The WPATH Files

PSEUDOSCIENTIFIC SURGICAL AND HORMONAL EXPERIMENTS ON CHILDREN, ADOLESCENTS, AND VULNERABLE ADULTS

By Mia Hughes

ENVIRONMENTAL PROGRESS
NATURE, PEACE & FREEDOM FOR ALL

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EXECUTIVE SUMMARY

The World Professional Association for Transgender Health (WPATH) enjoys the reputation of being the leading scientific and medical organization devoted to transgender healthcare. WPATH is globally recognized as being at the forefront of gender medicine.

However, throughout this report, we will show that the opposite is true. Newly released files from WPATH's internal messaging forum, as well as a leaked internal panel discussion, demonstrate that the world-leading transgender healthcare group is neither scientific nor advocating for ethical medical care. These internal communications reveal that WPATH advocates for many arbitrary medical practices, including hormonal and surgical experimentation on minors and vulnerable adults. Its approach to medicine is consumer-driven and pseudoscientific, and its members appear to be engaged in political activism, not science.

While there is a place in medicine for risky experiments, these can only be justified if there is a reliable, objective diagnosis; no other treatment options are available, and if the outcome for a patient or patient group is dire.[1] However, contrary to WPATH's claims, gender medicine does not fall into this category. The psychiatric condition of gender dysphoria is not a fatal illness, and the best available studies show that in the case of minors, with watchful waiting and compassionate support, most will either grow out of it or learn to manage their distress in ways less detrimental to their health.[2,3,4]

As such, this report will prove that sex-trait modification procedures on minors and people with mental health disorders, known as "gender-affirming care," are unethical medical experiments. This experiment causes harm without justification, and its victims are some of society's most vulnerable people. Their injuries are painful and life-altering. WPATH-affiliated healthcare providers advocate for the destruction of healthy reproductive systems, the amputation of healthy breasts, and the surgical removal of healthy genitals as the first and only line of treatment for minors and mentally ill people with gender dysphoria, eschewing any attempt to reconcile the patient with his or her birth sex. This report will show that this is a violation of medical ethics and, as is revealed by its own internal communications, WPATH does not meet the standards of evidence-based medicine. It will further show that the ethical requirement to obtain informed consent is being violated, with members admitting that children and adolescents cannot comprehend the lifelong consequences of sex-trait modification interventions, and in some cases, due to poor health literacy, neither can their parents.

Given the extent of the medical malpractice WPATH endorses, our report will conclude by calling on the U.S. government to oversee a bipartisan national inquiry to investigate how activists with little respect for the Hippocratic Oath could have risen to such prominence as to set the Standards of Care for an entire field of medicine, leading to the medical abuse of minors and vulnerable adults.

1 Earl, J. "Innovative Practice, Clinical Research, and the Ethical Advancement of Medicine." [In eng]. Am J Bioeth 19, no. 6 (Jun 2019): 7-18. https://doi.org/10.1080/15265161.2019.1602175.

2 Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder [Original Research]. Frontiers in Psychiatry, 12, 287. https://doi.org/10.3389/fpsyt.2021.632784

3 Steensma, T., & Cohen-Kettenis, P. "Gender Transitioning before Puberty?". Archives of sexual behavior 40 (03/01 2011): 649-50. https://doi.org/10.1007/s10508-011-9752-2.

4 Green, R. The Sissy Boy Syndrome the Development of Homosexuality. Yale University Press, 1987. doi:10.2307/j.ctt1ww3v4c. http://www.jstor.org/stable/j.ctt1ww3v4c.

PREFACE TO THE WPATH FILES

By Michael Shellenberger, Founder and President, Environmental Progress

Readers may rightly wonder why an environmental organization is publishing a report on what is known as "gender medicine." The short answer is that we are pro-human environmentalists, and our mission is to incubate ideas, leaders, and movements for nature, peace, and freedom for all. We thus work on a wide range of issues, from climate change to homelessness to freedom of speech, all of which constitute important aspects of our "environment."

The longer answer is that I felt the WPATH Files needed to be analyzed and put in a broader historical context than possible through a series of news articles. I received the WPATH Files from a source or sources who contacted me because they had seen my work on the Twitter Files.

We are releasing all of the unedited files precisely as I received them. Nothing has been removed or added by our team, but we have organized the files to improve accessibility. We have included dates where available in the files. All discussions in the files occurred within the last four years. We are leaving only the names of the president of WPATH, most surgeons, and other prominent members unredacted. While everyone aware of the information revealed by the WPATH Files is, to some extent, responsible, we did not feel that everyone in the conversations needed to be named. The files are preceded by a report that summarizes, analyzes, and draws implications from the information they contain.

The WPATH Files are semi-private conversations inside WPATH's internal online forum for discussing specific medical cases. This forum runs on software provided by DocMatter. I made clear to the source or sources that while I welcomed all or any information they chose to share, I would not and did not solicit or encourage anyone to retrieve any information from WPATH or any other organization. All information came to me unsolicited.

We are well within our legal rights to publish the WPATH Files. Like any publisher, Environmental Progress is governed by what's known as the Pentagon Papers Principle, established by the Supreme Court in 1971. Under the Court's ruling, interpreting the First Amendment to the United States Constitution, Americans can publish information, even if it was obtained illegally, so long as we do not encourage anyone to break the law in obtaining the information.

At a moral level, we feel duty-bound to publish the WPATH Files and do everything within our power to encourage as wide an audience as possible to access them. We believe they show that WPATH is neither a scientific nor medical organization and should not be treated as one.

ACKNOWLEDGMENTS

The author would like to acknowledge, first and foremost, the source or sources of the WPATH Files. They behaved nobly in their effort to protect children and vulnerable adults from harm.

Second, she would like to acknowledge Alex Gutentag and Michael Shellenberger; their contributions to this report went far beyond editing.

Third, she would like to thank Lily Markle and Phoebe Smith for their fact-checking, proofing, and general assistance.

Finally, the author would like to thank the Environmental Progress Board of Directors and financial supporters. Thank you for thinking outside the box of "the environment" to extend your concern to vulnerable people everywhere.

INTRODUCTION

Over the past decade, there has been a huge surge in the number of young people identifying as transgender and being referred to pediatric and adult gender clinics. A thorough analysis of all the possible explanations for this change is beyond the scope of this report, but there are two opposing viewpoints worth describing briefly. On one side, activists argue that the sudden increase is due to shifting societal attitudes and greater acceptance of the transgender community, making it easier for transgender people to come out of the closet and live as their true, authentic selves. On the other side, critics of gender-affirming care for minors favor the rapid-onset gender dysphoria hypothesis, which argues that there is strong peer and online influence as well as maladaptive coping mechanisms involved in the adoption of a transgender identity.

This "social genesis" or "social contagion" argument is supported by the fact that adolescent girls and young women now make up most of the referrals to gender clinics when, in the past, it was predominantly young boys and adult men. Teenage girls and young women have been at the forefront of almost every social contagion in recorded history, including contagions of hysteria, eating disorders, cutting, and dissociative identity disorder. The social contagion argument is also supported by the high prevalence of mental health and neurocognitive disorders among trans-identified youth, and the fact that these problems typically precede the onset of gender issues. Despite receiving criticism from activists, the rapid onset gender dysphoria theory has been endorsed by gender clinicians across the West.[5,6,7]

However, this report does not delve into the cultural factors responsible for the rising numbers. Instead, our focus narrows in on the conduct of WPATH members and the type of medical care the leading transgender health group endorses. The scope of this report is the potential harm inflicted upon adolescents and vulnerable adults within gender-affirming clinics.

WPATH is considered the leading authority on the care and treatment of individuals who have gender dysphoria and/or identify as transgender. WPATH publishes internationally respected Standards of Care, which it claims represent a professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria. Medical and mental health professionals worldwide look to these guidelines as the best available resource to guide them in caring for transgender and gender-diverse patients.

But the WPATH Files show something entirely different. Before discussing what they show, we recommend the reader turn to the files and read them in their entirety. They are complete from what a source or sources provided to us.

Now, we will put the WPATH Files in a wider historical and ethical context.

5 Hutchinson, A., Midgen, M., & Spiliadis, A. (2019). In Support of Research Into Rapid-Onset Gender Dysphoria. Archives of Sexual Behavior, 49. https://doi.org/10.1007/s10508-019-01517-9

6 Kaltiala, R. (2023). 'Gender-Affirming Care Is Dangerous. I Know Because I Helped Pioneer It.'. The Free Press. https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor

7 Levine, S. B. (2019). Informed Consent for Transgendered Patients. J Sex Marital Ther, 45(3), 218-229. https://doi.org/10.1080/0092623x.2018.1518885

A BRIEF HISTORY OF TRANSGENDER MEDICINE AND THE EARLY DAYS OF WPATH

The experiment to modify the sex characteristics of people suffering from the psychiatric disorder called gender dysphoria began in the early years of the 20th century with the pioneering work of German sexologist Magnus Hirschfeld. A gay man who engaged in cross-dressing, Hirschfeld coined the term transvestite in his 1910 book *Die Transvestiten* and regarded both homosexuals and transvestites to be "sexual intermediaries."[8, 9]

Hirschfeld oversaw the world's first attempt at "sex-reassignment" surgery performed on Martha/Karl Baer in 1906. While little is known about the precise nature of the surgery because the records were lost during the 1933 Nazi book-burning of Hirschfeld's research,[10, 11] it is believed to have been a metoidioplasty, which is the creation of a pseudo-phallus out of an enlarged clitoris. Baer is thought to have had a disorder of sexual development (DSD) and was reportedly genetically male.[12,13]

In 1919, Hirschfeld opened the Institute for Sexual Science in Berlin, which was a first-of-its-kind clinic providing counseling and treatment for "physical and psychological sexual disorders" as well as, in particular, for "sexual transitions."[14] Notably, Einar Wegener, or Lili Elbe, whose story was popularized in the film *The Danish Girl*, underwent surgical castration in Berlin under Hirschfeld's supervision in 1930.[15, 16] This was the first in a series of surgeries culminating in a womb transplant in 1931. Elbe died of heart failure three months after the final surgery, most likely due to organ rejection.[17,18]

That same year, Dora Richter underwent vaginoplasty, also under the care of Hirschfeld.[19] Erwin Gohrbandt performed Richter's surgery, which is considered the world's first successful male-to-female sex reassignment.[20,21] Gohrbandt then went on to join the Luftwaffe and participated in the hypothermia experiments conducted at Dachau concentration camp.[22]

Despite medical advances such as the development of antibiotics and the ability to create synthetic hormones, interest in sex-reassignment procedures waned over the next couple of decades, only to be rejuvenated in the 1950s with the sensational case of Christine Jorgensen.

On December 1, 1952, the New York Daily News ran a front-page story under the headline "Ex-GI Becomes

8 Matte, N. "International Sexual Reform and Sexology in Europe, 1897–1933." Canadian Bulletin of Medical History 22, no. 2 (2005): 253-70. https://doi.org/10.3138/cbmh.22.2.253.

9 Hill, Darryl B. "Sexuality and Gender in Hirschfeld's Die Transvestiten: A Case of the" Elusive Evidence of the Ordinary"." Journal of the History of Sexuality 14, no. 3 (2005): 316-32. https://muse.jhu.edu/article/195723.

10 "6 May 1933: Looting of the Institute of Sexology." Holocaust Memorial Day Trust, https://www.hmd.org.uk/resource/6-may-1933-looting-of-the-institute-of-sexology/.

11 "Karl M Baer: First Transgender Person to Undergo Female-to-Male (Ftm) Surgery." Let Her Fly, 2022, https://letherfly.org/karl-m-baer-the-first-person-in-the-world-to-undergo-sex-change-surgery/.

12 Funke, J. "The Case of Karl M.[Artha] Baer: Narrating 'Uncertain'sex." In Sex, Gender and Time in Fiction and Culture, 132-53: Springer, 2011.

13 "Recalling the First Sex Change Operation in History: A German-Israeli Insurance Salesman." Haaretz, 2015, https://www.haaretz.com/israel-news/2015-12-05/ty-article/.premium/the-first-sex-change-surgery-in-history/0000017f-f3fd-d5bd-a17f-f7ffa4970000?lts=1698264422989.

14 "The First Institute for Sexual Science (1919-1933)." Magnus-Hirschfeld-Gesellschaft, https://magnus-hirschfeld.de/ausstellungen/institute/.

15 "Publication History." Lili Elbe Digital Archive, http://lilielbe.org/narrative/publicationHistory.html.

16 "Books of the Times; Radical Change and Enduring Love." The New York Times, 2000, https://www.nytimes.com/2000/02/14/books/books-of-the-times-radical-change-and-enduring-love.html.

17 "Lili Elbe (Einar Wegener), 1882-1931." Danmarks Historien, https://danmarkshistorien.dk/vis/materiale/lili-elbe-einar-wegener-1882-1931/

18 "Lili Elbe." Biography 2022, https://www.biography.com/artists/lili-elbe.

19 Hirschfeld, https://www.hirschfeld.in-berlin.de/institut/en/personen/pers_34.html.

20 Abraham, F. "Genital Reassignment on Two Male Transvestites." International Journal of Transgenderism 2 (1998): 223-26. https://editions-ismael.com/wp-content/uploads/2017/10/1931-Felix-Abraham-Genital-Reassignment-on-Two-Male-Transvestites.pdf.

21 "Pioneers of Gender Reassignment Surgery." LGBT Health and Wellbeing, https://www.lgbthealth.org.uk/blog/pioneers-gender-reassignment-surgery/#:~:text=It%20was%20Dora%20Richter%20in,region%20to%20a%20poor%20family.

22 "The Nazi Doctors and the Nuremberg Code." Oxford University Press, 36. http://www.columbia.edu/itc/history/rothman/COL476I1854.pdf.

Blonde Beauty."[23] Jorgensen had traveled to Denmark the year before and, under the care of Dr. Christian Hamburger, underwent a series of surgeries involving castration and the creation of a semblance of external female genitalia.[24,25,26]

In 1953, after returning home to the US, Jorgensen became a patient of Dr. Harry Benjamin, a German endocrinologist with an interest in transsexualism, as it was known at the time.[27] Benjamin's career in medicine had had a disreputable beginning when, in 1913, he arrived in New York as the assistant of a quack peddling "turtle treatment," a fake tuberculosis vaccine.[28] Benjamin had no formal training in sexology, but as a lifelong friend of Hirschfeld, he had a fascination for the subject, and by the 1950s, his practice was almost exclusively focused on transsexualism.[29]

While Jorgensen brought fame and attention to Benjamin's obscure interest in transsexualism, it was another patient who brought the other essential element: money. Reed (Rita) Erickson, a female who transitioned to live as a man, became Benjamin's patient in 1963. Heir to a fortune, Erickson's philanthropic organization, Erickson Educational Foundation (EEF), funded the first three International Symposiums on Gender Identity as well as the newly formed Harry Benjamin Foundation.[30] This enhanced Benjamin's professional status, lending credibility to his sex change experiment. Benjamin coined and popularized the term "transsexual" with his 1966 book, *The Transsexual Phenomenon*.

Another of Erickson's philanthropic endeavors was to fund North America's first gender clinic at Johns Hopkins Hospital in Baltimore.[31] It was at this clinic that Dr. John Money conducted his unethical experiments on children born with disorders of sexual development, the most famous case being that of the Reimer twins. As a baby, David Reimer was the victim of a catastrophic medical accident when the cauterizing equipment malfunctioned during his circumcision, amputating his penis. Money convinced David's parents to raise him as a girl, an experiment that failed[32] and ultimately resulted in David committing suicide at age 38. His twin brother Brian had died two years previously of an overdose.

But Money didn't just experiment on children. During the same period, he attempted to perform sex changes on adults, claiming great success. But when Dr. Paul McHugh became psychiatrist-in-chief at Johns Hopkins in 1975, he commissioned a follow-up study of the adults who had undergone these procedures, which found that while most of the patients claimed to be satisfied and experiencing no regret, there was little change in their psychological functioning. McHugh concluded that Johns Hopkins was, therefore, wasting scientific and technical resources by cooperating with a mental illness rather than trying to study, cure, and prevent it.[33] The clinic was shut down in

23 "Ex Gi Becomes Blonde Beauty." Newspapers by Ancestry, https://www.newspapers.com/article/daily-news-ex-gi-becomes-blonde-beauty/25375703/.

24 Hamburger, C., Sturup, G. K., & Dahl-Iversen, E. "Transvestism; Hormonal, Psychiatric, and Surgical Treatment." [In eng]. J Am Med Assoc 152, no. 5 (May 30 1953): 391-6. https://doi.org/10.1001/jama.1953.03690050015006.

25 "A Gender-Affirming Surgery Gripped America in 1952: 'I Am Your Daughter'." The Washington Post, 2023, https://www.washingtonpost.com/history/2023/06/12/first-transgender-surgery-christine-jorgensen/.

26 Hadjimatheou, C. "Christine Jorgensen: 60 Years of Sex Change Ops." BBC News 30 (2012). https://www.bbc.com/news/magazine-20544095.

27 Schaefer, L. C., & Wheeler, C. C. "Harry Benjamin's First Ten Cases (1938–1953): A Clinical Historical Note." Archives of Sexual Behavior 24, no. 1 (1995/02/01 1995): 73-93. https://doi.org/10.1007/BF01541990.

28 Newspapers by Ancestry, https://www.newspapers.com/article/altoona-tribune/3750641/.

29 "Trans Medical Care at the Office of Dr. Harry Benjamin." NYC LGBT Historic Sites Project, 2023, https://www.nyclgbtsites.org/site/trans-medical-care-at-the-office-of-dr-harry-benjamin/.

30 "Reed Erickson and the Erickson Educational Foundation." University of Victoria, https://www.uvic.ca/transgenderarchives/collections/reed-erickson/index.php.

31 Ibid (n.30)

32 Diamond, M., & Sigmundson, H. K. "Sex Reassignment at Birth: Long-Term Review and Clinical Implications." Archives of Pediatrics & Adolescent Medicine 151, no. 3 (1997): 298-304. https://doi.org/10.1001/archpedi.1997.02170400084015.

33 "Surgical Sex." First Things, 2004, https://www.firstthings.com/article/2004/11/surgical-sex?s=04&fbclid=IwAR2ULl9vuPZZQAjVMDFQub4PZ9S78mVMtDf6ssJoHdl8qRnuJS0myHEVbzA.

1979.

Even Erickson's own story has no happily ever after, lending weight to McHugh's conclusions. After commencing hormonal and surgical sex change interventions under the care of Benjamin, Erickson developed a drug addiction and endured a lifelong battle with substance abuse. What followed was four failed marriages and a life of turmoil. Erickson's EEF folded in 1977, and the Harry Benjamin International Gender Dysphoria Association (HBIGDA) was formed in 1978, which would later become WPATH.

HBIGDA published its first Standards of Care (SOC) in 1979, followed closely by SOC2 in 1980, SOC3 in 1981, and SOC4 in 1990.[34] In its early days, HBIGDA members at least attempted to pursue science and an understanding of this complex psychiatric disorder and the various psychological, hormonal, and surgical interventions available as a form of treatment. But around the late 1990s, the group took a turn.

Dr. Stephen B. Levine was the chair of the SOC5 committee in 1998 and recommended that the guidelines require patients to obtain two letters from mental health professionals before commencing hormones.[35] Dr. Richard Green, HBIGDA president at the time, was unhappy with this requirement and so immediately commissioned SOC6, which was published just three years later and was almost identical but advised only one letter from a mental health professional.[36]

In the intervening years, activists began to overtake HBIGDA, and in 2002, Dr. Levine resigned his membership due to his "regretful conclusion that the organization and its recommendations had become dominated by politics and ideology, rather than by scientific process, as it was years earlier."[37] In 2007, the organization changed its name to the World Professional Association for Transgender Health. This change was significant. At the stroke of a brush, a loose affiliation of people had appointed themselves as the leading international authority on gender medicine.

With the publication of its SOC7 in 2012, the ideological shift identified by Levine was evident. SOC7 recommended puberty blockers as a fully reversible pause for adolescents despite the fact that the experiment was still in its earliest stages and no such conclusion could be drawn. Also, while on the one hand, SOC7 encouraged caution and psychotherapy that affirms the transgender identity, on the other, the guidance endorsed the "informed consent model of care,"[38] which omits the need for psychotherapy and enables healthcare professionals to provide hormones on demand.[39] This came two years after WPATH had issued a statement calling for the "de-psychopathologization of gender variance worldwide," which framed being transgender as a normal, healthy variation of human existence.[40] SOC7 followed on from this, suggesting that any mental health issue in a person identifying as transgender is due to "minority stress," a result of prejudice and discrimination in society.[41]

Then, a year after the publication of SOC7, in line with WPATH, the American Psychiatric Association (APA) released the 5th edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5), in which "gender identity disorder" was renamed "gender

34 "History and Purpose." WPATH, https://www.wpath.org/soc8/history.

35 Levine, S., Brown, G., Coleman, E., Cohen-Kettenis, P., Joris Hage, J., Maasdam, J., Petersen, M., Pfäfflin, F., & Schaefer, L. "The Hbigda Standards of Care for Gender Identity Disorders." Journal of Psychology & Human Sexuality 11 (12/06 1999). https://doi.org/10.1300/J056v11n02_01.

36 O'Malley, S. & Ayad, S. Pioneers Series: We Contain Multitudes with Stephen Levine. Podcast audio. Gender: A Wider Lens Podcast2022. https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-stephen-levine, 40:00.

37 "Dekker V Weida, Et. Al." 34-35. https://ahca.myflorida.com/content/download/21427/file/Dekker_v_Weida_Levine_Report.pdf.

38 "Standards of Care-7th Version." WPATH, 35. https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf.

39 Reisner, S. L., Bradford, J., Hopwood, R., Gonzalez, A., Makadon, H., Todisco, D., Cavanaugh, T., et al. "Comprehensive Transgender Healthcare: The Gender Affirming Clinical and Public Health Model of Fenway Health." Journal of Urban Health 92, no. 3 (2015): 584-92. https://doi.org/10.1007/s11524-015-9947-2.

40 "Wpath / Uspath Public Statements." WPATH, 2023, https://www.wpath.org/policies.

41 Ibid (n.38 p.4)

dysphoria." This redefinition shifted the focus of diagnosis from the identity itself to the distress and difficulty in social functioning arising from the incongruity between the mind and body.

In the decade that passed between the publication of SOC7 and SOC8 in 2022, WPATH veered into new terrain. Just two days after SOC8 was published in September 2022, the group hastily removed almost all lower age requirements from the document,[42] in a bid to avoid malpractice lawsuits.[43] SOC8 also contains a chapter on nonbinary medical interventions, which include recommendations on nullification procedures to create a smooth, sexless appearance for people who identify as neither male nor female and penis-preserving vaginoplasties for those patients who desire both sets of genitals.

Of note, an earlier draft of SOC8 had contained a chapter on ethics, but this was cut from the final version. However, it was the inclusion of a whole chapter on eunuch as a valid gender identity, eligible for hormonal and surgical castration, that sent shockwaves through the medical profession and provided the catalyst for the Beyond WPATH declaration, now signed by more than 2,000 concerned individuals, many of whom are clinicians working with gender diverse young people.[44] The declaration states that WPATH has discredited itself with its SOC8 and can no longer be viewed as a trustworthy source of clinical guidance in the field of gender medicine.

At Environmental Progress, we echo this call and go one step further, calling for reputable medical organizations like the American Academy of Pediatrics (AAP), the American Psychiatric Association (APA), and the American Medical Association (AMA) to cut ties with the organization and to abandon its guidelines in favor of ethical, evidence-based medicine.

The author of this report contacted each member who appears in the files and a leaked panel discussion requesting comment. However, despite these efforts, only one member of WPATH responded, and that response contained legal threats. Also, a source or sources shared an internal email showing WPATH advising against replying and informing the recipients that WPATH was seeking legal counsel.

42 "Wpath Explained." Genspect, 2022, https://genspect.org/wpath-explained/.

43 "Wpath Explains Why They Removed Minimum Age Guidelines for Children to Access Transgender Medical Treatments: So Doctors Won't Get Sued." The Daily Wire, 2022, https://www.dailywire.com/news/wpath-explains-why-they-removed-minimum-age-guidelines-for-children-to-access-transgender-medical-treatments-so-doctors-wont-get-sued.

44 "Beyond Wpath." Beyond WPATH, 2022, https://beyondwpath.org/.

WPATH HAS MISLED THE PUBLIC

WPATH advocates for minors to have access to gender-affirming care, which is the treatment pathway involving puberty blockers, cross-sex hormones, and surgeries that are intended to align the young person's body with their self-declared transgender identity. Implicit in this endorsement is the fact that adolescents can sufficiently comprehend the full implications of these treatments, and their parents can provide legal informed consent.

The organization at the forefront of transgender health care claims that clinical guidelines for youth with self-declared transgender identities "support the use of interventions for appropriately assessed minors."[45]

WPATH advises healthcare providers to use the World Health Organization's International Classification of Diseases (ICD-11) classification of "gender incongruence" over the DSM-5's "gender dysphoria." This recommendation is motivated by the fact that the ICD-11 diagnosis is categorized as a "condition related to sexual health" and not a mental disorder, a move intended to destigmatize transgender identities further.

A diagnosis of gender incongruence is even easier to obtain than one of gender dysphoria because all the patient needs to experience is a marked incongruence between their internal sense of self and their biological sex. There is no requirement for the presence of distress as a criterion, meaning a patient's "embodiment goals" can be deemed medically necessary care.

But while WPATH publicly supports minors and their families consenting to these hormonal and surgical treatments based on a nebulous inner sense of self, privately, some members admit that consent is not possible. Behind closed doors, WPATH-affiliated healthcare professionals confess that their practices are based on improvisation, that children cannot comprehend them, and that the consent process is not ethical. Thus, WPATH is dishonest with the public and knowingly operates without transparency.

WPATH Knows Children Do Not Understand the Effects of Hormone Therapy

WPATH's Standards of Care 8 recommends adolescents who have received a diagnosis of "gender incongruence" have access to puberty blockers, cross-sex hormones, and surgeries so long as the young person "demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment."

