kynama (de Vries et al., 2014) hefur viðurkennt að fyrir þá unglinga sem eru að leita meðferðar í dag, þ.e. þá sem upplifa fyrst kynmisræmi á unglingsárum og eru með aðrar geð- og taugaröskunargreiningar, sé sálræn meðferð líklegast meira viðeigandi en meðferð með hormónum og aðgerðum (de Vries, 2020).

Íslensk stjórnvöld ættu að fylgjast gaumgæfilega með þeirri þróun sem nú er að eiga sér stað í þessum efnum á alþjóðavettvangi en nágrannaþjóðir Íslands eru margar hverjar að setja strangari reglur um aðgengi að óafturkræfum inngripum fyrir börn og unglinga með kynama og mæla með sálrænni meðferð sem fyrstu meðferð. Á Íslandi virðast verklagsferlar um meðferð ungmenna með kynama nú vera á skjön við þá stefnu sem aðrar leiðandi Evrópuþjóðir eru að taka. Sem dæmi þá virðist svo kölluð félagsleg kynleiðrétting (e. Social transition) barna vera praxis á Íslandi. Á sama tíma hefur NHS (National Health Service) í Englandi nýlega ályktað að félagsleg kynleiðrétting sé sálfélagslegt inngrip sem felur í sér ákveðna áhættu og mæla gegn því fyrir börn. Ef þrátt fyrir allt sé

ákveðið að gangast í slíka aðgerð skuli barnið vera formlega greint með kynama af viðurkenndum aðilum og ávinningur af félagslegri kynleiðréttingu verður að vera metin meiri en áhættan. Enn fremur skal afla upplýsts samþykkis frá forráðamönnum barnsins. Þessar nýju leiðbeiningar frá NHS England eru tilkomnar vegna þess að nýlegar rannsóknir hafa sýnt að félagsleg kynleiðrétting barna hefur tilhneigingu til að festa kynmisræmi í sessi og beina þeim þannig inn á braut læknisfræðilegra inngripa (Olson, 2022; SEGM, 2022).

Á Íslandi virðist ekki vera gerð krafa um formlega greiningum kynama áður en félagsleg inngrip eru hafin og eftir því sem okkur skilst er enn ráðlagt að vísa ungmennum áfram til meðferðar með stopp-hormónum (e. puberty blockers). Þeir læknar og annað heilbrigðisstarfsfólk sem vilja vinna í samræmi við þróunina á alþjóðavettvangi og eftir góðum starfsháttum, þar sem ekki ífarandi sálrænum meðferðum er beitt fyrst áður tekið er til áhættusamara og óafturkræfa inngripa, eiga nú á hættu á ‚fari frumvarpið í gegn að óbreyttu, að vera sakaðir um bælingameðferð. Þannig mun frumvarpið óbeint hraða ferli læknisfræðilegra inngripa með lyfjum og aðgerðum hjá þegar útsettum og viðkvæmum hópi ungmenna. Þessi inngrip hafa óafturkræfar ævilangar afleiðingar í för með sér. Þar má sem dæmi nefna varanlega ófrjósemi (Laidlaw et al., 2019) sé farið eftir leiðbeiningum "WPATH" þar sem stöðva skal kynþroska snemma í ferlinu (Tanner stig II) og krosshormóna meðferð svo hafin frá því stigi (Coleman et al., 2022). Heilsufarsleg áhætta stopp-hormóna, kross-hormóna og skurðaðgerða er umtalsverð(Levine et al., 2022a) og það er ekki full ljóst hvort börn og unglingar geti gefið upplýst samþykki fyrir þessum meðferðum, sérstaklega ef valið um að reyna aðrar ekki ífarandi meðferðir fyrst stendur þeim ekki til boða (Levine et al., 2022b).

Fagfólk í geðheilbrigðisþjónustu hefur verðmæta sérþekkingu á sviði þroskasálfræði og ferli sjálfsmyndarþroska og spilar þannig mikilvægt hlutverk í lífi ungra skjólstæðinga sinna. Við hvetjum til þess að íslensk stjórnvöld taki skýrt fram að þau styðji við fagfólk í geðheilbrigðisþjónustu sem veitir sálræna meðferð og nálganir sem lið í meðhöndlun barna og ungmenna með kynama og tryggi þannig aðgengi að öllum þeim sálrænu meðferðarúrræðum sem eru í boði til að minnka vanlíðan.

SEGM hvetur því eindregið till þess að frumvarpinu verði vísað frá að óbreyttu.

Fyrir hönd stjórnarmeðlima "Society for Evidence-based Gender Medicine" (SEGM)

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