However, in video footage obtained by Environmental Progress of an internal WPATH panel titled Identity Evolution Workshop held on May 6, 2022, panel members admit to the impossibility of getting proper informed consent for hormonal interventions from their young patients.[46]

During the panel, Dr. Daniel Metzger, a Canadian endocrinologist, discussed the challenges faced when attempting to obtain consent from adolescents seeking this medical treatment. Metzger reminded those assembled that gender doctors are "often explaining these sorts of things to people who haven't even had biology in high school yet," adding that even adult patients often have very little medical understanding of the effects of these interventions.

Metzger describes young patients attempting to pick and choose the physical effects of hormone therapy, with some wanting a deeper voice without facial hair or to take estrogen without developing breasts. This suggests a very poor understanding of the workings of the human body and the treatment pathway on the part of adolescent

45 Leibowitz, S., Green, J., Massey, R., Boleware, A. M., Ehrensaft, D., Francis, W., Keo-Meier, C., et al. "Statement in Response to Calls for Banning Evidence-Based Supportive Health Interventions for Transgender and Gender Diverse Youth." International Journal of Transgender Health 21, no. 1 (2020/01/02 2020): 111-12. https://doi.org/10.1080/15532739.2020.1703652. https://shorturl.at/bDGUZ

46 Massey, R., Berg, D., Ferrando, C., Green, J., & Metzger, D. (2022, May 6th) WPATH GEI Identity Evolution Workshop [internal panel].

patients, something noted by the WPATH expert.

"It's hard to kind of pick and choose the effects that you want," concluded Metzger. "That's something that kids wouldn't normally understand because they haven't had biology yet, but I think a lot of adults as well are hoping to be able to get X without getting Y, and that's not always possible."

Metzger tells his young patients that they might not "be binary, but hormones are binary." He describes having to explain to children and even adults that "you can't get a deeper voice without probably a bit of a beard" and "you can't get estrogen to feel more feminine without some breast development."

There was agreement among the panel of experts about children's inability to comprehend the powerful and life-altering effects of the hormone therapy they are seeking. Another prominent WPATH member, Dianne Berg, a child psychologist and co-author of the child chapter of SOC8, chimed in to say that they wouldn't expect children and young adolescents to grasp the effects of the treatment because it is "out of their developmental range to understand the extent to which some of these medical interventions are impacting them."

The immaturity of these patients was further demonstrated when Berg said, "They'll say they understand, but then they'll say something else that makes you think, oh, they didn't really understand that they are going to have facial hair."

Yet, publicly, WPATH never discusses any of this. On the rare occasion that WPATH makes public statements, sex-trait modification interventions are presented as age-appropriate, essential medical care, and any opposition to such interventions is framed as transphobia.

"Anti-transgender health care legislation is not about protections for children but about eliminating transgender persons on a micro and macro scale," said WPATH President Dr. Marci Bowers in a May 2023 statement opposing US bans on gender-affirming care for minors. "It is a thinly veiled attempt to enforce the notion of a gender binary."[47]

It is the responsibility of parents to provide legal consent before a doctor can block a child's puberty or administer irreversible cross-sex hormones, but during the panel, Berg provides evidence that even some parents do not have sufficient levels of health literacy to comprehend the effects of this treatment protocol, and she admits that current practices are not ethical.

"What really disturbs me is when the parents can't tell me what they need to know about a medical intervention that apparently they signed off for," said Berg. She suggests a solution is to "normalize" that it is okay not to understand right away and to encourage patients to ask questions. That way, gender-affirming healthcare providers can do a "real informed consent process" rather than what is currently happening, which Berg thinks is "not what we need to be doing ethically."

WPATH Knows Children Cannot Consent to Iatrogenic Fertility Loss

Another crucial aspect of the informed consent process that these WPATH members confess is being violated is the issue of allowing minors to consent to a treatment pathway that could result in sterility. WPATH's SOC8 stipulates that doctors must inform the young person about "the potential loss of fertility and available options to preserve fertility." By advocating for adolescents in early puberty to have access to hormonal interventions that could leave them sterile, the world-leading transgender health group is implying that minors have the cognitive capacity to make such a decision about their future.

However, on the inside, prominent WPATH members confess that it is impossible for adolescents to understand the gravity of the decision. Dr. Ren Massey, a psychologist and co-author of the adolescent chapter of the latest

47 "Statement of Opposition to Legislation Banning Access to Gender-Affirming Health Care in the Us." WPATH, 2023, https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH_WPATH%20Statement%20re_%20GAHC%20march%208%202023.pdf.

standards of care, told the panel that, according to SOC8, "it's encouraged, and ethical, to talk about fertility preservation options," stressing that it is "even important for youth who are going on puberty blockers because many of those youth will go directly onto affirming hormone therapies which will eliminate the development of their gonads producing sperm or eggs," a function that the young patients may desire "if they want to be partners with somebody else later in contributing genetic material for reproduction."

Metzger responded that "it's always a good theory that you talk about fertility preservation with a 14-year-old, but I know I'm talking to a blank wall," adding, "they'd be like, ew, kids, babies, gross."

"Or, the usual answer is, 'I'm just going to adopt.' And then you ask them, well, what does that involve? Like, how much does it cost? 'Oh, I thought you just like went to the orphanage, and they gave you a baby.'"

This remark was met with smiles and nods from the panel. These comments prove that WPATH members are aware that the young patients who will lose their fertility as a consequence of gender-affirming treatments don't yet understand what they are sacrificing. They do not understand how they may come to want biological children of their own one day, nor do they even understand how adoption works or how arduous it can be to conceive a baby via in vitro fertilization.

These private comments are in stark contrast to WPATH's public stance. In a recent statement opposing US bans on sex-trait modification interventions for minors, WPATH said, "the benefits that these medically necessary interventions have for the overwhelming majority of youth … are well-documented. Providers who collaboratively assess youths' understanding of themselves, their gender identity, and their ability to make informed decisions regarding medical/surgical interventions (which are not offered prior to puberty and never without the youth's assent) play a very important role in minimizing future regret." However, WPATH members know this level of understanding is simply not possible, making WPATH's statement dishonest.

What's more, members are aware that there is already research showing significant reproductive regret among a cohort of Dutch patients who were some of the first to undergo early puberty suppression.

Metzger told the panel about data presented by Dutch researchers at a recent meeting of the Pediatric Endocrine Society. "Some of the Dutch researchers gave some data about young adults who had transitioned and [had] reproductive regret, like regret, and it's there," he said, "and I don't think any of that surprises us."

One reason Metzger is not surprised is that he has observed regret in his own patients.

"I think now that I follow a lot of kids into their mid-twenties, I'm like, 'Oh, the dog isn't doing it for you, is it?' They're like, 'No, I just found this wonderful partner, and now want kids' and da da da. So I think, you know, it doesn't surprise me," said Metzger.

In fact, the preliminary findings of the research to which Metzger appears to be referring were presented a few months later at WPATH's International Symposium in Montreal in September 2022.[48] The team of Dutch researchers gave a presentation of the results of the first long-term study of young people who had their puberty suppressed, and as Metzger suggested, the results were far from encouraging.

In a segment titled, Reflecting on the Importance of Family Building and Fertility Preservation, Dr. Joyce Asseler revealed that 27% of the young people who had undergone early puberty suppression followed by cross-sex hormones and surgical removal of the testes or ovaries, now, at an average age of 32, regret sacrificing their fertility, or as the Dutch researchers worded it, "find their infertility troublesome." A further 11% are unsure about

48 Steensma, T. D., de Rooy, F. B. B., van der Meulen, I. S., Asseler, J. D., & van der Miesen, A. I. R. (2022, September 16–20). Transgender Care Over the Years: First Long-Term Follow-Up Studies and Exploration of Sex Ratio in the Amsterdam Child and Adolescent Gender Clinic [Conference presentation].

how they feel about their infertility, and while none opted for fertility preservation in the form of freezing their eggs or sperm before embarking upon medical transition as adolescents, 44% of the natal females and 35% of the natal males would now choose fertility preservation if they could go back in time. The majority, 56%, of study participants either have the desire for children or have already "fulfilled this desire," presumably by adoption.

The 27% regret rate is also very likely an underestimate. Asseler quotes one participant who did not find their infertility "troublesome," who responded, "I can find it troublesome, but it's too little too late. Unfortunately, I can't change it, even if I would like to." Also, like most other studies in this field, this one suffers from a high loss to follow-up, with 50.7% of eligible participants failing to take part, so we cannot know the true regret rate in this cohort of young people.

Berg remarked that the issue of 9-year-olds grappling with understanding lifelong sterility has her "stumped," and Metzger acknowledged that "most of the kids are nowhere in any kind of a brain space to really talk about it in a serious way." This bothers the WPATH expert, who just wants "kids to be happy, happier, in the moment."

While prioritizing the alleviation of a child's distress in the present moment at the cost of their future fertility is deeply misguided, Metzger makes further comments indicating that WPATH's gender-affirming care doesn't even accomplish this dubious goal. Metzger says putting a nine-year-old on puberty blockers before they get to the age of developing their sexual identity "cannot be great," and admits that gender-affirming doctors are "to a degree robbing these kids of that sort of early-to-mid pubertal sexual stuff that's happening with their cisgender peers."

Adolescence is a difficult time for any young person as they yearn for acceptance among their peers. Erik Erikson, a child psychoanalyst, stated that the primary goal of adolescence is to establish identity.[49] He viewed adolescence as a time of confusion and experimentation. Building on Erikson's work, Canadian developmental psychologist James Marcia coined the term "identity moratorium," describing the stage of adolescence as an exploration rather than a time for a young person to commit to any single cause or identity.[50]

Identity development during this crucial phase relies heavily on social interactions, and the experience of isolation and loneliness is especially distressing for a young person still finding their way in the world. Therefore, Metzger's comments show that WPATH is knowingly promoting a medical treatment that might exacerbate an adolescent's social challenges rather than alleviate them, meaning this medical intervention, which comes at such an enormous cost, fails even to achieve Metzger's misguided aim of making kids "happier in the moment."

What's more, a thread in WPATH's internal messaging forum provides proof that some adolescents with developmental delays are being put on puberty blockers. A physician-assistant and professor at Yale School of Medicine posted in the group asking for advice about a developmentally delayed 13-year-old who was already on puberty blockers but may not reach the "emotional and cognitive developmental bar set by [SOC8] within the typical adolescent time frame if at all" to give cognitive consent to cross-sex hormones. The Yale professor and practicing clinician wanted to know when it would be ethical to allow the young patient to progress to "gender-affirming hormone therapy."

A psychiatrist from Nova Scotia replied that the "guiding principle would be weighing [the] harm of acting vs not acting." This WPATH member defined "harm" as halting puberty suppression and advised that puberty blockers cannot be continued indefinitely without a sex steroid hormone as well. A Pennsylvania therapist replied saying, "[k]ids with intellectual disabilities are able to consent to other surgeries," and wondered if there was

49 Erikson, E. H. (1968). Identity: youth and crisis. Norton & Co.

50 Kroger, J., & Marcia, J. (2011). The Identity Statuses: Origins, Meanings, and Interpretations. In (pp. 31-53). https://doi.org/10.1007/978-1-4419-7988-9_2

important context missing from the original post.

An activist and law professor at the University of Alberta shared a paper to help the Yale professor solve this ethical conundrum. "Regardless of patients' capacity, there is usually nobody better positioned to make medical decisions that go to the heart of a patient's identity than the patients themselves," says the paper, adding that because "gender uniquely pertains to personal identity and self-realisation, parents…are rarely better positioned to make complex medical decisions."[51]

Because parents are usually "cisgender," meaning not transgender, they "rarely have an intimate appreciation of transness or gender dysphoria, and never have an intimate appreciation of the patient's gender subjectivity," reads the paper. By contrast, patients, even developmentally delayed adolescents, have an "intimate understanding of their own gender subjectivity" and will almost always have a "substantial, although limited, appreciation" of the risk of harm and infertility.

Therefore, according to this logic, minors who identify as transgender, even those with severe mental health issues or developmental delays, can "appreciate both sides of the equation," meaning they are better positioned than their parents to make complex medical decisions that will have life-long consequences.

This political activist, who has no medical training, is a frequent contributor to the conversations inside the WPATH forum. However, this opinion is, in fact, in line with WPATH's official stance on allowing adolescents with developmental delays to give cognitive consent to experimental sex-trait modification interventions. In a 2022 public statement, WPATH called delaying or withholding puberty blockers and cross-sex hormones from adolescents with coexisting autism, other developmental differences, or mental health problems "inequitable, discriminatory, and misguided."[52]

Robbing adolescents of their developing sexual identities poses another problem for the panel of WPATH experts. As Metzger notes, this cohort's sexual urges are suppressed, meaning they are not "learning how to masturbate." However, these same healthcare providers are tasked with discussing fertility preservation options with their patients who are not developmentally equipped to understand the process. In the case of natal males, the freezing of sperm requires that the adolescent has reached this crucial developmental stage. Especially for boys, the logic of early intervention dictates that puberty be suppressed as soon as possible, meaning before endogenous hormones have had a chance to make the body fertile.

Berg is aware of this problem, telling the group, "In some ways, the stuff that you need to do to be able to preserve your fertility might be beyond where a youth is at in terms of their sexual development, and yet, that's kind of what's needing to happen."

In traditional pediatrics, this type of conversation would only occur in oncology. Fertility preservation is offered to children with certain disorders of sexual development (DSDs) and other rare health conditions,[53] but it is only cancer treatment and gender-affirming medicine that cause iatrogenic infertility, meaning it is the treatment protocol that destroys the young person's fertility. Prior to the advent of gender-affirming care, the only justifiable reason for sterilizing a minor was a potentially life-threatening cancer diagnosis.

In a WPATH public statement from 2020, which was co-authored by two of the Identity Evolution Workshop

51 Ashley, F. (2023). Youth should decide: the principle of subsidiarity in paediatric transgender healthcare. J Med Ethics, 49(2), 110-114. https://doi.org/10.1136/medethics-2021-107820 https://pubmed.ncbi.nlm.nih.gov/35131805/

52 WPATH, ASIAPATH, EPATH, PATHA, and USPATH Response to NHS England in the United Kingdom (UK). (2022). https://www.wpath.org/media/cms/Documents/Public%20Policies/2022/25.11.22%20AUSPATH%20Statement%20reworked%20for%20WPATH%20Final%20ASIAPATH.EPATH.PATHA.USPATH.pdf?_t=1669428978

53 Rodriguez-Wallberg, K. A., Marklund, A., Lundberg, F., Wikander, I., Milenkovic, M., Anastacio, A., Sergouniotis, F., Wånggren, K., Ekengren, J., Lind, T., & Borgström, B. (2019). A prospective study of women and girls undergoing fertility preservation due to oncologic and non-oncologic indications in Sweden-Trends in patients' choices and benefit of the chosen methods after long-term follow up. Acta Obstet Gynecol Scand, 98(5), 604-615. https://doi.org/10.1111/aogs.13559

panelists, the leading transgender health group claims that "in general, mental health and medical professionals conduct evaluations of each youth/family to ensure that interventions used to promote emotional and psychological wellness in these youth are appropriate and meet the young person's specific mental health and medical needs."[54]

"As a result, professionals with experience and training to understand adolescent development and family dynamics are poised to understand the underlying factors behind a specific clinical presentation," said WPATH. "The best interests of the child are always paramount for any responsible licensed provider."

Compare that to what WPATH members say when they think the public is not listening. Jamison Green, a trans rights activist, former WPATH president, and one of the co-authors of the statement, told the panel that many patients may never even see an endocrinologist and are instead getting their "hormones prescribed through their primary care provider who doesn't really know necessarily everything about trans care."

Green believes these primary care providers are just "trying to be supportive" but explains that because the field of gender medicine is "new" and "contentious," patients, even well-educated adults who are accessing care for the first time, will hastily glance at the informed consent form, not take any of the information in, and say, "show me where to sign. Cause this is my moment, I gotta grab it."

This comment is in complete contradiction to WPATH's official statement claiming that a team of medical and mental health professionals carefully evaluates young patients. And this doesn't just happen with access to hormones. Green makes the same remarks regarding patients consenting to life-altering surgeries.

"People also are afraid many times about surgery, and so they can read other people's descriptions about surgery, and they'll miss details, or they'll miss the most important piece of information for them simply because they're afraid to read it," explained Green.

54 Ibid (n.45)

WPATH IS NOT A SCIENTIFIC GROUP

WPATH presents itself to the world as a scientific organization. The group describes its "Standards of Care" as being "based on the best available science and expert professional consensus."

In a 2022 speech in Texas, the US Assistant Secretary for Health, Admiral Rachel Levine said that WPATH's approach to medicine is "free of any agenda other than to ensure that medical decisions are informed by science."[55] In an op-ed in the New York Times from April, 2023, WPATH President Bowers argued that the "field of transgender medicine is evolving rapidly, but it is every bit as objective- and outcome-driven as any other specialty in medicine."[56]

"Allow the remaining scientific questions to be answered by knowledgeable researchers, without the influence of politics and ideology," Bowers implored.

However, the scientific method is a systematic approach to establishing facts through rigorous testing and experimentation. In the realm of medical research, this process entails observing a medical condition requiring intervention and formulating a hypothesis regarding a potentially effective treatment. This hypothesis is then put to the test through rigorously controlled trials, preferably ones that are both randomized and double-blind, meaning the participants are randomly assigned to different groups, and neither the participants nor the researchers know which group is receiving the treatment and which is receiving a placebo or alternative intervention. The final crucial step in the process is a follow-up, meaning all participants must be monitored over a sufficient duration and the results carefully analyzed to gauge the treatment's efficacy and safety.

The WPATH Files contain abundant evidence that the world-leading transgender health group does not respect the well-established scientific process.

Even the term "standards of care" is a misnomer when applied to WPATH's SOC7 and SOC8. "Standard of care" is a legal term, not a medical term, and represents "the benchmark that determines whether professional obligations to patients have been met."[57] Failure to meet the standard of care is medical negligence, which can result in significant consequences for healthcare providers.

However, from WPATH's SOC7 onwards, there are no "standards." A 2021 systematic review of clinical guidelines in gender medicine did not merely rate SOC7 as low quality but also rated it as "do not recommend."[58] The review concluded with the hope that the upcoming SOC8 would improve on SOC7's numerous shortcomings, but instead, SOC8 strayed even further from meeting the definition of a standard of care.

WPATH's SOC8 gives gender-affirming healthcare providers permission to do whatever the patient requests, in the absence of scientific evidence, safe in the knowledge that insurance companies will offer coverage because every intervention is defined as "medically necessary." Simultaneously, these providers believe themselves to be protected from malpractice lawsuits because they adhere to these approved "standards of care" that, in truth, contain no actual "standards" since all criteria are optional.

The Weak Evidence Base for Puberty Suppression

Nowhere is WPATH's disregard for the scientific

55 Levine, R. (2022). Remarks by HHS Assistant Secretary for Health ADM Rachel Levine for the 2022 Out For Health Conference. U.S. Department of Health and Human Services. https://www.hhs.gov/about/news/2022/04/30/remarks-by-hhs-assistant-secretary-for-health-adm-rachel-levine-for-the-2022-out-for-health-conference.html

56 "What Decades of Providing Trans Health Care Have Taught Me." The New York Times, 2023, https://www.nytimes.com/2023/04/01/opinion/trans-healthcare-law.html.

57 Vanderpool, D. (2021). The Standard of Care. Innov Clin Neurosci, 18(7-9), 50-51. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8667701/#:~:text=The%20standard%20of%20care%20is%20a%20legal%20term%2C%20not%20a,legal%20standard%20varies%20by%20state.

58 Dahlen, S., Connolly, D., Arif, I., Junejo, M. H., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. BMJ Open, 11(4), e048943. https://doi.org/10.1136/bmjopen-2021-048943

process more evident than in its support for adolescent sex-trait modification involving puberty blockers, cross-sex hormones, and surgeries for minors suffering from gender dysphoria. The world's most prominent transgender healthcare group endorses this controversial treatment protocol, and the WPATH Files contain abundant evidence demonstrating just how little is known about the drugs and their long-term effects.

In the 2023 paper, The Myth of Reliable Research,[59] Abbruzzese et al. argue that the practice of performing sex-trait modifications on minors through the use of puberty blockers, cross-sex hormones, and surgeries is an experiment that "escaped the lab" before there was any strong scientific evidence to support it.

Rather than being "evidence-based" as WPATH claims, Abbruzzese et al. explain that pediatric sex-trait modification was an "innovative practice" embarked upon by researchers in a Dutch clinic in the late 1980s-early 1990s. The "innovative practice" framework allows clinicians to implement untested yet encouraging interventions in cases where leaving the condition untreated could have dire consequences, when established treatments appear ineffective, and when the patient population is small.

Innovative practice is a double-edged sword because while it has the potential to advance medicine rapidly, it is also capable of causing harm. Hence, it is an ethical requirement to follow innovative experiments with strict clinical trials to demonstrate that the treatment's advantages outweigh the associated risks.

The clinical trial stage is imperative to avoid a phenomenon called runaway diffusion, "whereby the medical community mistakes a small innovative experiment as a proven practice, and a potentially non-beneficial or harmful practice 'escapes the lab,' rapidly spreading into general clinical settings."[60]

Runaway diffusion is what happened with pediatric gender medicine. Based on a study group of just 55 participants, which suffered from high selection bias, and a study design so methodologically flawed that its results should have been completely invalidated, the international medical community began suppressing the puberty of adolescents suffering from gender dysphoria. The vital step of undertaking controlled research aimed at validating the hypothesized substantial and enduring psychological advantages was completely skipped.

In fact, as early as 2001, WPATH, then HBIGDA, endorsed the treatment in its Standards of Care 6, even though, at that time, the scientific evidence for the protocol consisted of just a single case study involving one young patient.[61,62,63] Then, before the second stage of the deeply flawed Dutch experiment had been completed, WPATH again endorsed the treatment in its Standards of Care 7 in 2012, thereby influencing the medical community and leading to the widespread adoption of the protocol.[64]

The speed of the runaway diffusion increased dramatically when the innovative medical experiment collided with the sudden surge of adolescents identifying as transgender in the mid-2010s.

While The Myth of Reliable Research specifically criticizes the adolescent sex-trait modification experiment, there have never been any properly controlled trials in the

59 Abbruzzese, E., Levine, S. B., & Mason, J. W. "The Myth of "Reliable Research" in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—and Research That Has Followed." Journal of Sex & Marital Therapy 49, no. 6 (2023): 673-99. https://doi.org/10.1080/0092623x.2022.2150346.

60 Ibid (n.59)

61 Biggs, M. "The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence." Journal of Sex & Marital Therapy 49, no. 4 (2023): 348-68. https://doi.org/10.1080/0092623x.2022.2121238.

62 Meyer III, W., Bockting, W.O., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., Gooren, L., et al. "The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version." Journal of Psychology & Human Sexuality 13, no. 1 (2002): 1-30. https://www.cpath.ca/wp-content/uploads/2009/12/WPATHsocv6.pdf.

63 Cohen-Kettenis, P. T., & van Goozen, S. H. "Pubertal Delay as an Aid in Diagnosis and Treatment of a Transsexual Adolescent." [In eng]. Eur Child Adolesc Psychiatry 7, no. 4 (Dec 1998): 246-8. https://doi.org/10.1007/s007870050073.

64 Ibid (n.38 p.18)

wider field of gender medicine, which also consistently lacks long-term data. Studies that show a positive outcome for sex-trait modification procedures have a very short follow-up period, and those that attempt to monitor how patients fare years after undergoing hormonal and surgical interventions are compromised by a high percentage of study participants lost to follow-up. The few attempts at long-term follow-up for adults who have undergone sex-trait modification interventions do not show positive outcomes, with individuals showing social difficulties and a significantly elevated rate of completed suicides and mental health issues.[65,66,67,68] While each of these studies has its methodological limitations, the findings cast serious doubt on any claims that sex-trait modification interventions result in overwhelmingly positive outcomes for patients. Not surprisingly, systematic reviews of the research on sex trait modification in minors have consistently found "low" or "very low" quality evidence for benefits.

Evidence in the Files of WPATH's Lack of Respect for the Scientific Process

A discussion in the WPATH Files involving WPATH's president, Dr. Marci Bowers, demonstrates the pseudoscientific, experimental nature of pediatric hormonal and surgical sex-trait modification. Bowers makes it abundantly clear that there is no scientific rigor to the treatment protocol when discussing how little is known about the impact puberty blockers have on the future sexual function of natal males.

In January 2022, WPATH President Bowers admitted in the forum that the effect of puberty blockers on fertility and "the onset of orgasmic response" is not yet fully understood. Also, Bowers conceded that there are "problematic surgical outcomes" for natal males who have their puberty blocked early.

In fact, almost everything Bowers contributed to the discussion board about fertility, puberty blockers, and sexual intimacy is proof that the leading transgender health group advocates for an unregulated experiment on young people.

Bowers told the group that the "fertility question has no research" and recommended that "Unless pre-pubertal dysphoria is enormous, allowing for a small amount of puberty before blockers might be preferable in the long run."

In this context, the use of the word "might" suggests that these doctors are improvising, experimenting without a structured framework, and, because of inadequate follow-up, failing to track the outcome of their experiment. This type of guesswork is acceptable in a small experiment but unethical when every major American medical association recommends the treatment and the wider medical community has already adopted it.

Bowers then said the question of whether or not these young males will be able to achieve orgasm later in life was "thornier," with the WPATH president admitting that all personal clinical experience up to that point indicated that boys who have their puberty blocked at Tanner Stage 2, the beginning of pubertal development, are completely unable to orgasm. "Clearly, this number needs documentation, and the long-term sexual health of these individuals needs to be tracked," said Bowers.

In other words, Bowers is aware that gender-affirming healthcare providers are robbing young natal males of the ability to orgasm and, therefore, their future ability to form long-term intimate relationships, which is an essential part of a fulfilling and happy life for most people. What's more, gender-affirming doctors are choosing this drastic medical

65 "Mistaken Identity." The Guardian, 2004, https://www.theguardian.com/society/2004/jul/31/health.socialcare.

66 Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. "Long-Term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden." PLoS ONE 6, no. 2 (2011): e16885. https://doi.org/10.1371/journal.pone.0016885.

67 Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M. D., & Birkhäuser, M. "Quality of Life 15 Years after Sex Reassignment Surgery for Transsexualism." Fertility and Sterility 92, no. 5 (2009): 1685-89.e3. https://doi.org/10.1016/j.fertnstert.2008.08.126.

68 "Part 3: Gender Identity." Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences, The New Atlantis, 2016, https://www.thenewatlantis.com/publications/part-three-gender-identity-sexuality-and-gender.

intervention as the first line of treatment for this vulnerable cohort of young people while ignoring the scientific literature that shows most children would overcome their dysphoria if allowed to grow and develop naturally without medical intervention.[69,70,71] While this literature predates the newly emerged adolescent-onset cohort, all existing knowledge about adolescent identity development strongly supports allowing these young patients the chance to grow and mature before making drastic, life-altering decisions.[72]

If WPATH, as Bowers claimed in the New York Times, were every bit as objective- and outcome-driven as any other specialty in medicine, these questions would have been answered before the group recommended the treatment protocol be rolled out into wider medical practice.

Bowers also mentioned the "problematic surgical outcomes" faced by these patients. Here, the WPATH president is referring to the fact that natal males who have their puberty suppressed at Tanner Stage 2 typically require a more complicated vaginoplasty surgery than the standard penile inversion.

In a fully developed adult male, vaginoplasty involves inversion of the penis, using the penile skin to line the surgical cavity that is meant to resemble a vagina. But in natal males who have their puberty blocked, the penis remains in a child-like state, meaning there is insufficient penile tissue to use during the procedure. Therefore, the surgeon must harvest tissue from a different part of the body. The most common technique uses a piece of the patient's colon, or less frequently, surgeons will use the peritoneum lining, which is the lining of the abdominal cavity. Some gender surgeons are even experimenting with using tilapia fish skin.[73]

There are two notable examples of the "problematic surgical outcomes" that can ensue as a result of these riskier surgeries. The first is the tragic death of an 18-year-old natal male who participated in the pioneering Dutch trial and died of necrotizing fasciitis.[74] This devastating outcome resulted from surgeons opting to use a section of the teen's intestines to construct the pseudo-vagina, a measure necessitated by the patient's lack of male puberty. This one death represents an almost 2% fatality rate associated with surgery in the Dutch study. In any other field of medicine, such a high fatality rate would result in the experiment instantly being halted and carefully studied to investigate what went wrong.

Then there is the story of Jazz Jennings, the trans-identified natal male star of the reality TV show I Am Jazz. Jennings was also one of the first children to take part in the puberty suppression experiment, and when it came time for vaginoplasty, Jazz also had insufficient penile tissue, making it necessary to use part of Jazz's peritoneum lining and a section of thigh skin. Bowers was the surgeon who performed the operation. Days after the surgery, the pseudo-vagina came apart, causing Jazz intense pain and requiring three corrective surgeries.

One study found that 71% of the natal males who had undergone puberty suppression at Tanner Stages 2-3 required the riskier form of intestinal vaginoplasty.[75] Another study found one-quarter of males who undergo

69 Ibid (n.2)

70 Ibid (n.4).

71 Wallien, M. S., & Cohen-Kettenis, P. T. "Psychosexual Outcome of Gender-Dysphoric Children." [In eng]. J Am Acad Child Adolesc Psychiatry 47, no. 12 (Dec 2008): 1413-23. https://doi.org/10.1097/CHI.0b013e31818956b9.

72 Ibid (n.49); Ibid (n.50)

73 Slongo, H., Riccetto, C. L. Z., Junior, M. M., Brito, L. G. O., & Bezerra, L. "Tilapia Skin for Neovaginoplasty after Sex Reassignment Surgery." [In eng]. J Minim Invasive Gynecol 27, no. 6 (Sep-Oct 2020): 1260. https://doi.org/10.1016/j.jmig.2019.12.004.

74 Negenborn, V. L., van der Sluis, W. B., Meijerink, W., & Bouman, M. B. "Lethal Necrotizing Cellulitis Caused by Esbl-Producing E. Coli after Laparoscopic Intestinal Vaginoplasty." [In eng]. J Pediatr Adolesc Gynecol 30, no. 1 (Feb 2017): e19-e21. https://doi.org/10.1016/j.jpag.2016.09.005.

75 van der Sluis, W. B., de Nie, I., Steensma, T. D., van Mello, N. M., Lissenberg-Witte, B. I., & Bouman, M. B. "Surgical and Demographic Trends in Genital Gender-Affirming Surgery in Transgender Women: 40 Years of Experience in Amsterdam." [In eng]. Br J Surg 109, no. 1 (Dec 17 2021): 8-11. https://doi.org/10.1093/bjs/znab213.

this type of vaginoplasty require follow-up corrective surgery.[76]

Further evidence of the uncertainty surrounding the puberty suppression experiment is present in the WPATH Files. In February 2022, a Seattle psychologist asked the forum for information about the impact puberty blockers have on a young person's height. The psychologist was confused after reading and hearing "some conflicting information." The patient who sparked the inquiry was a 10-year-old "premenarche" natal female who identified as a boy. The child was concerned that taking puberty blockers would stunt growth, so the psychologist asked the forum if starting the drugs so young could have a negative impact.

The reply from a pediatric endocrinologist demonstrates that the whole experiment is based on guesswork. She explains that blockers suppress puberty to keep growth plates open longer, so younger teens have more time to grow, but the typical adolescent growth spurt is also blocked. To remedy this, the endocrinologist says she gives a low dose of testosterone to these young teenage girls and gradually increases the dose, hoping that the growth plates don't close.

It's relevant at this point to note that the puberty suppression experiment began because transgender adult males were dissatisfied with the results of their medical transition because they did not "pass" well as women due to a "never disappearing masculine appearance."[77] Therefore, the Dutch researchers came up with the idea to use gonadotropin-releasing hormone agonists (GnRHa) to block the testosterone surge of male puberty in the hopes of achieving more feminine appearances in adulthood. The increased risk of false positives due to early intervention was noted, but the cosmetic advantages to adult natal males who identify as women were deemed more important.[78]

In 2014, Delemarre-van de Waal reviewed the puberty suppression experiment, stating that "an early intervention in a male-to-female transsexual may result in a more acceptable female final height." The word height was mentioned no fewer than 23 times in the paper.[79] There was only one mention of loss of fertility. As one researcher later noted, the "words orgasm, libido, and sexuality do not appear" even once.[80]

However, the aforementioned exchange in the WPATH Files indicates that natal females may experience poorer outcomes from having their puberty blocked. Testosterone use typically brings about convincing cosmetic changes in females who identify as male, making height the biggest challenge trans-identified natal females face when trying to pass as men. Since natal females constitute the majority of referrals to pediatric gender clinics, if it is indeed true that these drugs negatively affect the height of female patients, it calls into question the validity of the original hypothesis for their use.

What's more, the superficial focus on "passing" as a member of the opposite sex ignores the reality of human sexuality. A transgender person who passes when out in public is still going to experience difficulty finding a romantic partner because of the limitations of sex-trait modification interventions. For those who do not opt for genital surgery, their outward appearance is incongruent with their genitals, and for those who do opt for full surgical transition, there are limitations of what such

76 Bouman, M. B., van der Sluis, W. B., Buncamper, M. E., Özer, M., Mullender, M. G., & Meijerink, W. "Primary Total Laparoscopic Sigmoid Vaginoplasty in Transgender Women with Penoscrotal Hypoplasia: A Prospective Cohort Study of Surgical Outcomes and Follow-up of 42 Patients." [In eng]. Plast Reconstr Surg 138, no. 4 (Oct 2016): 614e-23e. https://doi.org/10.1097/prs.0000000000002549.

77 Waal, H., & Cohen-Kettenis, P. "Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects." European Journal of Endocrinology - EUR J ENDOCRINOLOGY 155 (10/30 2006). https://doi.org/10.1530/eje.1.02231.

78 Ibid (n.77)

79 Delemarre-van de Waal, H. A. "Early Medical Intervention in Adolescents with Gender Dysphoria." In Gender Dysphoria and Disorders of Sex Development: Progress in Care and Knowledge, edited by Baudewijntje P. C. Kreukels, Thomas D. Steensma and Annelou L. C. de Vries, 193-203. Boston, MA: Springer US, 2014. https://link.springer.com/chapter/10.1007/978-1-4614-7441-8_10#citeas

80 Ibid (n.61)

surgeries can achieve. In either case, the ability to form long-term sexual relationships is drastically compromised.

If WPATH were indeed a scientific organization dedicated to ensuring that its members provide the best possible care for patients suffering from gender dysphoria, including minors and those with serious psychiatric comorbidities, it would fund proper clinical trials to assess the safety, effectiveness, risks, and benefits of the treatment protocol for which it so strenuously advocates. An essential part of these trials would be long-term follow-up to measure the impact of allowing adolescents to compromise their health, fertility, and sexual function at such a young age.

WPATH IS NOT A MEDICAL GROUP

WPATH Has Abandoned the Hippocratic Oath

For over 2,500 years, physicians have been guided by the Hippocratic oath to first do no harm. While this exact adage is not present in the original text from 5th century BC Greece, the pledge is a distillation of the oath's overarching message to consider the benefit of patients and "abstain from whatever is deleterious and mischievous."

The phrase "First, do no harm," or its Latin translation, "Primum non nocere," is the bedrock upon which medical ethics standards are built, and it has provided a moral and ethical compass for physicians for thousands of years. While medicine and technology have advanced beyond recognition since the days of Hippocrates, the oath's guiding principle has always remained the same: the benefits of a medical treatment must always outweigh any harm.

Throughout the ages, medical professionals have sought to balance taking risks with patient safety, and still, to this day, that can be challenging, especially in high-stakes areas of medicine such as cancer treatment. In fact, it is appropriate to compare WPATH's gender-affirming care to cancer treatment because both protocols involve the use of powerful drugs that have a profound impact on future health and reproductive function, as well as, in many cases, the surgical removal of body parts.

But while most people would agree that doctors are justified in administering treatments such as chemotherapy that could result in sterility or amputating body parts if a child or young person has cancer and the surgery could save the patient's life, the ethics of sterilizing a young person suffering from the poorly defined psychiatric disorder called gender dysphoria, or amputating healthy parts of their body, are far more questionable.

Evidence Showing the Harmful Effects of Wrong-Sex Hormones

WPATH members adhere to the belief that attempting to help a patient overcome their feelings of gender incongruence and reconcile with their birth sex amounts to conversion therapy.[81] Therefore, the mental and medical professionals inside the leading transgender health group advocate for affirmation alongside invasive and harmful hormonal and surgical interventions as the first and only line of treatment for patients, including minors and the severely mentally ill, despite knowing the detrimental effects.

Inside the WPATH forum, there were plenty of discussions about the effects of cross-sex hormones on the sexual function of natal females, as well as natal males who had been allowed to go through puberty and were, therefore, able to orgasm.

For example, in the discussion thread dated March 24, 2022, a nurse practitioner asked about a "young patient" who developed pelvic inflammatory disease after three years of testosterone. The natal female "has atrophy with the persistent yellow discharge we often see as a result," the nurse wrote. Vaginal atrophy is the thinning, drying, and inflammation of the vaginal walls that occurs when a woman has less estrogen, typically after menopause. For many women, vaginal atrophy not only makes intercourse painful but also leads to distressing urinary symptoms.

Pelvic Inflammatory Disease (PID) is a serious condition which can lead to severe and potentially life-threatening health issues, including the spread of infection to other body parts as well as abscesses of the ovaries and fallopian tubes. It significantly raises the risk of ectopic pregnancy, which can also be life-threatening. As well, PID can negatively impact fertility. The longer PID remains untreated, the higher the likelihood of enduring

81 Ibid (n.52)

serious long-term health problems and infertility, and prolonged PID infections can result in permanent scarring of the reproductive organs. The condition can result in the need for a hysterectomy.

In the replies, one WPATH member shared a story about young natal females developing "pelvic floor dysfunction, and even pain with orgasm." A trans-identified natal female lawyer and prominent trans activist shared a personal account of developing a condition after years on testosterone that caused "splits in the skin which bled, and were excruciating." And another trans-identified natal female member described "bleeding after penetrative sex," painful orgasms, and an atrophied uterus.

Natal males don't fare any better on estrogen, either. When a doctor posted asking for "any insight as to why some transwomen may experience significant pain with erections post hormone therapy," the replies indicated that this is not an uncommon problem.

A trans-identified natal male counselor confirmed having experienced painful erections while taking estradiol and described "trying to avoid having them because of this," explaining that even when the erections were not painful, "they were physically uncomfortable and not pleasurable." A registered nurse told of natal male patients who described erections as "feeling like broken glass."

This is the treatment pathway WPATH endorses for adolescents. These exchanges indicate that gender-affirming healthcare providers are knowingly permitting young patients to compromise their sexual function when they do not have the maturity or experience to comprehend the implications of such a decision in the context of a long-term relationship. These youth are being allowed to sacrifice a crucial component of their sexual identity before they have any understanding of the impact the loss will have on their adult life.

Doctors on the forum also found that cross-sex hormones had severe adverse effects on some young people. In December 2021, a doctor described a 16-year-old patient who had developed large liver tumors after being on norethindrone acetate to suppress menstruation for several years and testosterone for one year. "Pt found to have two liver masses (hepatic adenomas) - 11x11cm and 7x7cm - and the oncologist and surgeon both have indicated that the likely offending agent(s) are the hormones," the doctor wrote.

Another doctor replied to this with an anecdote about a female colleague who, after about 8-10 years of taking testosterone, developed hepatocarcinomas. "To the best of my knowledge, it was linked to his hormone treatment," said the doctor, who had no more details because the cancer was so advanced that her colleague died a couple of months later.

The risk of female patients on testosterone developing hepatocellular carcinomas has been noted before. In 2020, The Lancet published a case study of a 17-year-old trans-identified natal female with a large hepatocellular carcinoma (HCC), the most common type of primary liver cancer which is most often seen in men and people with chronic liver diseases, such as cirrhosis caused by hepatitis B or hepatitis C infection. The 17-year-old had been on testosterone for 14 months, but her team had advised her to stop taking the hormone due to the "possible effects it might be having on the tumour." The outcome for the patient is not known, but the case study concluded by stating that the "relationship between exogenous testosterone and development and progression of HCC in peripubertal transgender patients is unknown."[82]

Researchers have also documented a second unusual case of liver cancer in a trans-identified natal female. This patient was 47 years old at the time of diagnosis and was found to have cholangiocarcinoma, a rare cancer of the bile duct that is normally only seen in older people.[83]

82 Lin, A. J., Baranski, T., Chaterjee, D., Chapman, W., Foltz, G., & Kim, H. "Androgen-Receptor-Positive Hepatocellular Carcinoma in a Transgender Teenager Taking Exogenous Testosterone." The Lancet 396, no. 10245 (2020): 198. https://www.thelancet.com/article/S0140-6736(20)31538-5/fulltext

83 Pothuri, V. S., Anzelmo, M., Gallaher, E., Ogunlana, Y., Aliabadi-Wahle, S., Tan, B., Crippin, J. S., & Hammill, C. H. "Transgender Males on Gender-Affirming Hormone Therapy and Hepatobiliary Neoplasms: A Systematic Review." Endocrine Practice 29, no. 10 (2023/10/01/ 2023): 822-29. https://pubmed.ncbi.nlm.nih.gov/37286102/.

The relatively unexpected ages in these two cases, absence of risk factors, and known association between exogenous testosterone and liver tumors prompted an investigation of existing literature on the relationship between gender-affirming hormone therapy and cancer of the liver. The systematic review was inconclusive, however, due to lack of available evidence."The available evidence is limited by the rarity of these tumor types [and] the historical lack of access to [gender-affirming hormone therapy]."[84]

It is not only liver cancer that is of concern for natal females taking exogenous testosterone. A 2022 cohort study demonstrated a high percentage of abnormal Pap tests in Natal females receiving testosterone. The researchers concluded that "[t]estosterone seems to induce changes in squamous cells and shifts in vaginal flora."[85] Other studies have suggested links between testosterone use and increased risk of heart attacks.[86,87]

In light of the significant increase in teenage girls and young women identifying as transgender and seeking testosterone therapy in recent years, coupled with WPATH's gender-affirming care model, there is an urgent need to investigate any potential life-threatening connections. Furthermore, the "informed consent model of care" endorsed by WPATH has streamlined access to this potent and potentially deadly hormone. In some states, for women as young as 18, it is as straightforward as signing a consent form at Planned Parenthood.[88]

Also, a 2018 study conducted by Kaiser Permanente found that natal males on estrogen had a 5.2% risk of a blood clot in the lungs or legs, a heart attack, or a stroke within a mean of 4 years after initiating estrogen (but the increased risk begins as early as one year), and the risks rise the longer a trans-identified natal male takes estrogen.[89]

The paucity of good quality research in the field of gender medicine was exposed in the 2020 Cochrane Library systematic review of the scientific literature on the safety and efficacy of cross-sex hormone therapy for natal males.[90] The review revealed that not one of the studies within the entire body of literature even reached the classification of very low quality, and as a result, not a single study fulfilled the inclusion criteria set by the review.

"Despite more than four decades of ongoing efforts to improve the quality of hormone therapy for [natal males] in transition, we found that no RCTs or suitable cohort studies have yet been conducted to investigate the efficacy and safety of hormonal treatment approaches for [natal males] in transition," wrote the researchers. "The evidence is very incomplete, demonstrating a gap between current clinical practice and clinical research."

Given the lack of scientific literature to indicate that cross-sex hormone therapy is safe and effective, as well as the number of known negative side effects and the possible serious negative outcomes, it is unethical for WPATH to advocate for minors and the severely mentally ill to bypass psychotherapy and have immediate access to these powerful drugs.

84 Ibid (n.83)

85 Lin, L. H., Zhou, F., Elishaev, E., Khader, S., Hernandez, A., Marcus, A., & Adler, E. "Cervicovaginal Cytology, Hpv Testing and Vaginal Flora in Transmasculine Persons Receiving Testosterone." [In eng]. Diagn Cytopathol 50, no. 11 (Nov 2022): 518-24. https://doi.org/10.1002/dc.25030.

86 Alzahrani, T., Nguyen, T., Ryan, A., Dwairy, A., McCaffrey, J., Yunus, R., Forgione, J., Krepp, J., Nagy, C., Mazhari, R., & Reiner, J. (2019). Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population. Circulation: Cardiovascular Quality and Outcomes, 12(4). https://doi.org/10.1161/circoutcomes.119.005597

87 Nota, N. M., Wiepjes, C. M., De Blok, C. J. M., Gooren, L. J. G., Kreukels, B. P. C., & Den Heijer, M. (2019). Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. Circulation, 139(11), 1461-1462. https://doi.org/10.1161/circulationaha.118.038584

88 "I Want to Transition. How Old Do You Have to Be to Get Hrt?" Planned Parenthood, 2023, https://www.plannedparenthood.org/blog/i-want-to-transition-how-old-do-you-have-to-be-to-get-hrt.

89 Getahun, D., Nash, R., Flanders, W. D., Baird, T. C., Becerra-Culqui, T. A., Cromwell, L., Hunkeler, E., Lash, T. L., Millman, A., Quinn, V. P., Robinson, B., Roblin, D., Silverberg, M. J., Safer, J., Slovis, J., Tangpricha, V., & Goodman, M. (2018). Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. Ann Intern Med, 169(4), 205-213. https://doi.org/10.7326/m17-2785n

90 Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. Cochrane Database of Systematic Reviews(11). https://doi.org/10.1002/14651858.CD013138.pub2

Doctors Improvising and Experimenting

As already shown, WPATH advocates for an unregulated experiment to be conducted on minors who are experiencing gender-related distress. There is no reliable evidence to support the safety and efficacy of puberty suppression for trans-identified adolescents. However, there is further evidence in the files that WPATH members are engaged in improvisation and experimentation rather than rigorous science.

For example, in the discussion threads concerning the debilitating reproductive organ pain experienced by both male and female patients due to hormone therapy, the advice is consistently anecdotal and little more than guesswork. In the thread about the young natal female who had required emergency room care for pelvic inflammatory disease (PID) after three years on testosterone, the New York nurse told the group that the estrogen cream "appears to have stopped working," and the patient has persistent yellow discharge. "Has anyone had luck with estrace tablets vs cream?" the nurse asked, seemingly in lieu of consulting scientific literature.

The replies contain vague anecdotal recommendations that topical creams can help a few patients, and a couple of trans-identified natal females tell of remedies that helped relieve some of their symptoms. A Michigan family physician tells the forum of the success she had treating two natal females with an antispasmodic drug to relieve their painful orgasms, specifying that the drug should be taken 30-60 minutes before orgasm.

However, anecdotes are not science, and no one in the forum provided links to actual scientific literature providing evidence-based recommendations for managing these painful iatrogenic symptoms.

The reason for this is there is no reliable science to consult. A 2021 review of the relevant literature states that the "field of transgender medicine is relatively new, and little is known of the effects of testosterone therapy," but did note that natal females on testosterone therapy frequently experience symptoms of vaginal atrophy similar to those of the post-menopausal state, including dryness, irritation, bleeding with vaginal penetration (sex or medical examination), and dyspareunia (pain during intercourse). The authors acknowledge that these symptoms can have "a substantial impact on quality of life" and may require local estrogen-based therapy, but "the efficacy of this approach has not been documented" in trans-identified natal females.[91]

Worse, a 2023 study found that testosterone use increases a natal female's libido while at the same time increasing pain during intercourse, with over 60% of participants reporting genital pain or discomfort during sexual activity. The researchers noted that the majority of trans-identified natal females experience "vulvovaginal" pain during sexual activity and concluded that "[g]iven this high burden, there is an urgent need to identify effective and acceptable interventions for this population."[92]

In the thread discussing an endocrinologist's question about why some trans-identified natal males experience "significant pain with erections post hormone therapy" and whether this pain was likely to persist after undergoing vaginoplasty, the responses were once again vague and anecdotal, with WPATH members speculating that the discomfort could be linked to factors such as tissue atrophy and thinning of penile skin, and infrequent erections. Some members even admitted to never addressing this concern with their patients. A trans-identified natal male counselor shared a personal anecdote about experiencing this symptom and indicated that it was resolved through penis amputation.

"My guess (and it's just a guess, I'm not a medical

91 Krakowsky, Y., Potter, E., Hallarn, J., Monari, B., Wilcox, H., Bauer, G., Ravel, J., & Prodger, J. L. "The Effect of Gender-Affirming Medical Care on the Vaginal and Neovaginal Microbiomes of Transgender and Gender-Diverse People." [In eng]. Front Cell Infect Microbiol 11 (2021): 769950. https://doi.org/10.3389/fcimb.2021.769950.

92 Tordoff, D. M., Lunn, M. R., Chen, B., Flentje, A., Dastur, Z., Lubensky, M. E., Capriotti, M., & Obedin-Maliver, J. "Testosterone Use and Sexual Function among Transgender Men and Gender Diverse People Assigned Female at Birth." [In eng]. Am J Obstet Gynecol (Sep 9 2023). https://doi.org/10.1016/j.ajog.2023.08.035.

person) would be that the pain is related to erectile tissue in [the] penis and that the removal of that tissue during vaginoplasty addresses the problem," said the counselor.

In another thread, a nurse practitioner told the group about a female patient who identified as non-binary and was requesting "masculinizing hormone therapy." The patient had asked about taking Finasteride, a 5α-reductase inhibitor used to treat prostatic hyperplasia (BPH) and male pattern hair loss, to prevent "bottom growth."

Bottom growth is a term used to describe the permanent enlargement of the clitoris due to testosterone use. This can cause significant pain and sensitivity.[93] The replies are once again a chorus of speculation, with no one providing any scientific literature to back up the experimental use of the drug for this purpose. One doctor from Massachusetts said she would "be interested to hear if others have tried using it to block clitoral growth," and a family physician from Manchester, who had also had a patient request the drug, had not been able to find any evidence to support using it for this reason. "Any resources, evidence or advice would be appreciated," he concluded.

In fact, Finasteride is mentioned in SOC8 as a possible treatment option for undesired male pattern hair loss in female patients on testosterone, but the authors caution that it "may impair clitoral growth and the development of facial and body hair."

There were plenty of examples of improvisation in our leaked panel discussion as well, where Dr. Cecile Ferrando, a surgeon, tells the assembled WPATH members that she experiments with "underdosing" natal females with testosterone. She explains that these females desire "cessation of menses" but not virilization. Ferrando added that these young women in their twenties "err on the masculine side of the spectrum but don't want to be fully masculinized." The gender surgeon tells the group that her experimental use of a Schedule III controlled substance improves the young women's "state of being" and "sense of wellbeing."

It's not just adults who are being experimented on either. Massey shares an account of a confused young patient being treated by equally confused healthcare providers. The child has been on puberty blockers for about two years, and her pediatric endocrinologist wants her to stay on a little longer. "The kid is vacillating, really not wanting facial hair," but unsure about having menstrual cycles, "and kind of vacillates about whether breast development, chest development, bothers them or not and which pronouns they use," explains Massey.

"So, is there more, um, benefit of staying on blockers or letting the kid switch back to their endogenous estrogen? Or is it better to go low-dose testosterone or what? You know, and at what point in time?" asks the confused therapist.

"So, if the kid doesn't want facial hair but maybe doesn't mind their chest growing, and they're planning on having chest surgery anyways. So we may want to be creative in how we help folks approach these situations that are complex," Massey concludes. It is safe to say that most parents do not want confused doctors being "creative" when it comes to performing life-altering medical interventions on their children.

Metzger describes putting 13-year-olds on cross-sex hormones as "like a journey," with the child's doctor "coming along for the ride." He explains that he lets his teenage patients lead when it comes to their hormone doses, asking them each time they show up for an appointment what they want to do with their hormones. He noted that "kids do shift with time, particularly the non-binary kids," who often end up not wanting to be as masculine as they first thought. "They find that there's a happy dose that's gotten rid of their periods or whatever, and that they're happy on that dose," he added. While it might seem odd to put a child in the driving seat in this way, it is entirely consistent with WPATH's affirmative

93 Wierckx, K., Van Caenegem, E., Schreiner, T., Haraldsen, I., Fisher, A., Toye, K., Kaufman, J. M., & T'Sjoen, G. (2014). Cross-Sex Hormone Therapy in Trans Persons Is Safe and Effective at Short-Time Follow-Up: Results from the European Network for the Investigation of Gender Incongruence. The Journal of Sexual Medicine, 11(8), 1999-2011. https://doi.org/10.1111/jsm.12571

model of care, which strives to help patients achieve their unique, and often shifting, "embodiment goals."

However, despite clear evidence that gender-affirming healthcare providers are experimenting on the patients in their care, WPATH's official stance is that these treatments are evidence-based. Interestingly, WPATH deliberately refrains from using the term "experimental" in its SOC8, all the while acknowledging the absence of evidence to support its recommendations.

For example, in the adolescent chapter, when addressing all the uncertainties surrounding whether or not gender identity is fixed from birth or part of a "developmental process," the authors concede that "[f]uture research would shed more light on gender identity development if conducted over long periods of time with diverse cohort groups."[94] In other words, there is no science to support the idea that gender identity is fixed or to justify permanently altering a young person's body using drugs and surgeries. Therefore, the whole treatment protocol is "experimental," except for the fact that it doesn't even meet that low bar because a real experiment involves control groups and diligent follow-up, neither of which occurs in WPATH's field of gender-affirming medicine. Of note, every European systematic review of the evidence for adolescent sex-trait modification interventions to date has concluded that the treatments are experimental.

What's more, WPATH is aware that this experiment is not just confined to minors. In the adult chapter of SOC8, the authors state that the "criteria in this chapter have been significantly revised from SOC-7 to reduce requirements and unnecessary barriers to care. It is hoped that future research will explore the effectiveness of this model."[95]

In the aforementioned section discussing the possible use of Finasteride to prevent unwanted side effects of testosterone use in females, the authors conclude that "[s]tudies are needed to assess the efficacy and safety of 5α-reductase inhibitors in transgender populations." Similar phrasing, synonymous with "experimental," can be found throughout SOC8.

The deliberate avoidance of the term "experimental" is due to the fact that experimental medicine is not covered by health insurance, and one of the primary objectives of WPATH's SOC8 is to secure insurance coverage, an aim the leading transgender health group prioritizes over adhering to best medical practices.

WPATH Members Causing Surgical Harm

WPATH members are also causing surgical harm to their patients, including minors and those suffering from severe mental illness. In a discussion that took place in May 2023, a Colombian surgeon was unsure how to proceed with a 14-year-old natal male who was requesting vaginoplasty surgery.

As previously stated, vaginoplasty is a major surgery that entails amputating the penis and using the penile tissue to create a pseudo-vagina. The procedure comes with a high complication rate, a long recovery time, and requires lifelong dilation of the surgical site to prevent the wound from closing.

Also, dilation, the physical insertion of a dilator to maintain the depth of the cavity, can cause discomfort and pain and must be performed three times a day in the immediate post-op period. This can take as much as 2 to 2.5 hours a day.[96] As the patient recovers, dilation needs to gradually taper off, but the surgical site needs to be dilated once a week for life.

Dr. Christine McGinn replied, recommending that he "tread lightly" because many hospitals are now banning

94 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. LC., Deutsch, M. B., Ettner, R., et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." International Journal of Transgender Health 23, no. sup1 (2022): S45. https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

95 Ibid (n.94 p.33)

96 "Use It or Lose It: The Importance of Dilation Following Vaginoplasty." MTF Surgery, 2023, https://www.mtfsurgery.net/dilation.htm.

surgeries for those under 18. McGinn reported performing about 20 vaginoplasties on patients under 18 over a 17-year period and confessed that "not all…had perfect outcomes," adding that, "None of these patients have regretted their decision ***that I am aware of.***" (emphasis added)

McGinn then explained that the "ones who had trouble" were the ones who were unable to adhere to the dilation schedule and suffered from vaginal stricture as a result, adding that patients over 18 can have the same dilation difficulties.

Vaginal stricture, or neovaginal stenosis, is a common complication following penile inversion vaginoplasty. A 2021 study found that almost 15% of males who underwent vaginoplasty at Mount Sinai Hospital had to have one or more revision surgeries due to neovaginal stenosis, 73.5% of whom had been unable to adhere to the post-op dilation schedule.[97] Vaginoplasty revision surgery is more difficult due to scar tissue, which also makes dilation post-revision surgery more challenging and painful.[98]

Neovaginal stenosis is just one of many complications that can arise after vaginoplasty. A 2018 review of the data on vaginoplasty complications provides a long list of all the possible complications, ranging from minor, aesthetic issues to severe complications such as rectal injuries and serious urinary dysfunction.[99]

Also, in May 2023, a gynecologist in the WPATH forum described a patient who, after penile inversion vaginoplasty, was leaking prostate secretions through the urethra and was finding it bothersome. The replies inform the gynecologist that there is no remedy, but one nursing lecturer, who self-described as a "woman of trans experience," suggested telling the distressed patient to "enjoy the ride," adding, "It's the ultimate physical sign of orgasm…what's not to like?"

These exchanges prove that WPATH surgeons are aware of these adverse outcomes post-vaginoplasty and yet still not only recommend minors undergo such drastic surgeries but also do no follow-up to monitor how the young patients fare later in life. An ethical surgeon performing any experimental procedures on minors would only do so in cases of the highest need, in the strictest of clinical trial settings, and with diligent follow-up of patients well into adulthood to evaluate the impact of such a drastic procedure on their adult functioning. A surgeon who is truly dedicated to delivering the highest quality of care would express genuine concern for their patient's capacity to establish and maintain long-term intimate relationships following genital surgery. But saying "that I am aware of" indicates that McGinn is just assuming the young patients recover well while having no way of knowing if the experiment resulted in a positive outcome.

But despite having no evidence that genital surgery improves life for natal males who undergo the procedure as adolescents, McGinn still believes that the ideal time for a young person to have this major, life-altering surgery is "the summer before their last year of high school," a sentiment shared by WPATH President Bowers, who in the replies expressed reluctance to perform the procedure on someone so young but agreed that "sometime before the end of high school does make some sense in that they are under the watch of parents in the home they grew up in."

As well, there is evidence in the files of members doing surgical harm to severely mentally ill patients. In an undated message thread, a therapist expresses concern about referring her "trans clients with serious mental illness" for surgery due to difficulty in predicting their future stability, "in particular, given the extensive recovery period and 'postnatal' care required for vaginoplasty."

A California marriage and family therapist replied, saying it depends on many factors, such as how much

97 Kozato, A., Karim, S., Chennareddy, S., Amakiri, U, O., Ting, J., Avanessian, B., Safer, J. D., et al. "Vaginal Stenosis of the Neovagina in Transfeminine Patients after Gender-Affirming Vaginoplasty Surgery." Plastic and Reconstructive Surgery – Global Open 9, no. 10S (2021). https://journals.lww.com/prsgo/fulltext/2021/10001/vaginal_stenosis_of_the_neovagina_in_transfeminine.103.aspx.

98 "Vaginal Depth and Avoiding Stenosis." Gender Bands, 2021, https://www.genderbands.org/post/marinating-vaginal-depth-and-avoiding-stenosis.

99 Ferrando, C. A. "Vaginoplasty Complications." [In eng]. Clin Plast Surg 45, no. 3 (Jul 2018): 361-68. https://pubmed.ncbi.nlm.nih.gov/29908624/.

support the mentally ill person has, whether they have a safe place to recover, and whether or not they understand instructions such as "dilate, wash, monitor." She added that in the last 15 years, she had only declined to write one referral letter, and that was mainly because "the person evaluated was in active psychosis and hallucinated during the assessment session."

"Other than that - nothing - everyone got their assessment letter, insurance approval, and are living (presumably) happily ever after," said the therapist, who has referred for genital surgery people diagnosed with major depressive disorder, c-PTSD, and who are homeless.

Here, the therapist's use of the word "presumably," like the previous surgeon's "that I am aware of," indicates no systematic follow-up of patients, which would be reasonable to expect from a surgeon who knows he or she is doing something risky, invasive and experimental. Without follow-up, there is no way to know whether the severely mentally ill person was able to cope with the arduous 2+ hours a day of post-op dilation, the long recovery period, and the lifelong impact of the surgery on the patient's physical health and ability to form intimate relationships. WPATH-affiliated surgeons do not appear to have even the slightest curiosity about the outcome for such patients.

While the therapist was right to be concerned about the level of support patients have during the immediate post-op period, her contribution demonstrates the myopic thinking of gender-affirming healthcare providers. WPATH members typically focus on short-term patient satisfaction from the drastic, life-altering interventions they endorse and appear to have little concern for how the patient will fare in 20, 30, or 40 years.

WPATH members are also willing to allow people with serious degenerative diseases to undergo sex trait modification surgeries. One New Jersey nurse practitioner in the files asked for advice regarding a 22-year-old natal male with Becker Muscular Dystrophy who wished to begin taking estrogen and later undergo vaginoplasty. While the nurse could find no obstacles to proceeding with "gender affirming hormone therapy," concerns were raised about the potential risks associated with anesthesia during the surgical procedure. Notably, there was no indication of the nurse expressing concern about the impact of vaginoplasty on the patient's overall health or ability to manage the extended post-operative recovery period.

Others inside the forum object to surgical restrictions based on high body mass index (BMI). It is widely recognized that obesity increases the risks associated with surgery, leading to complications such as prolonged operative time, increased risk of surgical site infections, and various other complications.[100,101] Therefore, it is standard practice for surgeons to have a BMI cap for elective surgeries.[102]

However, inside WPATH, some members are unhappy about obese female patients being denied elective bilateral mastectomies. A research associate within the group suggested that this denial is the result of "systemic fatphobia" and challenged the conventional belief that the patients' obesity directly contributes to adverse outcomes, instead suggesting that it was the result of "weight bias" influencing how patients are cared for and operated on. While acknowledging the "high prevalence of eating disorders in trans individuals," this WPATH member expressed concern that withholding surgery could potentially exacerbate these issues.

A Washington social worker contributed an anecdote about a "client seeking top surgery" who had been told to lose weight. This apparently triggered "disordered eating."

100 Tsai, A., & Schumann, R. (2016). Morbid obesity and perioperative complications. Curr Opin Anaesthesiol, 29(1), 103-108. https://doi.org/10.1097/aco.0000000000000279

101 Osman, F., Saleh, F., Jackson, T. D., Corrigan, M. A., & Cil, T. (2013). Increased Postoperative Complications in Bilateral Mastectomy Patients Compared to Unilateral Mastectomy: An Analysis of the NSQIP Database. Annals of Surgical Oncology, 20(10), 3212-3217. https://doi.org/10.1245/s10434-013-3116-1

102 Farquhar, J. R., Orfaly, R., Dickeson, M., Lazare, D., Wing, K., & Hwang, H. (2016). Quantifying a care gap in BC: Caring for surgical patients with a body mass index higher than 30. British Columbia Medical Journal, 58(6).

The social worker was considering contacting Dr. Mosser, a San Francisco surgeon and WPATH member, who does not have a BMI limit. Dr. Mosser's website states that he has performed elective bilateral mastectomies on patients with a BMI as high as 65.[103]

In 2022, Dr. Sidhbh Gallagher, a WPATH-affiliated surgeon famous for making quirky TikTok videos promoting her services to her hundreds of thousands of young followers, in which she refers to bilateral mastectomies as "yeet the teets," received backlash from several obese patients who claim to have experienced severe post-op complications.[104,105] One young patient told a harrowing tale of the surgical incision opening and a resulting infection that almost proved fatal.[106]

Dismantling Guardrails

WPATH's aversion to caution and dislike of psychiatric gatekeeping is evident in the files. In an undated thread, a psychotherapist expressed her dissatisfaction with the group regarding a surgeon's requirement of two referral letters from her before amputating the healthy breasts of a 17-year-old girl. To the psychotherapist, this seemed like "extra extra gatekeeping."

The letters appear to be little more than a formality for insurance purposes, but in the replies, a therapist suggested the reason could be that the insurance company wanted evidence that the "status of the client" had not changed over time.

However, the rest of the replies are a chorus of agreement that the request is unnecessary gatekeeping, with one even suggesting reporting the insurer to the local state regulator "for their clinically unsound coverage determination requirements."

A Florida non-binary counselor with they/them pronouns replied, offering her services. She told the therapist that she provides consultation specifically regarding letter writing. "If you're interested in consultation with a provider of lived experience, I'm happy to chat further," said the counselor. "I've written quite a few second letters and have written letters for minors as well," she added.

In another undated thread, a Virginia therapist with "several trans clients with serious mental illness" such as "bipolar disorder and autism or schizoaffective disorder" asked the group for advice on what criteria to use to determine whether or not a patient was ready for surgery. She was particularly concerned about "clients" with serious mental illness being capable of adhering to "post-surgical dilation protocols."

A California therapist replied that "as gender affirmative practitioners, we always consider harm reduction as our primary lens," meaning it is necessary to ask "what will happen to these patients if they do NOT undergo their affirmative treatment, which is also a medical necessity." This therapist said she was personally "not invested" in SOC7's requirement that mental illness be "well controlled" before the patient is allowed to consent to surgeries such as vaginoplasty and bilateral mastectomies. In fact, this thinking was in line with WPATH's official stance, as the group removed the requirement from its SOC8.

A trans-identified natal male therapist joined the discussion to say that according to WPATH's SOC7, the "letter of support" was primarily to establish the persistence of the patient's gender dysphoria and that "denying necessary surgical care (even for the severely mentally ill) encroaches strongly on a patient's autonomy."

This shift towards viewing the involvement of mental

103 Mosser, S. Top Surgery Eligibility FAQ. Gender Confirmation Center. https://www.genderconfirmation.com/eligibility-faq/#:~:text=Mosser%20does%20not%20have%20a,the%20patient%27s%20primary%20care%20physician

104 Gallagher, S. (2024). GenderSurgeon. https://www.tiktok.com/@gendersurgeon?lang=en

105 Buttons, C. (2024). TikTok Doc's Trans Patients Post More Gruesome Stories Of Post-Op Complications. The Daily Wire. https://www.dailywire.com/news/tiktok-docs-trans-patients-post-more-gruesome-stories-of-post-op-complications

106 Rylan. (2022). Top Surgery with Dr. Gallagher Almost Cost Me My Life. Medium. https://rylan545.medium.com/top-surgery-with-dr-gallagher-almost-cost-me-my-life-d68cda71c543

health professionals as superfluous began with Dr. Richard Green commissioning HBIGDA's SOC6 immediately after Dr. Stephen Levine's SOC5 had specified two referral letters were needed before starting hormones. Whereas Levine advocated for guardrails to be placed around access to medical transition in an effort to minimize regret, WPATH, since Green's day, has been intent on dismantling those safety measures.

WPATH Members Trivializing Detransitioner Stories of Harm

Gender-affirming healthcare providers have always maintained that the regret rate for sex-trait modification interventions is very low, but this belief is based on deeply flawed research.[107,108,109] Due to sloppy, inadequate follow-up, the true detransition rate is unknown, but recent studies indicate it is rising.[110,111,112,113] Several small studies provide valuable insights into the detransition experience.[114,115,116,117] As well, an increasing number of young people are speaking out about the harm they experienced at the hands of gender-affirming healthcare providers.[118,119,120] Yet many WPATH members in the forum remain in denial about the damage done, dismissing or trivializing the lifetime of regret now faced by many young people.

In response to a post by a Washington DC psychologist about a "distraught and angry" 17-year-old detransitioned girl who had been on testosterone for more than two years and felt she was "brainwashed," several WPATH members appear in the replies. There is talk of detransition being just another step in a patient's "gender journey" and not necessarily involving regret. By this self-serving logic, it is impossible for clinicians practicing the affirmative model to ever be wrong in their diagnosis or treatment decisions.

The notion of the "gender journey" to describe regret and detransition is used to insulate gender-affirming clinicians from criticism and accountability. Within the realm of gender-affirming care, as long as the healthcare provider affirms the regret and detransition phase as part of the "journey," any potential errors or misjudgments are considered acceptable.

As well, on more than one occasion, the WPATH

107 Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. "Regret after Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence." [In eng]. Plast Reconstr Surg Glob Open 9, no. 3 (Mar 2021): e3477. https://doi.org/10.1097/gox.0000000000003477.

108 "At What Point Does Incompetence Become Fraud?" Genspect, 2022, https://genspect.org/at-what-point-does-incompetence-become-fraud/.

109 Dhejne, C., Öberg, K., Arver, S., & Landén, M. "An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960-2010: Prevalence, Incidence, and Regrets." [In eng]. Arch Sex Behav 43, no. 8 (Nov 2014): 1535-45. https://doi.org/10.1007/s10508-014-0300-8.

110 Cohn, J. "The Detransition Rate Is Unknown." Archives of Sexual Behavior 52, no. 5 (2023): 1937-52. https://doi.org/10.1007/s10508-023-02623-5. https://dx.doi.org/10.1007/s10508-023-02623-5.

111 Irwig, M. S. "Detransition among Transgender and Gender-Diverse People—an Increasing and Increasingly Complex Phenomenon." The Journal of Clinical Endocrinology & Metabolism 107, no. 10 (2022): e4261-e62. https://doi.org/10.1210/clinem/dgac356.

112 Hall, R., Mitchell, L., & Sachdeva, J. "Access to Care and Frequency of Detransition among a Cohort Discharged by a Uk National Adult Gender Identity Clinic: Retrospective Case-Note Review." [In eng]. BJPsych Open 7, no. 6 (Oct 1 2021): e184. https://doi.org/10.1192/bjo.2021.1022.

113 Boyd, I., Hackett, T., & Bewley, S. "Care of Transgender Patients: A General Practice Quality Improvement Approach." [In eng]. Healthcare (Basel) 10, no. 1 (Jan 7 2022). https://doi.org/10.3390/healthcare10010121.

114 Littman, L. (2021). Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. Archives of Sexual Behavior, 50(8), 3353-3369. https://doi.org/10.1007/s10508-021-02163-w

115 Mackinnon, K. R., Gould, W. A., Enxuga, G., Kia, H., Abramovich, A., Lam, J. S. H., & Ross, L. E. (2023). Exploring the gender care experiences and perspectives of individuals who discontinued their transition or detransitioned in Canada. PLOS ONE, 18(11), e0293868. https://doi.org/10.1371/journal.pone.0293868

116 Littman, L., O'Malley, S., Kerschner, H., & Bailey, J. M. (2023). Detransition and Desistance Among Previously Trans-Identified Young Adults. Archives of Sexual Behavior. https://doi.org/10.1007/s10508-023-02716-1

117 Vandenbussche, E. (2022). Detransition-Related Needs and Support: A Cross-Sectional Online Survey. Journal of Homosexuality, 69(9), 1602-1620. https://doi.org/10.1080/00918369.2021.1919479

118 Reddit, 2023, https://www.reddit.com/r/detrans/.

119 "'I Literally Lost Organs:' Why Detransitioned Teens Regret Changing Genders." New York Post, 2022, https://nypost.com/2022/06/18/detransitioned-teens-explain-why-they-regret-changing-genders/.

120 "Why This Detransitioner Is Suing Her Health Care Providers." Public, 2023, https://public.substack.com/p/why-this-detransitioner-is-suing?utm_source=%2Fsearch%2Fmichelle&utm_medium=reader2.

members pass the blame to the young person. Another psychologist talks of a female patient who is still in high school and has decided to detransition, claiming that the girl "acknowledges that [she] was the driver in getting [her] to this point."

WPATH President Bowers then echoed this psychologist's opinion, stating that all medical treatments have regret rates that are typically much higher than for gender transition, and "patients need to own and take active responsibility for medical decisions, especially those that have potentially permanent effects." Bowers added that "legislatures and the media [do not] go after breast augmentation, tubal ligation or facelifts." Here, Bowers inadvertently concedes that sex-trait modification procedures are elective, cosmetic procedures, like facelifts and breast augmentation, which also often result in lifelong sterility, like tubal ligation.

However, a minor does not have the cognitive capacity to understand those "potentially permanent effects" and, therefore, cannot give cognitive consent, and the leaked panel discussion proves that WPATH members are aware of that fact. In many cases, a person suffering from severe mental illness also does not have the necessary decision-making capacity to assess the risks and life-long consequences of the treatment. In these circumstances, responsibility rests with the healthcare professionals who misdiagnosed the patient and neglected their duty to secure proper informed consent. In no other branch of medicine is the patient blamed for consenting to a treatment based on a misdiagnosis.

Furthermore, in the United States, it is highly unlikely that any medical professional would permit a healthy adolescent girl to provide consent for tubal ligation. This is because it is widely recognized that although many teenagers may strenuously insist that they never want children, such feelings are likely to change over time as the young person matures and their priorities shift. Metzger's "oh, the dog's not doing it for you now" remark during the panel proves that he and his fellow WPATH panelists understand this perfectly well.

If there were suddenly a surge of teenagers being given vasectomies and tubal ligation on demand, or if plastic surgeons were selling breast augmentation and facelifts to adolescents as a remedy for their mental disorders, it is certain that both the media and legislatures would weigh in on the issue.

Suspiciously Low Regret Rates

Bowers's comment that "all medical treatments have a regret rate higher than medical transition" should give WPATH members pause for thought. The statement, on the surface, appears to be true. A recent systematic review of regret rates following "gender affirmation" surgery found regret to be less than 1% for natal females who had undergone mastectomies and/or phalloplasty and less than 2% for natal males who had undergone vaginoplasty.[121] However, leaving aside the fact that the studies in this review had high loss to follow-up and/or extremely short follow-up periods, unusually narrow definitions of regret and detransition, and that the review contained an extraordinary number of errors even for a field of research known for sloppy practices, given the high rate of serious complications and the dramatic impact these procedures have on a person's ability to form intimate relationships, these numbers are suspiciously low.[122]

The case study of one of the earliest participants of the Dutch puberty suppression experiment sheds some light on why this might be. The study describes the natal female's level of satisfaction and psychological functioning at age 35.[123] The patient did not regret undergoing hormonal and surgical sex-trait modification but reported dealing with significant shame related to her genital appearance,

121 Ibid (n.107)

122 Ibid (n.108)

123 Cohen-Kettenis, P. T., Schagen, S. E., Steensma, T. D., de Vries, A. L., & Delemarre-van de Waal, H. A. "Puberty Suppression in a Gender-Dysphoric Adolescent: A 22-Year Follow-Up." [In eng]. Arch Sex Behav 40, no. 4 (Aug 2011): 843-7. https://doi.org/10.1007/s10508-011-9758-9.

experiencing depressive episodes, and having difficulty maintaining long-term relationships. In a previous follow-up study, performed just two years after surgery when the patient was age 20, high levels of satisfaction were recorded, and the female patient was pleased with the outcome of the metoidioplasty.[124] Metoidioplasty is a surgical procedure that involves constructing a small pseudo-penis out of an enlarged clitoris. When a natal female takes testosterone, the clitoris becomes permanently enlarged.

This case study highlights the problem with self-reporting when it comes to regret rates in the field of gender medicine. People who embark on sex-trait modification interventions often sacrifice their health, fertility, sexual function, and healthy body parts in the quest to find peace in their bodies. It's highly probable that, despite experiencing unfavorable outcomes, severe complications, and a clear adverse impact on their ability to establish intimate relationships, many will persist in convincing both themselves and others that their decision was not a mistake. This reluctance to acknowledge regret may stem from a reluctance to confront the consequences of their choices.

Indeed, the early Dutch clinicians were well aware of this possibility. In the first follow-up study of patients who at the time were referred to as transsexuals, conducted approximately 15 years after the Netherlands began offering sex trait modification interventions, the majority of participants reported being happy and feeling no regret despite researchers noting that improvement in "actual life situations [was] not always observed."[125] In the 1988 paper, the researchers considered the possibility that in an effort to reduce cognitive dissonance, participants who had undergone hormonal and surgical interventions "simply cannot accept the notion that all has been in vain. The self-reported happiness may have been distorted wishful thinking."

As already shown, studies that don't rely solely on self-report but instead measure factors such as social functioning and mental health status indicate far less positive outcomes.[126]

When more people regret knee replacement surgery than penis amputation, or more women regret undergoing prophylactic mastectomies for breast cancer risk than gender-affirming mastectomies, these surprising outcomes should raise red flags in a medical organization dedicated to scientific truth.[127,128,129,130] Rather than being proof that sex-trait modification surgeries are the cure for gender distress, these low regret rates are cause for investigation.

Permanently Medicalizing Transient Identities

Passing the blame onto minors isn't the only way WPATH members minimize the harm done to detransitioners. On November 6, 2021, a medical student responded to a member who shared a 2021 study of detransitioners in the forum, arguing that it was important to emphasize it is "okay for gender and interest in medical options to change over time for each individual," likening irreversible sex change interventions to tattoos or minor plastic surgeries.[131] The student then went on to suggest

125 Kuiper, B., & Cohen-Kettenis, P. (1988). Sex reassignment surgery: a study of 141 Dutch transsexuals. Arch Sex Behav, 17(5), 439-457. https://doi.org/10.1007/bf01542484

126 Ibid (n.68)

127 Mahdi, A., Svantesson, M., Wretenberg, P., & Hälleberg-Nyman, M. "Patients' Experiences of Discontentment One Year after Total Knee Arthroplasty-a Qualitative Study." [In eng]. BMC Musculoskelet Disord 21, no. 1 (Jan 14 2020): 29. https://doi.org/10.1186/s12891-020-3041-y.

128 Olson-Kennedy, J., Warus, J., Okonta, V., Belzer, M., & Clark, L. F. "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults." JAMA Pediatrics 172, no. 5 (2018): 431. https://doi.org/10.1001/jamapediatrics.2017.5440.

129 Borgen, P. I., Hill, A. D., Tran, K. N., Van Zee, K. J., Massie, M. J., Payne, D, & Biggs, C. G. "Patient Regrets after Bilateral Prophylactic Mastectomy." [In eng]. Ann Surg Oncol 5, no. 7 (Oct-Nov 1998): 603-6. https://doi.org/10.1007/bf02303829.

130 Bruce, L., Khouri, A. N., Bolze, A., Ibarra, M., Richards, B., Khalatbari, S., Blasdel, G., et al. "Long-Term Regret and Satisfaction with Decision Following Gender-Affirming Mastectomy." JAMA Surgery 158, no. 10 (2023): 1070-77. https://doi.org/10.1001/jamasurg.2023.3352.

131 Ibid (n.114)

that learning "new things about your gender or what you want from your medical care should be something to be celebrated, and we don't have to see it as a mistake that was made."

However, the procedures many of these patients undergo are far more extreme than a tattoo or a nose job. In the replies to the post about the distraught and angry detransitioned 17-year-old, a gynecologist from Barcelona explained she also had a patient wishing to detransition who was seeking vaginoplasty reversal surgery. This procedure involves surgically removing the pseudo-vagina and performing phalloplasty surgery, which is the creation of a non-functional pseudo-penis using skin stripped from the patient's forearm or thigh.[132,133] It is doubtful any individual would find that cause for celebration.

Many detransitioners feel intense anger and grief regarding the irreversible changes wrought by gender-affirming care. They mourn the loss of their body parts and the experiences, such as bearing children or breastfeeding, that have been taken from them.

An Ontario family physician is the only WPATH member in the files who respects the experience of detransitioners and dares to challenge Bowers and her colleagues on their disrespectful framing of detransition. She told the group her detransitioned patients were all young women who were allowed to change their bodies in permanent ways at a time in their lives when "their physical and sexual identities were in developmental flux." Most had comorbidities that were not fully addressed and were rushed into irreversible medical interventions. The physician described this group of patients as being "immersed in their own suffering, loss and grief."

The fact that a significant number of WPATH members downplay this distressing ordeal by implying that medical professionals did not err in misdiagnosing these youths and subjecting them to unnecessary, invasive procedures serves as proof that WPATH lacks ethical integrity.

In fact, there are members within WPATH who acknowledge that some teenagers are mistaking their emerging homosexuality as a gender identity issue. During the panel, Massey described young patients who, after exploring their sexuality, "got to clarify some of their gender identity issues."

This is one of the many risks associated with WPATH's approach to gender medicine. In bypassing exploratory psychotherapy, or indeed just not allowing children to grow and mature but instead immediately placing adolescents on the medical conveyor belt, WPATH-affiliated healthcare providers are inadvertently engaging in a new form of conversion therapy, sterilizing gay and lesbian teens before they have had a chance to understand and accept their sexuality.[134] Data from gender clinics and numerous studies indicate that children and adolescents suffering from gender dysphoria are disproportionately likely to grow up to be homosexual adults, and recent studies of detransitioners likewise show that a significant proportion are also

132 Djordjevic, M. L., Bizic, M. R., Duisin, D., Bouman, M. B., & Buncamper, M. "Reversal Surgery in Regretful Male-to-Female Transsexuals after Sex Reassignment Surgery." [In eng]. J Sex Med 13, no. 6 (Jun 2016): 1000-7. https://doi.org/10.1016/j.jsxm.2016.02.173.

133 "Phalloplasty for Gender Affirmation." Johns Hopkins Medicine, 2023, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/phalloplasty-for-gender-affirmation.

134 "Current Debates." Gender Identity Development Service, 2023, https://gids.nhs.uk/gender-identity-and-sexuality/#:~:text=For%20young%20people,males%20or%20females.

homosexual.[135,136,137,138,139,140]

The unethical and unscientific slant of WPATH is also evident in the way detransition is framed by some within the forum. On November 10, 2021, a research coordinator in the forum suggested that the very idea of detransitioning is "problematic" because it "frames being cisgender as the default and reinforces transness as a pathology." The young member argued that "it makes more sense to frame gender as something that can shift over time, and figure out ways to support people making the choices they want to make in the moment, with the understanding that feelings around decisions make [sic] change over time."

However, it raises serious ethical questions when surgeons are tasked with the removal of healthy body parts, especially when such procedures are in pursuit of aligning a young person's physical form with an identity that is recognized as unstable and as yet unsettled.

Of yet more concern is the possibility that some young people are adopting a transgender identity as a trauma response, and WPATH-affiliated professionals are permanently medicalizing these distressed individuals. In malpractice lawsuits filed by Prisha Mosley and Isabelle Ayala, the trauma of being the victim of sexual assault at a young age is described as a contributing factor in the adoption of a transgender identity. Inside WPATH, members are aware of this possibility, yet still, the group's official position is immediate affirmation and access to drugs and surgeries if that is what the patient desires.[141] This approach also has opportunity costs, as the focus on gender identity and medical interventions may divert attention from the essential therapy needed to effectively address and manage the underlying trauma in these young individuals.

In a September 2021 thread in the forum, a counselor noted that "[t]rauma is common among trans clients," and several replies indicated that others had observed this trend as well. In the panel discussion, Metzger and his colleagues discuss a young person who, like Mosley and Ayala, began identifying as transgender after "an unfortunate, traumatic sexual event." Massey talks about the hope that the therapists involved could "help the young person distinguish between the assault and their gender identity" but points out the difficulty of this task because "there are times working with young people where they don't even disclose an assault or some type of sexually coercive or unpleasant experience."

Massey states that "even good therapists" are going to be limited at times, unable to get everything that's going on with a child. "Sometimes even adults don't bring it forward, so it's a high bar to cross sometimes to try to catch everything that may be affecting somebody's view of themselves and across domains of their life experiences."

WPATH Has Broken the Chain of Trust in Medicine

In medicine, there is a concept called the "chain of trust."[142,143] Doctors must be able to trust that their professional training is grounded in robust scientific evidence because, given the limited time available to medical professionals, it is not feasible for them to thoroughly investigate every aspect (diagnosis, prognosis,

135 Ibid (n.70)

136 Ibid (n.2)

137 Ibid (n.114)

138 Vandenbussche, E. "Detransition-Related Needs and Support: A Cross-Sectional Online Survey." Journal of Homosexuality 69, no. 9 (2022/07/29 2022): 1602-20. https://doi.org/10.1080/00918369.2021.1919479.

139 Drescher, J., & Pula, J. (2014). Ethical issues raised by the treatment of gender-variant prepubescent children. Hastings Cent Rep, 44 Suppl 4, S17-22. https://doi.org/10.1002/hast.365

140 Cantor, J. M. (2020). Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. J Sex Marital Ther, 46(4), 307-313. https://doi.org/10.1080/0092623x.2019.1698481

141 "Active and Resolved Cases." Campbell Miller Payne, 2023, https://cmppllc.com/our-cases, Isabelle Ayala and Prisha Mosley's Cases.

142 "Heidi Larson, Vaccine Anthropologist." The New Yorker, 2021, https://www.newyorker.com/science/annals-of-medicine/heidi-larson-vaccine-anthropologist.

143 Herman, R. (1994). RESEARCH FRAUD BREAKS CHAIN OF TRUST. The Washington Post. https://www.washingtonpost.com/archive/lifestyle/wellness/1994/04/19/research-fraud-breaks-chain-of-trust/ffd456e7-b8f7-496e-9b02-6c41c30dfd0a/

and treatment) of every illness. For medicine to function efficiently, doctors must be confident that those who issue practice guidelines have diligently and rigorously evaluated all the relevant evidence for the safety and efficacy of treatments.[144]

WPATH has broken the chain of trust in gender medicine. WPATH presents itself as scientific but is in fact an advocacy group promoting risky, experimental, and cosmetic procedures in the guise of well-researched and "medically necessary" care. WPATH is held up as the source of all knowledge about gender-affirming care, but the scientific basis for their recommendations is exceptionally weak. The group exists solely to shield doctors from legal liability, through the creation of guidelines it conveniently calls "standards of care," and to ensure insurance coverage for sex-trait modification procedures.

Due to its outward appearance as a professional medical association, complete with a peer-reviewed journal and bibliography of scientific literature, the wider medical community places its trust in WPATH's "Standards of Care." WPATH and its members have also influenced the position statements and practice guidelines of the American Academy of Pediatrics (AAP), the American Psychological Association (APA), and The Endocrine Society.

Further down the chain, parents and vulnerable patients trust the recommendations of their pediatricians, endocrinologists, and mental health professionals– clinicians who are either themselves WPATH-affiliated or who look to their WPATH-influenced professional associations for guidance on how to deal with children who feel distressed about their bodies.

144 O'Malley, S. & Ayad, S. Pioneers Series: We Contain Multitudes with Stephen Levine. Podcast audio. Gender: A Wider Lens Podcast2022. https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-stephen-levine, 34:53.

WPATH HAS NO RESPECT FOR MEDICAL ETHICS

Traditional medical ethics is more than just "first, do no harm." The guiding principle of Hippocratic medicine is that illness places the afflicted into a compromised state against their will and preference. It is in this compromised state that the person enters into the doctor-patient relationship. Therefore, the patient must be able to trust that their doctor will use his or her knowledge and expertise only for the purpose of healing or ameliorating symptoms and easing suffering, always with the priority of minimizing harm.

Throughout most of medical history, medicine did not involve intentionally destroying a healthy, functioning bodily system. It is only in the 20th century that a new pseudo-medical approach has emerged that views the patient more as a consumer and the doctor as a supplier of pharmaceutical and surgical interventions tasked with fulfilling the patient's desires, which are quickly defined as needs. In the past, the emphasis on autonomy in medical ethics was meant to act as a shield: there were things a doctor could not do to you without your consent. Nowadays, and especially in gender medicine, autonomy acts as a sword: in its name, there is nothing a doctor may deny you.

The consumer-driven model of autonomy involves giving the patient whatever he or she wants, so long as certain criteria are met: The clinician is technically capable of doing it; the patient wants it for whatever reason; it's legal, and the patient can pay for it.

This consumer-driven approach to healthcare is the model adopted by WPATH. The world-leading transgender health group advocates for a transition-on-demand style of care, valuing patient autonomy over avoidance of harm. WPATH's SOC8 more closely resembles a shopping list of risky and invasive cosmetic interventions, with each chapter concluding that the procedures are medically necessary if the patient so desires.

Such recommendations extend as far as non-binary "nullification" surgeries to create a smooth, sexless appearance or "bi-genital" surgeries involving the creation of a second set of genitals. There is also a chapter on people who identify as eunuchs and seek chemical or surgical castration as a means to affirm their "eunuch identities." Within the WPATH Files, there are discussions regarding these "non-standard" procedures and how to manage them. However, notably absent from these discussions is any consideration of the ethical concerns surrounding surgeries that destroy healthy reproductive organs in pursuit of creating bespoke anatomical features that do not exist in nature.

The Ethics of Informed Consent

Informed consent in medicine is the process by which a healthcare provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention.[145]

Obtaining informed consent in medicine is a process that should include three primary components: first, the provision of accurate, up-to-date information regarding the nature of the condition, the proposed treatment, and all available alternatives; second, an evaluation of the patient's understanding, and when applicable, the caregiver's understanding of the presented information and their ability to make informed medical decisions; and third, obtaining signatures confirming that informed

145 Shah, P., Thornton, I., Turrin, D., & Hipskind, JE. "Informed Consent.[Updated 2020 Aug 22]." StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing (2021). https://www.ncbi.nlm.nih.gov/books/NBK430827/#:~:text=Introduction,undergo%20the%20procedure%20or%20intervention.

consent has been secured.[146,147]

A discussion about *all* potential risks of a treatment, as well as all the uncertainties surrounding the benefits, is an integral part of informed consent. This involves addressing general risks, risks specific to the procedure, possible consequences of not undergoing treatment, and exploring alternative treatment options.

Minors Cannot Consent to Sex Trait Modification Procedures

WPATH members believe that minors can understand and give cognitive consent to sex-trait modification interventions that could have a life-long impact on their health, fertility, and future sexual function. In the files, the chief medical officer from Texas advised a concerned therapist to allow a troubled 13-year-old girl to begin testosterone therapy; a therapist discussed starting a 10-year-old girl on puberty blockers; WPATH President Bowers openly admitted that natal male children are being left anorgasmic for life; and one surgeon reported performing 20 vaginoplasties on minors.

Minors lack the maturity and cognitive capacity to understand the risks associated with such interventions and the long-term implications for their well-being. Additionally, their limited or nonexistent sexual experiences make it impossible for them to grasp the magnitude of what they are forfeiting. The leaked panel discussion proves that WPATH members know this. Yet, WPATH continues to advocate for placing minors, some as young as nine years old, on this irreversible medical pathway.

As a way to rationalize allowing minors to consent to sex-trait modification treatments, the full effects of which they could not possibly comprehend, some of the Identity Evolution Workshop panelists drew an analogy with treating childhood-onset diabetes.

"When a kid takes diabetic medication, do they have to understand everything about their pancreas and everything that's happening?" Berg asked the panel rhetorically. Later, Green said, "If you have a known condition, like diabetes, you don't have to understand every nuance about what the insulin is going to do to you in order to give informed consent."

However, the analogy is flawed for several reasons. In order to obtain a diabetes diagnosis, there is a biological test to confirm the illness. The cause is known; the treatment protocol is well-studied; the outcome of treating with insulin is understood, and the risks involved in not treating are clear. Indeed, if left untreated, the illness is fatal. Insulin therapy also does not result in lifelong sterility, nor does it impact a young person's future sexual function. It is a treatment with solid scientific evidence that the benefits greatly outweigh the risks, making the informed consent process straightforward.

But the same cannot be said for using puberty blockers and cross-sex hormones to help young adolescents manage their discomfort with their sex. There is no diagnostic test to confirm a diagnosis of gender dysphoria; instead, it is based on a young person's subjective sense of self that is constantly changing and evolving. Likewise, there is no way to predict which children and adolescents will persist in their transgender identities as adults. There is also no good-quality scientific evidence to support the use of puberty blockers as a remedy for this poorly defined disorder, and there are no long-term outcome studies demonstrating that the benefits outweigh the risks; in fact, there is mounting evidence to the contrary.

The combination of puberty blockers and cross-sex hormones could leave a young patient sterile for life, and the drugs come with a host of known and anticipated side effects, including brittle bones, cognitive impairment, and heightened risk of cancer and cardiovascular disease, as well as uncertainty concerning resolution of gender dysphoria.

146 "Informed Consent." AMA Code of Medical Ethics, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent.

147 Katz, A. L., and Webb, S. A. "Informed Consent in Decision-Making in Pediatric Practice." [In eng]. Pediatrics 138, no. 2 (Aug 2016). https://doi.org/10.1542/peds.2016-1485.

What's more, all studies from the era of gender medicine pre-dating the puberty suppression experiment show that most children, if not affirmed and socially and medically transitioned, will desist and reconcile with their birth sex during or after puberty.[148] Although there is at present no scientific literature available regarding persistence rates for the recently emerged adolescent-onset cohort, which currently comprises the majority of referrals to pediatric gender clinics, existing knowledge about adolescent development suggests significant uncertainty regarding the stability of this group's transgender identities into adulthood.[149]

That experts within WPATH cannot see the difference between the two treatment protocols is further proof that members of this organization do not have a solid understanding of science.

Misinformed Parents Cannot Give Informed Consent

For legal reasons, it falls to parents to sign the consent form for their child's sex-trait modification hormonal and surgical interventions, but WPATH's public and private communications indicate that members are misinforming parents about the experimental treatment protocol.

Parents can only give informed consent if they are told the truth about every stage of the "transition" process, starting with social transition.

Changing names and pronouns is often portrayed as a harmless, non-medical step to alleviate a child's distress. It is sold to parents as completely reversible at any time, but all available evidence suggests the contrary.

Social transition has a powerful iatrogenic effect, meaning affirming a child's transgender identity and allowing a change of name and pronouns serves to concretize the identity in the young person's mind, making desistance far less likely. Historically, in the absence of social transition, the majority of gender dysphoric children would naturally desist and reconcile with their birth sex during or after puberty.[150,151,152] Most would come out as gay.

In her interim report for the independent review of England's youth gender service, Dr. Hilary Cass noted this iatrogenic effect, stating that social transition is not a "neutral act" but rather "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."[153]

However, in March 2023, WPATH made a public statement in response to Missouri Attorney General Andrew Bailey's emergency regulation banning sex-trait modification for minors, citing a July 2022 article published by the American Academy of Pediatrics. The paper by Dr. Kristina R. Olson et al. showed five years after their initial social transition, 97.5% of youth who identify as transgender continued to do so.[154,155] This article, WPATH appears to believe, is evidence that these young people are truly transgender and, therefore, deserving of medical treatment. In truth, what it shows is that social transition serves to lock in the transgender identity.

While it is not necessary to sign a consent form before

148 Cantor, J. M. (2016). Do trans- kids stay trans- when they grow up? http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html

149 Ibid (n.49); Ibid (n.50)

150 Ibid (n.2)

151 Ibid (n.3)

152 Kaltiala-Heino, R., Bergman, H., Työläjärvi, M., & Frisén, L., "Gender Dysphoria in Adolescence: Current Perspectives." [In eng]. Adolesc Health Med Ther 9 (2018): 31-41. https://doi.org/10.2147/ahmt.S135432.

153 "The Cass Review: Independent Review of Gender Identity Services for Children and Young People: Interim Report." 2022, 62. https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf.

154 WPATH. (2023). USPATH and WPATH Confirm Gender-Affirming Health Care is Not Experimental; Condemns Legislation Asserting Otherwise. WPATH. https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH_WPATH%20Response%20to%20AG%20Bailey%20Emergency%20Regulation%2003.22.2023.pdf

155 Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender Identity 5 Years After Social Transition. Pediatrics, 150(2). https://doi.org/10.1542/peds.2021-056082

a minor socially transitions, if WPATH members are failing to warn parents of the iatrogenic effect of social transition, the parents' decision is not an informed one.

The next step of the transition pathway for a minor is puberty blockers, and again, there is evidence that WPATH members are not providing parents with the most up-to-date information about this intervention. In January 2022, Bowers described puberty blockers as "fully reversible" despite the fact that by this point, there was abundant evidence to the contrary.

In fact, very early in the puberty suppression experiment, it was noted that almost every adolescent who commences puberty blockers proceeded to cross-sex hormones, when historical data showed that most children would cease to identify as members of the opposite sex after puberty.[156, 157,158] This means that puberty suppression is almost certainly the first step in a longer treatment protocol, not a mere "window of time" for the adolescent to think about his or her identity. Therefore, it cannot be called "fully reversible."

Massey's comments in the May 2022 panel discussion prove that people within WPATH understand this. The WPATH therapist stressed the importance of discussing "fertility preservation" with youth who are going on puberty blockers because many of those youth will go directly onto affirming hormone therapies that will eliminate the development of their gonads producing sperm or eggs."

Clinicians and researchers have long recognized that the cognitive development that occurs as a result of endogenous puberty is the remedy for childhood gender dysphoria. This was noted by the Dutch clinicians who pioneered puberty suppression and who also happen to be members of WPATH. Blocking puberty, therefore, means blocking the natural cure to gender dysphoria.

Metzger's comments during the panel indicate that, privately, WPATH members understand this negative impact of freezing adolescents in a child-like state. When Metzger spoke about "robbing these kids of that sort of early to mid pubertal sexual stuff that's happening with their cisgender peers," he was referring to robbing children of the same developmental process that would almost certainly have enabled them to overcome their dysphoria naturally.

Therefore, any WPATH-affiliated healthcare professional who tells parents that puberty blockers are "fully reversible" is providing inaccurate information and consequently failing to obtain proper informed consent.

Furthermore, true informed consent can only be obtained if the healthcare provider informs parents that the evidence base for the life-altering interventions of puberty suppression, cross-sex hormones, and surgeries is low quality, as has been found by every systematic review to date;[159,160,161,162] and that other countries that once offered gender-affirming care have since drastically scaled back the practice due to concerns about iatrogenic harm. These parents must also understand the often debilitating side effects and long-term serious health risks of cross-sex

156 Ibid (n.2)

157 Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. "Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspectsthis Paper Was Presented at the 4th Ferring Pharmaceuticals International Paediatric Endocrinology Symposium, Paris (2006). Ferring Pharmaceuticals Has Supported the Publication of These Proceedings." European Journal of Endocrinology 155, no. Supplement_1 (2006): S131-S37. https://doi.org/10.1530/eje.1.02231. https://doi.org/10.1530/eje.1.02231.

158 Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. M. "Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the Uk." PLOS ONE 16, no. 2 (2021): e0243894. https://doi.org/10.1371/journal.pone.0243894. https://dx.doi.org/10.1371/journal.pone.0243894.

159 Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., et al. "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline." [In eng]. J Clin Endocrinol Metab 102, no. 11 (Nov 1 2017): 3869-903. https://doi.org/10.1210/jc.2017-01658.

160 "Nice Evidence Reviews." The Cass Review, https://cass.independent-review.uk/nice-evidence-reviews/.

161 "Hormonbehandling Vid Könsdysfori - Barn Och Unga." SBU UTVÄRDERAR, 2022, https://www.sbu.se/contentassets/ea4e698fa0c4449aaae964c5197cf940/hormonbehandling-vid-konsdysfori_barn-och-unga.pdf.

162 "One Year since Finland Broke with Wpath "Standards of Care"." Society for Evidence Based Gender Medicine, 2021, https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors.

hormones before the consent form is signed.

Lastly, many parents are told inaccurate suicide statistics. They are informed that if they don't consent to their child undergoing experimental sex-trait modification, there exists a substantial risk of suicide. The ultimatum, "You can either have a living son or a dead daughter?" is put to parents in gender clinics all over North America.[163,164,165] This constitutes coercion, emotional blackmail, and medical malpractice. Rather than proper informed consent, it is misinformed consent obtained under duress.

The Transition-or-Suicide Myth

WPATH members, and gender-affirming clinicians in general, often frame sex trait modification as "life-saving" care and assert that without it, transgender-identified youth and adults are at high risk of suicide.

Many trans activists perpetuate this transition-or-suicide narrative. "Gender-affirming care is medical care. It is mental health care. It is suicide prevention care. It improves quality of life, and it saves lives," said Admiral Rachel Levine during a 2022 speech in Texas.[166] "Fifty percent of transgender youth attempt suicide before they are age 21," claimed Jeannette Jennings, mother of transgender reality TV star Jazz, in a 2016 interview published in the American Academy of Pediatrics (AAP) journal.[167]

But how much truth is there to the claim that gender-affirming care is "suicide prevention care"? The answer is very little. It's important to distinguish the difference between suicide ideation (or thoughts), suicide attempts, and completed suicides. The term "suicidality" is often used to refer to all three phenomena despite the important differences between them. For example, middle-aged men are at higher risk of death by suicide than adolescents of both sexes, but adolescent girls and young women exhibit the highest rates of non-lethal suicidal gestures, which could be better interpreted as cries for help.

As indicated in surveys, transgender-identified youth are at elevated risk for suicidality and suicide.[168] Crucially, however, completed suicide in this population is extremely rare, and elevated suicidality is most likely because of comorbid psychopathology, which is extremely common and independently linked to suicidal ideation and behavior. In short, there is no suicide epidemic striking transgender-identified youth, and the claim that "gender" is the cause of and solution to this group's suicidal tendencies is a classic mistaking of correlation for causation.[169]

Research showing a higher rate of suicidality among trans-identified young people usually compares the transgender cohort to the general adolescent population who have no mental health issues. When trans-identified youth are compared to adolescents with similar mental health problems, there is little difference in suicidality.[170]

As well, the elevated suicide risk exists at all stages of the transition process. During a two-year study funded by the National Institutes of Health (NIH) of 315 American youth undergoing "gender-affirming hormone therapy," there were two completed suicides, and 11 youth reported

163 "Affidavit of Jamie Reed."11. https://ago.mo.gov/wp-content/uploads/2-07-2023-reed-affidavit-signed.pdf.

164 "Chloe Cole V. Kaiser Permanente." Dhillon Law Group, 2023, https://www.dhillonlaw.com/lawsuits/chloe-cole-v-kaiser-permanente/.

165 "Active and Resolved Cases: Ayala V. American Academy of Pediatrics." Campbell Miller Payne, 2023, 26. https://cmppllc.com/our-cases.

166 "Remarks by Hhs Assistant Secretary for Health Adm Rachel Levine for the 2022 out for Health Conference." U.S. Department of Health and Human Services, 2022, https://www.hhs.gov/about/news/2022/04/30/remarks-by-hhs-assistant-secretary-for-health-adm-rachel-levine-for-the-2022-out-for-health-conference.html.

167 "Trans Teen Shares Her Story." Pediatrics in Review, 2016, https://publications.aap.org/pediatricsinreview/article-abstract/37/3/99/34959/Trans-Teen-Shares-Her-Story?redirectedFrom=fulltext?autologincheck=redirected.

168 Toomey, R. B., Syvertsen, A. K., & Shramko, M. "Transgender Adolescent Suicide Behavior." [In eng]. Pediatrics 142, no. 4 (Oct 2018). https://doi.org/10.1542/peds.2017-4218.

169 Biggs, M. "Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom." [In eng]. Arch Sex Behav 51, no. 2 (Feb 2022): 685-90. https://doi.org/10.1007/s10508-022-02287-7.

170 de Graaf, N. M., Steensma, T. D., Carmichael, P., VanderLaan, D. P., Aitken, M., Cohen-Kettenis, P. T., de Vries, A. L. C., et al. "Suicidality in Clinic-Referred Transgender Adolescents." [In eng]. Eur Child Adolesc Psychiatry 31, no. 1 (Jan 2022): 67-83. https://doi.org/10.1007/s00787-020-01663-9.

considering suicide.[171] These deaths are all the more striking, considering that the researchers screened participants for suicidality. Despite these tragic outcomes, the authors, many of whom are considered some of WPATH's most prominent members, concluded that gender-affirming hormones "improved appearance congruence and psychosocial functioning." In the UK, one study showed four completed suicides, representing 0.03% of youth referred to the Gender Identity Development Service (GIDS) between 2010 and 2020. Two out of the four patients were already in the care of the service, and two were on the waiting list.[172]

What's more, we know that autism,[173] eating disorders,[174] and other mental health issues[175] result in elevated suicide risk for young people. We also know that many adolescents who identify as transgender disproportionately suffer from these very same psychiatric comorbidities and, in many cases, the other mental health issues started long before the teen announced a transgender identity.[176] It is, therefore, theoretically possible that youth already at an elevated risk of suicide and suicidality are drawn to identify as transgender because they see medical transition as a solution to their mental distress, as several detransitioner testimonies indicate.[177,178,179] In such a scenario, sex-trait modification interventions would do nothing to reduce or eliminate suicide risk and, in fact, in the long run, may increase the risk if the young, mentally unwell person comes to regret undergoing hormonal and surgical procedures.

There is also concern from some experts that many cases of adolescent-onset gender dysphoria are actually cases of borderline personality disorder (BPD). Symptoms of BPD include "identity disturbance" and "recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviour."[180] According to Canadian sexologist James Cantor, "BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population." Therefore, Cantor argues, "if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria."[181]

In such cases, misdiagnosing BPD as adolescent-onset gender dysphoria and allowing the young person to undergo hormonal and surgical interventions would do nothing to reduce suicidal behavior and could, in fact, lead to a worsening of such behavior. Indeed, a malpractice lawsuit filed by a detransitioned young woman by the name of Prisha Mosley alleges that her BPD was ignored. Instead, her healthcare team convinced her that sex-trait modification interventions would resolve her severe mental

171 Chen, D., Berona, J., Chan, Y., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A. C., & Olson-Kennedy, J. "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones." New England Journal of Medicine 388, no. 3 (2023): 240-50. https://doi.org/10.1056/nejmoa2206297.

172 Biggs, M. (2022). Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom. Arch Sex Behav, 51(2), 685-690. https://doi.org/10.1007/s10508-022-02287-7

173 O'Halloran, L., Coey, P., & Wilson, C. "Suicidality in Autistic Youth: A Systematic Review and Meta-Analysis." Clinical Psychology Review 93 (2022/04/01/ 2022): 102144. https://www.sciencedirect.com/science/article/pii/S0272735822000290.

174 Smith, A. R., Zuromski, K. L., & Dodd, D. R. "Eating Disorders and Suicidality: What We Know, What We Don't Know, and Suggestions for Future Research." [In eng]. Curr Opin Psychol 22 (Aug 2018): 63-67. https://doi.org/10.1016/j.copsyc.2017.08.023.

175 Galaif, E. R., Sussman, S., Newcomb, M. D., & Locke, T. F. "Suicidality, Depression, and Alcohol Use among Adolescents: A Review of Empirical Findings." [In eng]. Int J Adolesc Med Health 19, no. 1 (Jan-Mar 2007): 27-35. https://doi.org/10.1515/ijamh.2007.19.1.27.

176 Diaz, S., and Bailey, J. M. "Retracted Article: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases." Archives of Sexual Behavior 52, no. 3 (2023): 1031-43. https://doi.org/10.1007/s10508-023-02576-9.

177 Ibid (n.141)

178 "Luka Hein V. Unmc Physicians." Liberty Center, https://libertycenter.org/cases/hein-v-unmc/.

179 "Kiefel First Amendment Complaint ", 2022, https://static1.squarespace.com/static/5f232ea74d8342386a7ebc52/t/63a0afdfc02f9322762974cf/1671475168006/Kiefel+First+Amended+Complaint+%28file+stamped%29.pdf.

180 Biskin, R. S., & Paris, J. (2012). Diagnosing borderline personality disorder. Cmaj, 184(16), 1789-1794. https://doi.org/10.1503/cmaj.090618

181 "The Science of Gender Dysphoria and Transsexualism." 2022: 22. https://ahca.myflorida.com/content/download/4865/file/AHCA_GAPMS_June_2022_Attachment_D.pdf.

distress. Her lawyers allege that this "substantially and permanently compounded Prisha's physical suffering and mental anguish."[182]

In a small study of 28 Canadian detransitioners, two participants had a co-existing BPD diagnosis, with one young woman expressing frustration that her BPD was only diagnosed after she had undergone a bilateral mastectomy and her mental health deteriorated.[183] Another detransitioned woman from Canada who has filed a malpractice lawsuit against her healthcare team also received a BPD diagnosis years after being misdiagnosed as transgender and undergoing hormonal and surgical sex trait modification interventions.[184]

Thus, the transition-or-suicide narrative is, as Finland's leading expert on pediatric gender medicine has put it, "purposeful disinformation," the spreading of which is "irresponsible."[185] Using suicide threats to influence parents in their decisions over healthcare for their children is a violation of medical ethics and amounts to malpractice. It also makes the false promise that these experimental interventions will eliminate the risk of suicide for the young person when no evidence exists to support such a claim.

As previously mentioned, the few long-term follow-up studies of the adult transgender population also do not indicate that sex-trait modification interventions eliminate or greatly reduce the risk of suicide. A Swedish study[186] of 324 individuals who had undergone genital surgery between 1973 and 2003 revealed rates of completed suicide post-surgical transition to be greatly elevated over the general population, with trans-identified natal females 40 times more likely to die by suicide and trans-identified natal males 19 times more likely.[187,188]

The largest study conducted to date on the 8,263 patients who passed through the gender clinic in Amsterdam from 1972 to 2017 found that both male and female transgender people had a quadruple rate of suicide and concluded that "the suicide risk in transgender people is higher than in the general population and seems to occur during every stage of transitioning."[189]

A recent long-term Danish study concluded that people who have undergone sex-trait modification interventions in Denmark have a 3.5 times increased rate of completed suicide post "transition" compared to the general population and 7.7 times the rate of suicide attempts.[190] Another long-term Dutch study found male-to-female transsexuals had a sixfold increased risk of suicide after undergoing sex-trait modification procedures.[191]

Therefore, the sex-trait modification experiment advocated for by WPATH cannot be considered "harm reduction" or "life-saving," and it is unethical for any medical or mental health professional to assert otherwise. It is also unethical to offer minors and adults with severe mental illness harmful, irreversible medical interventions without first attempting to address their psychiatric

182 "Active and Resolved Cases: Mosely V. Emerson, Et Al." Campbell Miller Payne, 2023, 2. https://cmppllc.com/our-cases.

183 Ibid (n.115)

184 Humphreys, A. (2023). Ontario detransitioner who had breasts and womb removed sues doctors. National Post. https://nationalpost.com/news/canada/michelle-zacchigna-ontario-detransitioner-sues-doctors

185 Mutanen, A. (2023). A professor who treats adolescent gender anxiety says no to minors' legal gender correction. Helsingin Sanomat. https://www.hs.fi/tiede/art-2000009348478.html

186 Ibid (n.66)

187 Ibid (n. 186)

188 Levine, S. B., Abbruzzese, E., & Mason, J. W. "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults." Journal of Sex & Marital Therapy 48, no. 7 (2022): 706-27. https://doi.org/10.1080/0092623x.2022.2046221.

189 Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. "Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972-2017)." [In eng]. Acta Psychiatr Scand 141, no. 6 (Jun 2020): 486-91. https://doi.org/10.1111/acps.13164.

190 Erlangsen, A., Jacobsen, A. L., Ranning, A., Delamare, A. L., Nordentoft, M., & Frisch, M. "Transgender Identity and Suicide Attempts and Mortality in Denmark." JAMA 329, no. 24 (2023): 2145-53. https://doi.org/10.1001/jama.2023.8627.

191 Asscheman, H., Giltay, E. J., Megens, J. A., de Ronde, W. P., van Trotsenburg, M. A., & Gooren, L. J. "A Long-Term Follow-up Study of Mortality in Transsexuals Receiving Treatment with Cross-Sex Hormones." [In eng]. Eur J Endocrinol 164, no. 4 (Apr 2011): 635-42. https://doi.org/10.1530/eje-10-1038.

problems through less invasive means.

Allowing Severely Mentally Ill Patients to Consent to Life-Altering Medical Interventions

Some patients discussed in the files do not appear to have been in a state of sound mind when deciding to undergo sex-trait modification procedures, meaning that it is doubtful that they would have been able to weigh the long-term impact on their future health and sexual function.

Several message threads suggest that WPATH members are allowing mentally unstable people to consent to hormones and surgeries. In an undated post, a nurse practitioner from Halifax, NS, described a patient with very complex mental health issues, including PTSD, major depressive disorder (MDD), observed dissociations, and schizoid typical traits. The nurse told the group that the patient is eager to start hormones, but psychiatry is recommending holding off.

"My practice is based fully on the informed consent model however this case has me perplexed; struggling internally as to what is the right thing to do," said the nurse.

Dr. Dan Karasic of the University of California San Francisco (UCSF), the lead author of the mental health chapter of WPATH's SOC8, was baffled by the nurse's perplexity. "I'm missing why you are perplexed," said Karasic. "The mere presence of psychiatric illness should not block a person's ability to start hormones if they have persistent gender dysphoria, capacity to consent, and the benefits of starting hormones outweigh the risks."

While Karasic is correct that the mere presence of mental illness does not automatically mean a patient is incapable of consenting to a medical procedure, it is questionable that a patient in such a state could rationally weigh up the long-term implications of irreversible cross-sex hormones. Also, given the aforementioned negative impact of these hormones on a patient's sexual function, it is doubtful that the benefits outweigh the risks, even in a healthy individual. People suffering from mental illness often struggle to form long-term romantic relationships. Hormone therapy places an enormous medical burden on the body and impairs sexual function, making life more difficult for a mentally ill person already struggling.

However, in the files, Karasic's opinion enjoys the support of his fellow members, with the aforementioned California therapist reporting having patients with DID, MDD, bipolar, and schizophrenia that "do just fine on HRT" and an orchiectomy making a "huge difference" to the life of a homeless person. An orchiectomy is the surgical removal of the testes. But again, without long-term follow-up, it is impossible to know if these claims of success are accurate.

There are other therapists in the WPATH Files discussing patients suffering from dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), being allowed to consent to sex-trait modification procedures. The MPD epidemic of the 1980s and 1990s was iatrogenic in nature, meaning it was created and spread by misguided therapists. After the scandal collapsed under the weight of lawsuits, MPD was rebranded as DID, and as a diagnosis, its occurrence decreased significantly. However, there has been a recent resurgence, with TikTok providing an important vector for the contagion and certain WPATH members embracing DID "alter" identities as deserving of affirmation along with transgender identities.[192]

In 2017, Karasic gave a presentation at the conference of WPATH's US branch, USPATH, about the importance of affirming "plural" identities.[193] During the presentation, the prominent WPATH psychiatrist detailed case studies of patients with DID who had undergone hormonal and/or surgical sex trait modification interventions.

One patient was a male who identified as

192 #dissociativeidentitydisorder. (2024). TikTok. https://www.tiktok.com/tag/dissociativeidentitydisorder?lang=en

193 Not plural-phobic: USPATH psychiatrist promotes transition for multiple personalities. (2017). 4thWaveNow. https://4thwavenow.com/2017/12/29/not-plural-phobic-uspath-psychiatrist-promotes-transition-for-multiple-personalities/

"genderqueer" and underwent "flat front" nullification surgery, or the amputation of the genitals to create a smooth, sexless appearance. This male suffered from bipolar disorder and "alcohol use disorder" and was treated with spironolactone, an anti-androgen hormone blocker, followed by estradiol, or synthetic estrogen. Karasic reported that the patient had seven alters, two of which were "agender" and one female. "Alters were in agreement about surgery," Karasic assured the audience.

Another DID patient was a 27-year-old male who identified as a "genderqueer system." A system is multiple distinct personalities sharing one body. This particular patient, who was diagnosed with autism in childhood, had 85 "headmates," with the primary "front" alter being female. The patient was on estradiol along with a drug to prevent breast growth and had undergone an orchiectomy at age 25.

Karasic told the audience he had had several patients who identified as trans and plural, which he put down to his reputation "as a psychiatrist who was not plural phobic." This is the caliber of expert WPATH felt appropriate to appoint as the lead author of its SOC8 mental health chapter.

At WPATH's 2022 International Symposium in Montreal, a team of researchers presented the preliminary findings of their research into the confluence of transgender and "plural" identities.[194] The team grappled with the complexity of obtaining informed consent for sex-trait modification hormones and surgeries from patients with hundreds of alters, many with differing gender identities. Their research quoted an individual called The Redwoods, who identifies as nine separate people sharing a "trans body," explaining the difficulties faced by patients who were forced to choose between their gender dysphoria diagnosis and their DID diagnosis "because providers wrongly believed you could not be both."

The research team drew few solid conclusions but recommended affirmation of both trans and plural identities, which could lead to "gender and plural euphoria," as well as the suggestion that plurals have their separate personalities use an app to talk to each other to reach an agreement about hormonal and surgical sex trait modification interventions. The lead researcher appears in the WPATH Files in a thread dated September 2021, discussing the "robust community developing of people who identify as plural" as well as "plural positivity" conferences. He stated there was a "general consensus that mental health and medical providers need more training on this topic so they can provide affirming care."

Inside the WPATH forum, members grapple with how to manage "trans clients" with DID when "not all the alters have the same gender identity," with one North Carolina psychologist stressing that it was "imperative to get all the alters who would be affected by HRT to be aware and consent to the changes."

"Ethically, if you do not get consent from all alters you have not really received consent and you may be open to being sued later, if they decide HRT or surgery was not in their best interest," said the psychologist. This reply was one of only two mentions of ethics in the whole WPATH Files.

Another therapist admitted lying about her patients' diagnosis of DID in referral letters, calling it "complicated PTSD" instead because she didn't "think surgeons would blink at that as much as DID." But she also confessed that two patients with DID whom she had referred for hormones now experience regret and feel that "their decision to start hormones was colored by trauma and DID and now, after more therapy and understanding, wish they had dug deeper before starting hormones."

These two cases of regret demonstrate how WPATH's approach of prioritizing "gender" and bypassing exploratory psychotherapy that seeks to uncover the origins of distress risks setting patients up for iatrogenic harm and later regret.

McGinn, the aforementioned surgeon who has

194 Wolf-Gould, C., Flynn, S., McKie, S. (2022, September 16-20). An Exploration of Transgender and Plural Experiences [Conference presentation].

performed 20 vaginoplasties on minors, joined the discussion to report performing two "vulvovaginoplasty" surgeries and one bilateral mastectomy on patients suffering from DID and happily stated that all three "did ok out to the six-month mark."

However, once again, a follow-up period of six months is not long enough to declare the surgeries a success. In the short term, there may be misleading signs of improved mental well-being, but how will the patient, particularly one who consented while in a state of severe mental instability, feel about their genital surgery or bilateral mastectomy in 10, 20, or 30 years? Gender-affirming healthcare providers never seem to ask this vital question and yet claim to be providing ethical medical care.

A Virginia doctor in the forum was of the opinion that as long as persistent gender dysphoria is present, those with severe mental health issues such as bipolar disorder, autism, and schizoaffective disorder should be allowed to consent to vaginoplasty. "It would be great if every patient could be perfectly cleared prior to every surgical intervention, but at the end of the day it is a risk/benefit decision," she said, shrugging off the possibility that the severely mentally unwell patients may be unable to cope with the grueling dilation schedule and may suffer serious complications as a result.

In fact, within all the files, the sole instance where WPATH members express concern regarding the potential dangers and adverse effects of a medical procedure is found in a conversation involving a trans-identified natal male interested in hormone-induced lactation purely for the sake of experiencing it, with no intention of nursing an infant. From the information given, the patient appears to be otherwise mentally well, but his doctor described having ethical issues with this request, as it was not without some risk.

The replies echoed the doctor's concerns, with one doctor calling the request unethical because it was a "medical intervention that is not necessary" and a San Francisco ethicist calling the reason for the intervention "questionable." The ethicist reminded the doctor that he is a professional "to whom society gives certain privileges" in exchange for his "prudent use of resources" and his "commitment to interventions where benefits outweigh risk and to 'at least do no harm.'"

"I understand your patient's desire to experience lactation as one function of her womanhood," continued the ethicist. "But that is [an] insufficient reason, in my estimation, to intervene medically." While this expert in medical ethics is not required to comment on every post within the forum, it is telling that she does not appear in any of the discussions regarding allowing people with severe mental illness to consent to vaginoplasty or threads concerning the creation of second sets of genitals for people who identify as non-binary, reminding WPATH surgeons to do no harm. Nor does she comment in message threads about drastic hormone interventions for minors that will leave them anorgasmic for life, reminding WPATH doctors that benefits must outweigh risks. By comparison, the male's request to induce lactation just to experience it is trivial.

Notably, all the WPATH members in the discussion avoid tackling the uncomfortable truth about the patient's motivation. The man being discussed in the forum may fit the description of having physiologic autogynephilia, meaning his desire to lactate may have been for erotic purposes.

Contrast how members talk about the natal male wishing to use drugs to induce lactation with the discussion about a 13-year-old girl who identified as non-binary and wished to begin taking testosterone. Her therapist was worried that 13 was too young and also mentioned a "possible complication," which was that "there is some purposeful malnutrition and restrictive eating for a more non-binary appearance."

But instead of recommending addressing the eating disorder and general mental health issues before starting the distressed teenager on such a powerful hormone, or indeed questioning the ethics of allowing an obviously troubled girl to consent to the irreversible effects of testosterone, a pediatric endocrinologist informed the

therapist that WPATH has removed all the minimum age requirements in its latest standards of care. Then, a chief medical officer of a health center in Texas cautioned that "waiting appears to increase the rate of suicide" because the patient would have to deal with "menstrual periods and complete breast development." The expert in medical ethics is conspicuously absent from the discussion.

Minority Stress

WPATH's belief system has a built-in answer to the problem of high rates of psychiatric comorbidities before and after transition as well as post-transition suicides. That answer is the minority stress model. According to WPATH, the mental health issues experienced by members of the transgender community before, during, and after sex-trait modification interventions are the result of living in a transphobic society, in other words, the stress of being a member of an oppressed minority.[195] Research produced by some WPATH members claims that gender-affirming care can resolve psychiatric comorbidities such as depression, anxiety, suicidality, or even autism.[196,197,198]

The minority stress hypothesis, borrowed from the gay rights movement, has never been empirically verified in the context of transgender medicine, but it serves as a way for gender-affirming healthcare providers to deny culpability when a person regrets their transition or when the transition doesn't improve their mental health.[199] It enables these doctors to blame society for being intolerant, rather than themselves for allowing a minor or a mentally unstable adult to undergo drastic, life-altering medical interventions. As well, because "intolerance" is defined by the activist clinician-researchers themselves in ever more implausible ways, minority stress is essentially an unfalsifiable and, thus, unscientific theory. It is thus also an all-too-convenient insurance policy for gender clinicians against malpractice allegations.

In fact, Sweden serves as a counter-argument to the minority stress model. As a highly tolerant nation, if the minority stress model were correct, we would expect to see far lower rates of mental illness and suicidal behavior among the transgender population, but the opposite is true. The long-term Swedish study found post-op transgender adults had a significantly elevated risk of suicide as well as increasing mortality rates.[200]

Realistic Expectations

Numerous studies indicate that many adolescents experiencing adolescent-onset gender dysphoria suffer from multiple psychiatric comorbidities that pre-date the onset of distress about their sex.[201,202,203,204] Detransitioner testimony supports the hypothesis that some mentally distressed people could be drawn to self-diagnosing as transgender after being led to believe that sex-trait modification procedures are a miracle cure for all their

195 Meyer, I. H., Russell, S. T., Hammack, P. L., Frost, D. M., & Wilson, B. D. M. "Minority Stress, Distress, and Suicide Attempts in Three Cohorts of Sexual Minority Adults: A U.S. Probability Sample." PLOS ONE 16, no. 3 (2021): e0246827. https://doi.org/10.1371/journal.pone.0246827.

196 Turban, J. L. "Potentially Reversible Social Deficits among Transgender Youth." [In eng]. J Autism Dev Disord 48, no. 12 (Dec 2018): 4007-09. https://doi.org/10.1007/s10803-018-3603-0.

197 Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation." [In eng]. Pediatrics 145, no. 2 (Feb 2020). https://doi.org/10.1542/peds.2019-1725.

198 Turban, J. L., & van Schalkwyk, G. I. ""Gender Dysphoria" and Autism Spectrum Disorder: Is the Link Real?" [In eng]. J Am Acad Child Adolesc Psychiatry 57, no. 1 (Jan 2018): 8-9.e2. https://doi.org/10.1016/j.jaac.2017.08.017.

199 Mayer, L. S., and McHugh, P. R. "Part Two: Sexuality, Mental Health Outcomes, and Social Stress." Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences, The New Atlantis 50 (2016): 73-75. https://www.thenewatlantis.com/publications/part-two-sexuality-mental-health-outcomes-and-social-stress-sexuality-and-gender.

200 Ibid (n.66)

201 Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. "Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development." [In eng]. Child Adolesc Psychiatry Ment Health 9 (2015): 9. https://doi.org/10.1186/s13034-015-0042-y.

202 Bechard, M., VanderLaan, D. P., Wood, H., Wasserman, L., & Zucker, K. J. "Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A "Proof of Principle" Study." [In eng]. J Sex Marital Ther 43, no. 7 (Oct 3 2017): 678-88. https://doi.org/10.1080/0092623x.2016.1232325.

203 Kozlowska, K., Chudleigh, C., McClure, G., Maguire, A. M., & Ambler, G. R., "Attachment Patterns in Children and Adolescents with Gender Dysphoria." Frontiers in psychology (2021): 3620. https://www.frontiersin.org/articles/10.3389/fpsyg.2020.582688/full.

204 Ibid (n.176)

psychological suffering.[205]

In the files, there is evidence that WPATH members encourage such false hopes. A Montana trans-identified natal female therapist said that "receiving gender-affirming care can often significantly stabilize client's [sic] mental health." The California therapist who claimed surgical castration made a huge difference in the life of a homeless person told the forum that withholding hormones can intensify mental health symptoms and suggested hormone therapy is "harm reduction and so doing nothing is not a 'neutral option.'"

WPATH's SOC8 also states that "studies suggest mental health symptoms experienced by [transgender/gender diverse] people tend to improve" following sex-trait modification interventions despite there being no good quality research to support this claim.[206]

Suggesting that hormonal and surgical sex-trait modification interventions can improve depression, PTSD, and even schizophrenia is a breach of the requirement to present accurate information to the patient when obtaining informed consent. It is akin to a cosmetic surgeon telling a patient that a nose job is the remedy for depression or breast augmentation is the cure for bipolar disorder.

Due to such false promises, people suffering from gender dysphoria often have unrealistic expectations about undergoing sex-trait modification procedures. The anticipation and excitement about starting cross-sex hormones or having a mastectomy or genital surgery often become a focal point for the distressed mind, with individuals pinning their hopes on these medical procedures to resolve all their pain and suffering. WPATH members endorsing sex-trait modification drugs and surgeries as a cure for mental distress do little to dispel these fantasies.

However, it does not have to be this way. Approximately two decades ago, at the Portman adult gender clinic in London, a British psychiatrist demonstrated that giving trans-identified patients a realistic idea of what sex-trait modification can achieve is a highly effective strategy for quelling the desire for medical intervention and minimizing transition regret.

Dr. Az Hakeem ran therapy groups that combined patients wishing to embark upon surgical transition with post-operative transsexuals who regretted their surgeries. In an interview, he described the pre-operative group as one of excitement and euphoria and the post-operative group as one of "mourning, depression, and sadness."

"The typical pattern was gender dysphoria, transgender euphoria, and then transgender dysphoria," Hakeem said of the post-op regretters. "They realized they didn't really feel that authentic in their transgender identity, so they were still feeling just as inauthentic, but just in a different body." Hakeem observed that this process took, on average, seven years, which casts further doubt on the validity of short-term follow-up studies showing high patient satisfaction post-transition rates.[207]

Meyer and Hoopes of Johns Hopkins made the same observation in 1974. They described an "initial phase of elation" that extended for two to five years post-transition, but after that honeymoon period is over, "the patient is overtaken by the painful realization that nothing has really changed except certain elements of body configuration."[208] This honeymoon period has also been observed more recently.[209]

The aforementioned first Dutch follow-up study in 1988 described those in the early stages of the sex trait

205 Ibid (n.177-179)

206 Ibid (n.94)

207 Hughes, M. (2023). Dr. Az Hakeem: Trans Is the New Goth. Public. https://public.substack.com/p/dr-az-hakeem-trans-is-the-new-goth#details

208 Meyer, J. K., Hoopes, J. E., & Meyer, J. K. "The Gender Dysphoria Syndromes: A Position Statement on So-Called "Transsexualism"." Plastic and Reconstructive Surgery 54, no. 4 (1974). https://journals.lww.com/plasreconsurg/fulltext/1974/10000/the_gender_dysphoria_syndromes__a_position.9.aspx.

209 Nobili, A., Glazebrook, C., & Arcelus, J. "Quality of Life of Treatment-Seeking Transgender Adults: A Systematic Review and Meta-Analysis." Reviews in Endocrine and Metabolic Disorders 19, no. 3 (2018): 199-220. https://doi.org/10.1007/s11154-018-9459-y.

modification journey as "taking a loan on the future," and the study concluded that "[sex reassignment surgery] is no panacea." The researchers observed that the "[a]lleviation of gender problems does not automatically lead to a happy and lighthearted life" and that, on the contrary, "SRS can lead to new problems."[210]

It is essential that people wishing to embark upon life-altering sex-trait modification procedures be brought face-to-face with this reality. There is no evidence in the files that WPATH members realistically prepare patients for the difficulties of life after hormonal and surgical body modification. By contrast, Hakeem's innovative approach proved very effective, with almost all of his preoperative patients ultimately not undergoing surgery because they understood the limitations of their "fantasy solution," and the small number who went through with it had much more realistic expectations.

Consumer-Driven Gender Embodiment

There has been a significant increase in the number of young people identifying as "non-binary" in recent years, and WPATH now advocates for these individuals to be eligible for hormonal and surgical sex-trait modification interventions.[211]

The nonbinary chapter of WPATH's SOC8 states that healthcare providers must avoid overly focusing on gender-related distress because "it is also important to consider experiences of increased comfort, joy, and self-fulfillment that can result from self-affirmation and access to care."[212]

Gender nullification surgeries, defined by WPATH as "procedures resulting in an absence of external primary sexual characteristics," and bigenital surgeries, such as the creation of a pseudo-vagina cavity without amputating the penis, are the end result of activists overtaking WPATH. In WPATH's SOC8, there is a shopping list of extreme body modification procedures which includes options such as vaginoplasty "with retention of penis and/or testicle" and "flat front" procedures.[213] These surgeries do not even meet the definition of experimental, as they are not being studied in any controlled manner.

Members inside the WPATH messaging forum discuss best practices for these "non-standard" procedures.

When Dr. Thomas Satterwhite, a renowned California surgeon, asks for the group's input for "non-standard" procedures such as "top surgery without nipples, nullification, and phallus-preserving vaginoplasty," no one raised any ethical questions about the destruction of perfectly healthy reproductive organs to fulfill customized body modification desires. Instead, members of the group policed Satterwhite's language, with one therapist arguing that such procedures could also be "selected by those with binary gender identities;" another therapist who identifies as non-binary agreed and called his language "cisgenderist," and a trans-identified natal female med school student stressed the importance of "de-gendering" sex-trait modification procedures. In the SOC8, these procedures are euphemistically referred to as "individually customized" surgeries.

Further demonstrating WPATH's priorities when it comes to radical and untested surgeries, Dr. Rajveer S. Purohit outlined the important topics to discuss with patients before their nullification surgery, such as whether they want orgasms or not and if they want to sit while urinating. Completely absent from the discussion was any mention of the impact such drastic procedures will have on a patient's fertility, sexual function, ability to form long-term stable romantic partnerships or general state of health.

210 Ibid (n.125)

211 Chew, D., Tollit, M. A., Poulakis, Z., Zwickl, S., Cheung, A. S., & Pang, K. C. "Youths with a Non-Binary Gender Identity: A Review of Their Sociodemographic and Clinical Profile." The Lancet Child & Adolescent Health 4, no. 4 (2020): 322-30. https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(19)30403-1/fulltext.

212 Ibid (n.94)

213 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, E., et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." [In eng]. Int J Transgend Health 23, no. Suppl 1 (2022): Ch. 13. https://doi.org/10.1080/26895269.2022.2100644.

In one post, Satterwhite gives a disturbing account of a patient who became "dangerous and threatening" while still undergoing post-op care as a result of "undiagnosed mood disorders that did not surface until post-op." This is proof that not every patient benefits from extreme body modification procedures being available on demand with no prior psychological assessment or psychotherapeutic support.

Valuing Patient Autonomy Over Risk Aversion

WPATH places a high value on patient autonomy and a low value on minimizing potential harm. Or rather, it conceptualizes harm, as in "do no harm," as unfulfilled consumer desire.

In 2022, the aforementioned activist professor who believes developmentally delayed minors ought to be allowed to consent to life-altering experimental hormones and surgeries, posted in the forum in defence of "trans people whose embodiment goals do not fit dominant expectations," such as those who want "mastectomies without nipples, mastectomies for people who do not want breasts from estrogen [and] vagina-preserving phalloplasties."

The professor, who has previously described "trans embodiment as a free-form artistic expression of gender," and believes teenagers should have the right to treat their body like a "gendered art piece,"[214] demonstrates the flawed beliefs held within WPATH when claiming that transgender health care is about creating bodies that "challenge cisnormativity."

"Trans health is about bodily autonomy, not normalizing bodies," said the activist professor in the files. "We didn't reject the idea that you can't change your gender only to double down on the idea that gender is binary and defined by genitals."

In a separate discussion about "non-standard" surgeries, a Minnesota therapist who believes WPATH needs a "different way of looking at gender that is not through a cisgenderist gaze" asked the group, "If adult patients have body autonomy, what is the issue with having top surgery without nipples, for example?" adding that "[s]urgical tattoos can help if the patient changes their mind later."

These comments are a clear indication that WPATH is not scientific. Medical professionals devoted to providing ethical care to their patients should not destroy healthy reproductive organs in pursuit of creating smooth, sexless bodies or second sets of genitals. Such highly invasive, life-altering procedures are not an attempted remedy for a recognised psychiatric condition but are instead consumer-driven extreme body modification masquerading as medicine. This is a violation of medical ethics and the Hippocratic Oath.

A Brave New World

Many WPATH members see themselves as being on the vanguard of a new medical frontier. A British psychiatrist took exception to Satterwhite's use of the term "non-standard," suggesting that such interventions "may become standard in the future."

A California physician who once famously quipped that if teenage girls later in life regret having their healthy breasts amputated, they can just "go and get them,"[215] replied to say that the field of gender care will soon be "overhauled by younger people," something she is thankful for. She called for medical and surgical interventions to be reframed as an individual's "embodiment of gender" rather than being "responsive to the poorly defined 'gender dysphoria.'"

In the Identity Evolution Workshop, Berg even discussed embodiment goals for children as a guide for medical decision-making. "Embodiment is certainly a concept that I'm using a lot more of with my adolescents and children," said the prominent WPATH expert.

214 Ashley, F. "Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising." [In eng]. J Med Ethics 45, no. 7 (Jul 2019): 480-82. https://doi.org/10.1136/medethics-2018-105293.

215 "[Physician] Explains Why Mastectomies for Healthy Teen Girls Is No Big Deal." Youtube, 2019, https://www.youtube.com/watch?v=5Y6espcXPJk.

Despite the unusual nature of the non-binary procedures, the files contain evidence that insurance companies provide coverage for these experimental body modification surgeries, as shown when Satterwhite tells the group that his clinic in San Francisco is consistently able to get insurance coverage for his patients. Dr. Daniel Dugi of Oregon Health and Science University confirms also having no trouble getting insurance coverage.

There have been two cases in Ontario, Canada of non-binary individuals winning the right to have the surgical creation of a second set of fake-genitals paid for by the province's taxpayers, decisions that will pave the way for such procedures to be covered by provincial health insurance.[216,217] In *Ks v Ontario*, the non-binary chapter of WPATH's SOC8 is quoted extensively throughout, and the Ontario Health Services Appeal and Review Board adopted the logic and vocabulary of WPATH in its ruling, stating that gender diverse presentations may lead to "individually customized surgical requests" that ought to be covered by provincial health plans.[218]

While realizing extreme body modification goals may be very gratifying for a person, at least in the short term, governments and insurance companies should not confuse this with medicine and necessary medical care. Non-binary surgeries demonstrate WPATH's total abandonment of science and medicine in pursuit of unrestrained consumerism.

A counselor from Virginia predicted a "wave of non-binary affirming requests for surgery" and informed the group he had worked with "clients who identify as non-binary, agender, and Eunuchs" who had requested "atypical surgical procedures, many of which either don't exist in nature or represent the first of their kind."

Perhaps the best indication that WPATH has lost its way as a medical organization is the group's decision to include an entire chapter in its SOC8 dedicated to gender-affirming care for people who identify as eunuchs. In the glossary, the world-leading transgender health group defines eunuch-identified men as individuals "assigned male at birth" who feel that "their true self is best expressed by the term eunuch. Eunuch-identified individuals generally desire to have their reproductive organs surgically removed or rendered non-functional."

The Eunuch chapter contains not only the claim that children can be eunuch-identified, but also a hyperlink to the Eunuch Archives website where anonymous men with castration fetishes congregate and share their child castration fantasies.[219] In April 2023, on TikTok, a popular WPATH-affiliated gender surgeon advertised gender-affirming care for people who identify as eunuch to her 250K+ young followers.[220]

During WPATH's 2022 International Symposium in Montreal, the coauthor of the SOC8 eunuch chapter spoke about the first "eunuch-identified" patient he ever saw, who was a 19-year-old man living in his parent's basement, who "may have been on the autism Asperger's spectrum," and wanted to revert to a prepubertal state.[221] The young man didn't explicitly identify as a eunuch. The WPATH expert had applied the label to him. "I deduced it just because it was on my radar," he explained to the audience. In other words, instead of viewing this patient as a troubled individual in need of deep psychotherapeutic support, the WPATH expert labeled him a eunuch-identified person in need of gender-affirming surgical castration. Reframing such serious psychiatric disorders as "identities" to be affirmed and resolved with chemical and surgical

216 "Ks V Ontario (Health Insurance Plan)." CanLII, 2023, https://www.canlii.org/en/on/onhsarb/doc/2023/2023canlii82181/2023canlii82181.html?searchUrlHash=AAAAAQANdmFnaW5vcGxhc3R5IAAAAAAB&resultIndex=1.

217 "Ohip Reverses Course, Will Fund Gender-Affirming Surgery for Ottawa Public Servant." The Globe and Mail, 2023, https://www.theglobeandmail.com/canada/article-ohip-gender-affirming-surgery-case/#:~:text=OHIP%20has%20reversed%20its%20stance,procedure%20for%20nearly%20a%20year.

218 Ibid (n.216)

219 Ibid (n.94 p. 88-89)

220 GenderSurgeon (2023). #testicleremoval #orchiectomy #eunuch. https://www.tiktok.com/@gendersurgeon/video/7218932161934822702

221 "Of Eunuchs and Wannabes." Year Zero, 2022, https://wesleyyang.substack.com/p/of-eunuchs-and-wannabes.

castration is an enormous breach of medical ethics and a clear indication that WPATH does not have the health and well-being of patients as its priority.

At the end of the Eunuch session, which was held in the grand salon of the conference venue, not off in a side room, Satterwhite and Dr. Thomas W. Johnson, the lead author of the SOC8 Eunuch chapter, and its co-author, Dr. Michael Irwig, had an interesting conversation. Satterwhite took to the microphone and told of how Johnson had helped him overcome his emotional discomfort in one of his earliest cases of a gay man who wanted to be castrated. He asked Johnson for advice on how to "get more surgeons on board" with performing this type of procedure, explaining that he'd had a mixed response from fellow attendees at the conference to his willingness to perform "non-standard" genital surgery.

After commending Satterwhite for "being open to new ideas," Johnson said he hoped "having the [eunuch] chapter in the Standards of Care will open the possibilities," that surgeons will see it and "say, yep, this is something that I ought to be willing to consider." Irwig agreed, saying it was "huge" that eunuch was now in the SOC, because now doctors wouldn't have to fear losing their license for castrating these psychologically troubled men.

"The more sessions like this we have, the more educated people will get, and then we'll get more people like you to be able to do this," said Irwig to Satterwhite.

PAST CASES OF PSEUDOSCIENTIFIC HORMONAL AND SURGICAL EXPERIMENTS ON CHILDREN AND VULNERABLE ADULTS

History is full of examples of the medical world getting things catastrophically wrong and yet taking decades to face up to the mistake and self-correct. Today's scandal perpetrated by WPATH combines elements of past attempts to cure mental illness by surgical means such as lobotomy and ovariotomy with the misguided experiment by pediatric endocrinologists to correct the height of tall girls and short boys using puberty blockers and hormones. There is also the scandal in the recent past of a surgeon amputating the healthy legs of men with body integrity identity disorder that bears a striking resemblance to the type of medical care WPATH endorses.

Examining historical medical blunders offers insights into the current scandal unfolding in gender clinics. By distancing ourselves from our cultural biases and preconceptions, a clearer view of the ease with which doctors are led astray emerges.

Lobotomy

A case study comparing the pseudoscientific surgical destruction of healthy brains in the 20th century and the pseudoscientific surgical destruction of healthy genitals of vulnerable people today

In the mid-20th century, a widely held belief in the medical world was that the most effective and humane treatment for mental illness was the lobotomy: a brutal surgical procedure that involved blindly swinging sharp instruments in the brain to sever the frontal lobe connections.

Despite the obvious dangers and devastating side effects, the medical community rapidly embraced the practice of performing lobotomies as a treatment for a wide range of mental disorders, including depression, obsessive-compulsive disorder (OCD), epilepsy, and schizophrenia.

Lobotomists were not vilified; rather, they were held in high regard by many. Antonio Egas Moniz, the inventor of the lobotomy, was honored with the Nobel Prize in 1949 for his contribution to medicine. Walter Freeman and James Watts, who popularized the procedure in the United States, were warmly received at annual American Medical Association (AMA) meetings, where they set up "psychosurgery" exhibits providing information about their brain-mutilating surgery.

While there was early opposition to the brutality and imprecision of the procedure, little of it was published in medical journals because, at the time, to criticize fellow doctors was viewed as unethical. Instead, the prestigious New England Journal of Medicine gave the procedure scientific validity by publishing an article touting the operation as being based "on sound physiological observation."[222]

The popular press also played a crucial role. In 1936, the New York Times called the procedure "a turning point in treating mental cases," predicting that Freeman and Watts were likely "going down in medical history as another shining example of therapeutic courage," and in 1937, claimed the surgery "cuts away sick parts of the human personality and transforms wild animals into gentle creatures."[223,224] Over the next five years, lobotomy was frequently featured in popular publications, including Reader's Digest, Time, and Newsweek. The narrative

222 "The Surgical Treatment of Certain Psychoses." New England Journal of Medicine 215, no. 23 (1936): 1088-88. https://sci-hub.ru/10.1056/NEJM193612032152311.

223 "Find New Surgery Aids Mental Cases; Drs. Freeman and Watts Say Operation on Brain Has Eased Abnormal Worry. 6 Selected Patients Gain No Data yet Available on Permanent Effects, Scientists Tell Southern Medical Group." The New York Times, 1936, https://www.nytimes.com/1936/11/21/archives/find-new-surgery-aids-mental-cases-drs-freeman-and-watts-say.html.

224 "Surgery Used on the Soul-Sick Relief of Obsessions Is Reported; New Brain Technique Is Said to Have Aided 65% of the Mentally Ill Persons on Whom It Was Tried as Last Resort, but Some Leading Neurologists Are Highly Skeptical of It." The New York Times, 1937, https://www.nytimes.com/1937/06/07/archives/surgery-used-on-the-soulsick-relief-of-obsessions-is-reported-new.html.

overall was positive, downplaying the barbaric reality of the procedure.[225]

Many desperate patients and their families sought lobotomies after reading these articles. Conditions in mental asylums at the time were deplorable, and alternative remedies for mental illness, such as insulin coma therapy and electroshock therapy, were also harsh and often violent. Therefore, even though a lobotomy often left patients in a state of "surgically induced childhood," to many, this was preferable to the other options available.

At no point during lobotomy's rapid rise in popularity did any of the significant American medical associations, including the American Psychiatric Association and the American Medical Association, stand in official opposition to the surgery.

Freeman, who invented the "transorbital lobotomy," which involved hammering a surgical instrument resembling an ice pick through a patient's eye socket and into the brain, considered his procedure a success if his patients were able to leave the asylum and be cared for at home "at the level of a domestic invalid or household pet."[226] He also became convinced that the earlier the procedure was performed, the better because of the misguided belief that patients were destined to deteriorate otherwise. This meant he advocated for the surgery as a first line of treatment for those with only mild mental illness.

Many of Freeman's patients didn't even meet his questionable measure of success, with some ending up permanently disabled and approximately 15% dying.[227] In 1941, Rosemary Kennedy, sister of President John F. Kennedy, became Freeman's most famous victim when her lobotomy left her condemned to live out the rest of her days in a private psychiatric hospital, unable to care for herself, barely able to speak, and with no memory of her family.[228]

But what is arguably Freeman's most egregious crime was that he performed lobotomies on children, 19 in total, with 11 such cases described in the 1950 edition of his book, *Psychosurgery*.[229,230] The youngest was just four years old, and two out of the 11 died of cerebral hemorrhages.

Even as Moniz was awarded the Nobel Prize in 1949 for the invention of lobotomy, and in its reporting, the New York Times declared that "surgeons now think no more of operations on the brain than they do of removing an appendix,"opposition to the procedure was starting to mount.[231] Critics highlighted the severe side effects experienced by many patients, raised concerns about the criteria used to measure success, and accused surgeons of conducting procedures without preliminary psychiatric evaluations.

However, it was the invention of the antipsychotic drug Chlorpromazine that triggered lobotomy's precipitous fall in popularity because, all along, it was the lack of humane alternative treatments that had caused psychiatrists to go to such desperate lengths.

In 1967, after what was destined to be his last patient died of a brain hemorrhage, a disgraced Freeman was stripped of his hospital privileges. He spent the rest of his days driving across the US, tracking down his patients and their families, searching for proof that his beloved procedure had helped and not harmed.

The horrifying story of lobotomy should have served as a cautionary tale for the medical world, illustrating the dire consequences that can occur when doctors swiftly embrace novel, innovative procedures without first subjecting them to thorough scientific scrutiny to establish their value, safety, and effectiveness.

225 Diefenbach, G., Diefenbach, D., Baumeister, A., & West, M. "Portrayal of Lobotomy in the Popular Press: 1935-1960." Journal of the history of the neurosciences 8 (05/01 1999): 60-9. https://doi.org/10.1076/jhin.8.1.60.1766.

226 Whitaker, R. Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill. Basic Books, 2001. https://archive.org/details/madinamericabads00whit

227 "Lobotomy: The Brain Op Described as 'Easier Than Curing a Toothache'." BBC News, 2021, https://www.bbc.com/news/stories-55854145.

228 "Postmodern Lobotomy Blues." Compact Magazine, 2023, https://compactmag.com/article/postmodern-lobotomy-blues.

229 "The Lobotomist." PBS, 2008, 48:20. https://www.pbs.org/wgbh/americanexperience/films/lobotomist/.

230 Offit, P. A. Pandora's Lab: Seven Stories of Science Gone Wrong. National Geographic Books, 2017.

231 "Explorers of the Brain." The New York Times, 1949, https://www.nytimes.com/1949/10/30/archives/explorers-of-the-brain.html.

But 70 years later, we find ourselves without the moral high ground. In the age of evidence-based medicine, we once again find ourselves witness to a medical world performing surgical mutilation on healthy bodies in the quest to cure mental illness. But instead of targeting the brain, today's surgeons target the genitals.

In both medical scandals, the victims are either minors or the mentally ill (or both), and the surgeries performed result in permanent disfigurement and disability. The most fortunate of Freeman's patients managed to live semi-independent lives, holding down low-skilled jobs, but most weren't so lucky. Many had their long-term memory destroyed and struggled even with the most basic tasks. Many were left permanently disabled.

In today's scandal, in the best-case scenario, male patients are left with a cavity that needs to be dilated for life and drastically reduced sexual function. The less fortunate endure severe complications, such as neovaginal stenosis, urinary issues, and fistulas. Ritchie Herron, a detransitioned man who underwent vaginoplasty during a mental health crisis, describes his life post-surgery as a living nightmare. "There is no dignity in living like this," said the 32-year-old victim of today's medical crime, who suffers from ongoing pain, numbness, and urinary dysfunction.[232,233]

Female patients undergo a procedure called phalloplasty that involves surgeons harvesting tissue from a donor site, usually the forearm but sometimes the thigh, and using the tissue to fashion a non-functional pseudo-penis. The surgery comes with an extraordinarily high complication rate and typically requires a full hysterectomy and vaginectomy, which is the surgical removal of the vagina.[234, 235]A 2021 study of 129 females who underwent the risky procedure to construct a pseudo-penis found the group reported 281 complications requiring 142 revisions.[236]

Both lobotomies and genital surgeries also involve the destruction of a core part of a person's humanity. Freeman and Watts noted that each of their patients lost "something by this operation, some spontaneity, some sparkle, some flavor of the personality." Today's gender surgeons are attacking an equally important aspect of what makes us human. Our sexual identities are an intrinsic part of who we are, making the amputation of genitals akin to performing a sexual lobotomy.

Gender surgeons, like the lobotomists who came before them, bypass ethical requirements that a surgical intervention be proven safe and beneficial before it is rolled out into mainstream medical practice. No long-term studies existed to prove that the benefits of lobotomy outweighed the harms, and the same can be said for today's genital surgeries. The few long-term studies that exist show significantly impaired social functioning, high rates of mental illness, and elevated suicide risk. Yet despite the lack of good quality science to support such drastic life-altering surgeries, just as the AMA and the APA did not openly condemn the medical crime of lobotomy, today those same organizations endorse minors and mentally ill adults undergoing genital amputation at the hands of WPATH surgeons. The reason is that they regard sex trait modification as a "human rights" issue first and foremost, and only secondarily, if at all, as a medical question.

In 1941, the New York Times described lobotomy patients as having "worries, persecution complexes, suicidal intentions, obsessions, indecisiveness and nervous

232 "'Heartbroken' Father Sues NHS to Stop Autistic Son's Sex Change." The Telegraph, 2023, https://www.telegraph.co.uk/news/2023/06/04/nhs-gender-clinic-judicial-review-autistic-son-sex-change/.

233 Ritchie, "This Isn't Even the Half of It. And This Isn't Regret Either, This Is Grief and Anger…," @TullipR, June 13, 2022, 2:57 PM, https://twitter.com/TullipR/status/1536422563458465793?s=20.

234 Rashid, M., & Tamimy, M. S. "Phalloplasty: The Dream and the Reality." [In eng]. Indian J Plast Surg 46, no. 2 (May 2013): 283-93. https://doi.org/10.4103/0970-0358.118606.

235 Wierckx, K., Van Caenegem, E., Elaut, E., Dedecker, D., Van de Peer, F., Toye, K., Weyers, S., et al. "Quality of Life and Sexual Health after Sex Reassignment Surgery in Transsexual Men." [In eng]. J Sex Med 8, no. 12 (Dec 2011): 3379-88. https://doi.org/10.1111/j.1743-6109.2011.02348.x.

236 Robinson, I. S., Blasdel, G., Cohen, O., Zhao, L. C., & Bluebond-Langner, R. "Surgical Outcomes Following Gender Affirming Penile Reconstruction: Patient-Reported Outcomes from a Multi-Center, International Survey of 129 Transmasculine Patients." [In eng]. J Sex Med 18, no. 4 (Apr 2021): 800-11. https://doi.org/10.1016/j.jsxm.2021.01.183.

tensions literally cut out of their minds with a knife by a new operation on the brain," giving the brutal surgery the air of a miracle cure.[237] Almost a century later, in the WPATH forum, the California therapist told her colleagues of the remarkable healing power of surgical castration for her mentally ill patients, who were put "on the road to emotional recovery" and presumably lived happily ever after.

Today, many patients report being satisfied with the outcome of their genital surgery despite being plagued by complications and experiencing significant social and romantic difficulties. Likewise, many families were genuinely grateful to Freeman for helping their loved ones despite the enormous burden of care placed upon them by the surgery and the devastating impact on the patient. Both situations suggest a certain level of self-deception, or what the early Dutch researchers worried was happiness "distorted by wishful thinking." Families who consented to their loved one undergoing a lobotomy would have an incentive to cling to the belief that it was the right decision, wilfully ignoring the obvious signs that it wasn't. Many adolescents, or their parents, as well as vulnerable adults may face a similar internal struggle today.

To understand how the medical world could have so swiftly endorsed lobotomies and why families and even the victims may have been grateful for the procedure, it is necessary to paint a picture of life for the severely mentally ill at the turn of the 20th century. This was an era long before the invention of antipsychotic drugs when the outlook for the mentally ill was bleak. Most ended up in overcrowded, understaffed mental asylums where the conditions were deplorable. Those suffering from the worst cases were kept restrained and in isolation, sometimes for years on end. One investigation of mental asylums in the United States found patients crammed naked in a dark room, the floor filthy with human waste.[238]

The field of psychiatry's desperation in the early decades of the 20th century gave rise to several brutal somatic remedies, from insulin coma therapy[239] to malaria therapy,[240] as well as the more widely-known electroshock treatments. These were risky and violent, and success was uncertain. It was in this context that news of Moniz's groundbreaking psychosurgery emerged. Psychiatrists, asylum staff, families, and the patients themselves were desperate for a solution. When lobotomy enabled patients to leave the asylum and be cared for at home by loved ones, or at least allowed the most violent cases to escape the confines of isolation and move freely within the ward, many saw it as a humane option. This resulted in a powerful, willful blindness to the barbaric nature of the procedure and its associated side effects.

But the world of today's victims could not be more different. The minors and vulnerable adults seeking surgical solutions to their poorly defined psychiatric condition are not confined to mental asylums, restrained in straitjackets, or chained to walls in isolation wards. They are not subjected to electroconvulsive shock therapy and face a lifetime of confinement and misery. Most are simply caught up in a mad cultural moment, suffering from a culture-bound mental illness that has produced an identity that is almost certainly transient.

For these young patients who still have their whole lives ahead of them, there is an ethical, non-invasive approach to treatment available with a strong track record of success: watchful waiting, coupled with psychotherapy as needed. All available evidence from the time before WPATH politicized gender medicine indicates that the majority of minors suffering from distress about their sex

237 "Turning the Mind inside Out." Saturday Evening Post, 1941, https://picryl.com/media/turning-the-mind-inside-out-saturday-evening-post-24-may-1941-page-18-2d7a77.

238 Maisel, A. Q. "Bedlam 1946: Most Us Mental Hospitals Are a Shame and a Disgrace." Life Magazine 20, no. 18 (1946): 102-18. https://mn.gov/mnddc/parallels2/prologue/6a-bedlam/bedlam-life1946.pdf.

239 Jones, K. "Insulin Coma Therapy in Schizophrenia." Journal of the Royal Society of Medicine 93, no. 3 (2000): 147-49. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1297956/pdf/10741319.pdf.

240 "The Psychiatrist Who Gave His Patients Malaria." Psychology Today, 2023, https://www.psychologytoday.com/ca/blog/psychiatry-a-history/202303/the-psychiatrist-who-gave-his-patients-malaria .

will reconcile with their bodies during or after puberty–assuming they are not socially transitioned and medicalized. Watchful waiting, caring support, and allowing the young person to grow and mature is the humane alternative to WPATH's "gender lobotomy." [241]

The scientific literature on adults is less conclusive, but for the severely mentally ill patients seeking genital surgery, deep psychotherapeutic work to alleviate their complex mental health issues and uncover the origin of their gender distress is preferable to ignoring all comorbidities and leaping directly to genital mutilation. Often, as Dr. Az Hakeem at the Portman clinic demonstrated, bringing the patients face-to-face with the reality of genital surgery is enough to quell the patient's obsessive desire.

But because WPATH is not a medical group seeking to find the best way to care for people suffering from gender dysphoria, its members consider attempting to avert the need for invasive, life-altering surgical intervention to be "conversion therapy." So instead, WPATH members advocate for surgical interventions as the only line of treatment, even for minors and the severely mentally ill, much the same as Freeman and his colleagues believed lobotomy was the only hope for the poor unfortunate souls confined to mental asylums.

Freeman saw himself as the savior of the severely mentally ill, believing that he gave hope to the hopeless. At the height of his career, he could never have imagined a day when his miraculous cure would be reviled and considered an atrocity. The same can be said for WPATH and its members. Spurred on by the thought of themselves as civil rights heroes fighting on behalf of the oppressed, they see themselves as being on the cutting edge of medicine, providing necessary medical care to patients in need. However, we believe that adolescents and vulnerable adults undergoing the surgical destruction of healthy genitals is destined to be recorded in history as a crime of equal or even greater magnitude than the lobotomy.

Ovariotomy

A case study comparing the attempt to cure mental illness with gynecological surgery in the 19th century with today's attempt to cure mental illness with gynecological surgeries and bilateral mastectomies

One of the greatest medical scandals of the 19th century was the practice of removing healthy ovaries as the treatment for a variety of mental illnesses in women, ranging from "menstrual madness," nymphomania, masturbation, and "all cases of insanity." This practice, known as ovariotomy, enjoyed the support of many of the leading gynecologists and psychiatrists of the era, and it is estimated that over 100,000 women had their healthy ovaries removed between 1872 and 1900.[242] This being a time long before the invention of antibiotics and adequate surgical cleanliness procedures, approximately 30% of the women died as a result of this medically unnecessary operation.[243]

The practice had its origins in reflex theory, the pseudoscientific idea that the spine connected all organs in the body, meaning one organ could produce symptoms in a distant organ, including the brain. This logic caused patients to become fixated on organs that had nothing to do with their symptoms and resulted, during the period we will describe, in droves of women seeking the removal of their ovaries as a means to resolve their mental distress.

This, combined with the era's fashionable belief that a variety of complaints, including hysteria, neurasthenia (what would today be called chronic fatigue syndrome), menstrual madness (premenstrual dysphoric disorder, or PMDD), and lunacy, were the result of masturbation and nymphomania, set the scene for the ovaries to be implicated in women's mental disorders. And from implicating the ovaries in the cause of mental disorders, it was a natural progression that surgeons should want to

241 Ibid (n.2-4)

242 Studd, J. "Ovariotomy for Menstrual Madness and Premenstrual Syndrome--19th Century History and Lessons for Current Practice." [In eng]. Gynecol Endocrinol 22, no. 8 (Aug 2006): 411-5. https://doi.org/10.1080/09513590600881503.

243 Longo, L. D. "The Rise and Fall of Battey's Operation: A Fashion in Surgery." Bulletin of the History of Medicine 53, no. 2 (1979): 256.

remove them as a treatment.

In 1872, within the space of just weeks, two ovariotomies were performed on opposite sides of the Atlantic. German Alfred Hegar performed the world's first on a healthy woman as a treatment for psychological distress, but his patient died a week later of peritonitis. Not a month later, English gynecologist Lawson Tait and American Robert Battey, unaware of Hegar's attempt, removed the ovaries of a woman who suffered from menstrual symptoms and convulsions that left her in a semi-comatose state. She almost met the same fate as Hegar's patient after developing sepsis but later recovered and was pronounced cured of her female woes.

The procedure was destined to take Battey's name and became known as Battey's Operation. Battey believed that madness in women was "not infrequently caused by uterine and ovarian disease." Battey is believed to have performed the procedure on several hundred women between 1872 and 1888, and it enjoyed a period of immense popularity in most of Europe and across the US, with women having their ovaries excised for a range of disorders from epilepsy to hysterical vomiting. It was considered a therapy to prevent "moral decline."

According to medical historian Edward Shorter, justification for performing this life-threatening surgery on women was found in data that was gathered, without statistical controls, showing that a disproportionate number of mentally ill women suffered from pelvic lesions. For instance, one study carried out by Russian gynecologist Valentin Magnan found that 35 out of his 45 patients with mental illness or hysteria had various genital lesions, and only 4 had no gynecological abnormality.[244] Of course, these findings were meaningless in the absence of a control group, but this was an era long before the development of evidence-based medicine.

Thus, the medical world rapidly adopted the dangerous, potentially deadly treatment, and it wasn't long before psychiatrists were recommending the surgery for "all cases of lunacy." It became so popular that psychiatric hospitals opened operating rooms where surgeons could remove the ovaries of female inmates.[245]

Supporters of ovariotomy considered it "one of the unequalled triumphs of surgery," and considered anyone who sought to deny women this medically necessary treatment to be "wanting in humanity" and "guilty of criminal neglect of patients."[246] This was the view held by the leading surgeons of the time, including Lawson Tait, one of the pioneers of the procedure. By its opponents, the operation was called "pernicious and dreadful,"[247] and the surgeons performing it "gynecological perverts."[248]

A sham surgery performed by James Israel in Paris in 1880 wasn't enough to dampen the enthusiasm. Israel claimed to have cured a woman by making an incision and sewing it back up, thereby proving the placebo effect and psychosomatic nature of the symptoms.[249] But Hegar is said to have performed an ovariotomy on her later that year to cure her of her incessant vomiting. Hegar then encouraged German surgeons to embrace the procedure, which, according to gynecologist and medical historian John Studd, is an indication that it was seen as being on the cutting edge of medicine.[250]

Women who had imbibed the popular reflex theory of the day, and begun to fixate on their reproductive organs as the source of their mental distress, began presenting to

244 Shorter, E. From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era. Simon and Schuster, 2008: 210. https://www.simonandschuster.ca/books/From-Paralysis-to-Fatigue/Edward-Shorter/9780029286678.

245 "Removal of the Ovaries, Etc., in Public Institutions for the Insane." Journal of the American Medical Association XX, no. 9 (1893): 258-58. https://doi.org/10.1001/jama.1893.02420360034006.

246 Ibid (n.243)

247 Ibid (n.243)

248 Barnesby, N. Medical Chaos and Crime. M. Kennerley, 1910. https://catalog.libraries.psu.edu/catalog/39665261.

249 Studd, J. "Ovariotomy for Menstrual Madness and Premenstrual Syndrome--19th Century History and Lessons for Current Practice." [In eng]. Gynecol Endocrinol 22, no. 8 (Aug 2006): 411-5. https://doi.org/10.1080/09513590600881503.

250 Ibid (n.249)

gynecologists requesting to be "Battey-ized" as the procedure gained in popularity.[251]

Dr. William Goodell called for the surgery to be performed for "all cases of insanity," an opinion supported by others, assuring his fellow gynecologists: "If the operation be not followed by a cure, the surgeon can console himself with the thought that he has brought about a sterility in a woman who might otherwise have given birth to an insane progeny."[252] Goodell believed that such a woman was destined to "transmit the taint of insanity to her children and her children's children for many generations."[253]

Some medical reports included the self-reported satisfaction of women who had undergone the surgery. One woman told of how she was so desperate before the operation that she almost took her own life but stated that she was "a well, happy, and cheerful girl" after having her healthy ovaries removed.[254]

Geroge H. Rohé, an ovariotomy enthusiast, operated for a wide range of mental disorders, including cases of epilepsy, melancholia, and hysterical mania. He believed his patients were able to give "valid consent" during "lucid intervals."[255]

This unbridled enthusiasm for the surgery eventually brought its fall from grace. An investigation in 1893 into the presence of a surgical ward at the State Hospital for the Insane in Norristown, Pennsylvania, opened to perform "bilateral oophorectomy," as ovariotomy was otherwise known, concluded that the operation was "illegal… experimental [in] character…brutal and inhumane, and not excusable on any reasonable ground." This report marked the beginning of the end of ovariotomy to treat mental disorders.[256] Leading gynecologists started to speak out in opposition. By the end of the century, Battey's operation was largely forgotten.

Like in the case of lobotomy, the medical world should have learned a crucial lesson from the ill-fated history of ovariotomy. Surgeons should have recognized the peril of hastily embracing new procedures with profound, life-long effects on vulnerable patients. Furthermore, it ought to have alerted doctors to the role of medical influence in shaping symptoms of patients, often women, who internalize doctors' beliefs, causing them to manifest psychosomatic symptoms and seek surgical solutions. And yet, astonishingly, in the 21st century, we are once again observing another such event, one that bears a disconcerting resemblance to the ovariotomy blunder.

There are many striking parallels between the surgeons who removed women's healthy ovaries as a treatment for mental distress in the 19th century and the WPATH doctors today who are advocating for surgeons to remove the healthy breasts and reproductive organs of teenage girls and young women also as a treatment for their mental distress.

While from the outset ovariotomy was horribly misguided, the surgeons at least began with a certain level of caution. The procedure was initially indicated for conditions such as menstrual madness, epilepsy, nymphomania, and masturbation, but later became the treatment for all forms of insanity, including for hysteria, the psychiatric epidemic of the age.

Sex-trait modification procedures for people who identify as transgender followed the same trajectory. Medical intervention was initially reserved for only the most persistent of gender dysphoria cases. However, when activists captured WPATH, hormonal interventions

251 Shorter, E. From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era. Simon and Schuster, 2008: 221. https://www.simonandschuster.ca/books/From-Paralysis-to-Fatigue/Edward-Shorter/9780029286678.

252 MacCormac, W., & Makins, G. H. Transactions of the International Medical Congress, Seventh Session, Held in London, August 2d to 9th, 1881. Vol. 4: JW Kolckmann, 1881. https://babel.hathitrust.org/cgi/pt?id=mdp.39015007091385&seq=315.

253 Goodell, W. "Clinical Notes on the Extirpation of the Ovaries for Insanity." American Journal of Psychiatry 38, no. 3 (1882). https://sci-hub.ru/10.1176/ajp.38.3.294.

254 Ibid (n.243 p.256)

255 Ibid (n.243 p.261)

256 Ibid (n. 243 p. 262)

became the first line of treatment because psychotherapy to help the patient reconcile with his or her birth sex was deemed conversion therapy. As we have seen in the discussions in the WPATH Files, prolonged testosterone use in women leads to uterine atrophy and the need for a hysterectomy, with some opting to have their healthy ovaries removed along with their uterus. The medical attack on the reproductive organs of adolescent girls and vulnerable women in the 21st century may have added one more step along the way, but that doesn't make this any less of a medical crime.

An eerie echo of the past can be heard in the Identity Evolution Workshop, when, more than a century after the ovariotomy scandal ended, Ferrando discussed "early oophorectomy" with her fellow WPATH members. The WPATH-affiliated surgeon described explaining to young women that with "early removal of the ovaries" comes the need for lifelong hormone supplements for cardiovascular and bone health.

"So those are the things that we think about in this cohort of 20-year-olds in whom we're removing the ovaries," said Ferrando.

In fact, just like the ovariotomists of the past, Ferrando has no reliable science to guide her in treating these young patients. A 2019 review of the literature to support the practice of removing the healthy ovaries of young women who identify as men found the supporting evidence to be "lacking" and described an urgent need for research into the "metabolic and cardiovascular risk" to these female patients.[257]

The removal of ovaries from Victorian women did not alleviate their mental health issues, as their psychological struggles were not rooted in their ovaries. Similarly, the removal of healthy breasts and reproductive organs today often does not resolve the challenges faced by adolescent girls and vulnerable women, many of whom come to realize too late that their mental distress was related to coexisting psychiatric disorders, autism, trauma, or difficulty accepting their emerging homosexual orientation.

Much like women in the 19th century who internalized the reflex theory narrative, fixating on their reproductive organs as the root cause of their mental distress and subsequently requesting ovarian removal surgeries, vulnerable women and girls in the 21st century are now embracing the narrative of the modern trans rights movement that tells them if they hate their female bodies, it is an indication of the need for surgical alteration. Once again, they are fixating on their reproductive organs, and this time their breasts too, as the source of their anguish and seeking a surgical solution.

In Shorter's analysis, the unwavering conviction that one needs a surgical procedure represents a psychosomatic symptom, wherein the patient coalesces their vague and troubling sensations into a fixed diagnosis. Victorian women, influenced by the prevailing reflex theory, perceived their various feelings of sadness and anxiety through this cultural perspective. They interpreted these symptoms as being an indication of unhealthy ovaries, and once convinced of this belief, they firmly believed that undergoing an ovariotomy would alleviate all their mental anguish.

Today, many teenage girls are interpreting their normal pubertal woes as a sign they are transgender because they are viewing their suffering through a cultural lens that teaches them that their distress is an indication that they were born in the wrong body and that sex-trait modification procedures are the only solution. Once they latch onto this explanation, they become preoccupied with the idea of removing their breasts and reproductive organs, firmly believing that these surgical procedures will alleviate all their emotional difficulties, bringing them health and happiness.

Thus, the WPATH members who endorse such thinking and facilitate teenage girls and young women in

257 Reilly, Z. P., Fruhauf, T. F., & Martin, S. J. (2019). Barriers to Evidence-Based Transgender Care: Knowledge Gaps in Gender-Affirming Hysterectomy and Oophorectomy. Obstetrics & Gynecology, 134(4), 714-717. https://doi.org/10.1097/aog.0000000000003472

altering their bodies based on entirely unfounded beliefs are akin to the gynecologists and psychiatrists of the 19th century who enabled the women seeking the medically unnecessary removal of their healthy ovaries.

Ovariotomy enjoyed the support of many of the most respected surgeons of the time, including J. Marion Sims, Lawson Tait, and Spencer Wells. This endorsement lent an aura of credibility to the procedure despite the absence of sound scientific justification for the removal of healthy organs. Today, the surgical removal of breasts and reproductive organs as a solution for a woman's psychological distress is supported by all significant American medical associations, even though these procedures likewise lack a solid foundation in scientific research.

Doctors who opposed ovariotomy were accused of being "wanting in humanity" and "guilty of criminal neglect of patients" when, in truth, the procedure was pseudoscientific, extremely risky, and entirely ineffective. Doctors who oppose the removal of healthy body parts as a cure for gender dysphoria are vilified in much the same way, facing accusations of transphobia and hate and the possible loss of their livelihood.

The surgeons removing healthy ovaries to cure mental illness lived in an age long before the development of evidence-based medicine and rigorous scientific standards. This was the Wild West of medicine, with scalpel-happy surgeons, many excited by the new possibilities opened up by the invention of anesthetics, trying out new surgical techniques with no oversight or regulation. It was only when the ovariotomists overstepped the mark by opening surgical wards in mental asylums that the practice drew widespread condemnation and was brought to an end.

But gender surgeons today have no such excuse for their unethical behavior. Today, we expect medical professionals to adhere to strict protocols. We expect randomized controlled trials and meticulous follow-up. There are no such studies to prove that removing the healthy breasts and reproductive organs of teenage girls and young women is safe, ethical, and effective in relieving their mental distress.

A medical experiment based upon an untested article of belief was unacceptable in the 19th century. It is unforgivable today.

Apotemnophilia

A case study comparing the desire to have healthy limbs amputated with the desire to have surgically-created abnormal genitalia

In 2000, a surgeon in Scotland made headlines when it was revealed that he had performed leg amputations on two men who were physically healthy but afflicted with a psychiatric condition known as apotemnophilia, or what is now more commonly referred to as body integrity identity disorder (BIID).[258]

In 1997, Dr. Robert Smith amputated the healthy lower leg of a man at Falkirk and District Royal Infirmary, and two years later, in 1999, Smith amputated the healthy leg of a second man.[259] He was set to amputate the leg of a third man, Dr. Gregg Furth, a New York child psychologist, when the hospital ethics board investigated his actions and ruled that the procedures were unethical. The NHS removed his funding, and Smith was banned from further mutilating healthy bodies.

Dr. Russell Reid, a psychiatrist based in London, had diagnosed the men with "apotemnophilia," a rare psychiatric condition characterized by an intense fixation on having healthy limbs amputated. Typically, this obsession focuses on one leg, although some patients express a desire to remove both legs, an arm, or occasionally specific fingers or toes. Paradoxically, those afflicted with this disorder assert that they do not feel complete with all four limbs or all ten digits, believing their true identity is that of an amputee. According to Dr. Reid,

258 "Surgeon Defends Amputations." BBC News, 2000, http://news.bbc.co.uk/2/hi/uk_news/scotland/625680.stm.

259 Dyer, C. "Surgeon Amputated Healthy Legs." [In eng]. Bmj 320, no. 7231 (Feb 5 2000): 332. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1127127/.

traditional psychotherapy "doesn't make a scrap of difference in these people."[260]

Many researchers, including Reid, have noted the obvious parallel with transgenderism, or transsexualism as it was known during the early 2000s when the controversy surrounding Smith's surgeries triggered a flurry of interest in this obscure psychiatric condition.[261,262]

The term apotemnophilia, literally "love of amputation," was coined by the infamous Dr. John Money in the 1970s. Noting the erotic motivation of many, or perhaps most, of these patients, Money categorized the disorder as a paraphilia, or in other words, a sexual deviancy, recognizing that these individuals achieved sexual fulfillment by fantasizing about being an amputee, or indeed actually becoming one. Many apotemnophiles also suffer from what Money termed acrotomophilia, which is to be sexually attracted to amputees.

Smith described the two leg amputations he performed on his apotemnophile patients as being the most rewarding operations of his career and said he felt no regret at satisfying the men's wishes.[263] He argued that the surgeries were life-saving, claiming that apotemnophiles will either attempt to perform the amputation themselves or go to extraordinary lengths to self-inflict injuries, such as with dry ice, guns, or chainsaws, in a desperate bid to force surgeons to amputate.[264,265]

Indeed, in 1998, 79-year-old Philip Bondy of New York paid $10,000 to John Brown, a surgeon in Tijuana, to have his left leg amputated. He died two days later of gangrene, and Brown was charged with second-degree murder. It was reported during Brown's trial that Bondy wished to have his leg amputated to fulfill a "sexual craving." Brown had lost his medical license in 1977 after three patients nearly died from sex-change surgeries he had reportedly performed in locations such as a garage and a hotel.[266]

Another case is that of a 55-year-old American man who amputated his own arm using a home-made guillotine.[267] Further examples can be found in the 2003 documentary Whole, which featured the stories of a Florida man who shot himself in the leg so that it would need to be amputated and that of a man from Liverpool, England who packed his leg in dry ice. The latter called his amputation a "body correction surgery."[268,269] Smith also appears in the documentary, arguing that refusing to amputate a healthy limb is a violation of the Hippocratic Oath. "The Hippocratic oath says first do your patients no harm," he said, before going on to explain that the real harm is to refuse to help such a patient, "leaving him in a state of permanent mental torment," when all it would take for him "to live a satisfied and happy life" would be to amputate.

This unusual psychiatric disorder is not new. Since the late 1800s, there have been cases described in medical literature of men and women being sexually attracted to amputees or people with other disabilities, as well as people

260 "Complete Obsession." BBC Home, 2000, https://www.bbc.co.uk/science/horizon/1999/obsession_script.shtml.

261 Lawrence, A. A. "Clinical and Theoretical Parallels between Desire for Limb Amputation and Gender Identity Disorder." [In eng]. Arch Sex Behav 35, no. 3 (Jun 2006): 263-78. https://doi.org/10.1007/s10508-006-9026-6.

262 Bailey, M. J., Hsu, K. J., & Jang, H. H. "Elaborating and Testing Erotic Target Identity Inversion Theory in Three Paraphilic Samples." Archives of Sexual Behavior (2023/07/06 2023). https://doi.org/10.1007/s10508-023-02647-x. https://doi.org/10.1007/s10508-023-02647-x.

263 Elliott, C. "A New Way to Be Mad." Atlantic monthly (Boston, Mass.: 1971) (12/01 2000): 73-84.

264 "Healthy Limbs Cut Off at Patients' Request." The Guardian, 2000, https://www.theguardian.com/society/2000/feb/01/futureofthenhs.health.

265 First, M. B. "Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder." [In eng]. Psychol Med 35, no. 6 (Jun 2005): 919-28. https://doi.org/10.1017/s0033291704003320.

266 "Ex-Doctor Tried in Amputation-Fetish Death." Tampa Bay Times, 1999, https://www.tampabay.com/archive/1999/09/29/ex-doctor-tried-in-amputation-fetish-death/.

267 Dua, A. (2010). Apotemnophilia: ethical considerations of amputating a healthy limb. J Med Ethics, 36(2), 75-78. https://doi.org/10.1136/jme.2009.031070

268 Gilbert, M. "Whole." 2003. https://www.imdb.com/title/tt0429245/.

269 Henig, R. M. "At War with Their Bodies, They Seek to Sever Limbs." New York Times 22 (2005): F6. https://www.nytimes.com/2005/03/22/health/psychology/at-war-with-their-bodies-they-seek-to-sever-limbs.html.

who pretend to be disabled or wish to become disabled.[270] But it was the dawn of the Internet era that drew attention to this group of individuals with such unusual sexual interests, and online chat rooms provided a place for like-minded people to congregate and share their amputation fantasies and desires.

Online, they call themselves devotees, pretenders, and wannabes (DPWs). Devotees are non-disabled people who are sexually attracted to people with disabilities; pretenders are non-disabled people who act out having a disability, usually with the aid of crutches, wheelchairs and leg braces; and wannabes are people who actually wish to become disabled.

A 2005 study by Dr. Michael First of 52 sufferers of BIID found that the primary reason for desiring the amputation of a healthy limb was the feeling that it would "correct a mismatch between the person's anatomy and sense of his or her 'true' self (identity)."[271]

Some examples of the answers study participants gave include: "[After the amputation] I would have the identity that I've always seen myself as," and "I feel myself complete without my left leg…I'm overcomplete with it." The most strikingly similar statement to the "born in the wrong body" narrative of today's transgender rights movement was: "I felt like I was in the wrong body; that I am only complete with both my arm and leg off on the right side."[272]

Despite a small amount of scientific literature to suggest that BIID sufferers benefit from having safe access to amputations, to our knowledge, there are no surgeons in North America, or indeed the developed world, willing to perform such extreme elective operations. Even in this day and age, when WPATH-approved genital and breast amputations are commonplace and even performed on minors, the idea of amputating healthy limbs is reviled by most people.

In the WPATH Files, a discussion thread makes the obvious comparison between BIID and gender dysphoria, with an Australian clinician noting that it is "clear these individuals do display some characteristics similar to trans people." However, not everyone inside WPATH agrees. Bowers was questioned on the topic in a 2022 documentary and denied any similarity between the two disorders, calling apotemnophilia "a mental diagnosis and a psychiatric condition" and describing those who seek amputation of a healthy limb as "kooky."[273]

However, the similarities are clear. In the 2005 New York Times article with the headline, At War With Their Bodies, They Seek to Sever Limbs, Dr. First, author of the aforementioned 2005 study, compared the amputation of healthy limbs to sex-reassignment surgery. "When the first sex reassignment was done in the 1950's, it generated the same kind of horror," said First. "Surgeons asked themselves, 'How can I do this thing to someone that's normal?' The dilemma of the surgeon being asked to amputate a healthy limb is similar."[274]

But as First pointed out, the analogy falls short of being perfect. "It's one thing to say someone wants to go from male to female; they're both normal states," he said. "To want to go from a four-limbed person to an amputee feels more problematic. That idea doesn't compute to regular people."

While there are many parallels with traditional sex-reassignment surgeries, including similarities between

270 Bruno, R. L. "Devotees, Pretenders and Wannabes: Two Cases of Factitious Disability Disorder." Sexuality and Disability 15, no. 4 (1997/12/01 1997): 243-60. https://doi.org/10.1023/A:1024769330761. https://doi.org/10.1023/A:1024769330761.

271 First, M. B. "Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder." [In eng]. Psychol Med 35, no. 6 (Jun 2005): 919-28. https://doi.org/10.1017/s0033291704003320.

272 Ibid (n.271)

273 "What Is a Woman?". 2022. https://www.dailywire.com/videos/what-is-a-woman.

274 Henig, R. M. "At War with Their Bodies, They Seek to Sever Limbs." New York Times 22 (2005): F6. https://www.nytimes.com/2005/03/22/health/psychology/at-war-with-their-bodies-they-seek-to-sever-limbs.html.

apotemnophilia and autogynephilia,[275] which is a paraphilia that drives some men to seek medical sex changes, perhaps a closer parallel can be drawn with those who desire their healthy male or female genitals to be reconfigured into abnormal states such as nullification and bigenital surgeries, as well as those seeking to become eunuchs.

The surgeries described by Satterwhite and his devoted followers in the WPATH Files involve creating a type of body that does not exist in nature, in the same way that turning a four-limbed person into an amputee creates a type of body that is abnormal. This ought to generate a feeling of horror in any surgeon dedicated to the Hippocratic Oath, not to mention in all policymakers, insurance companies, and the general public at large.

The amputation of a healthy limb is viewed by most as a violation of the Hippocratic Oath. Still, it is at least a relatively straightforward surgical procedure with few complications and risks, and BIID is also a recognised psychiatric disorder. The same cannot be said for the amputation of healthy genitalia or the creation of a second set of genitals in the service of meeting body modification goals and experiencing "gender euphoria." As well, an apotemnophile who undergoes an amputation can get a prosthesis that functions reasonably well, but there is no such prosthesis that can replace an amputated penis.

In the nullification surgeries offered by Satterwhite and discussed in the WPATH Files, a surgeon amputates the healthy genitalia of a man to create a smooth, sexless body. This pointless form of extreme body modification not only drastically impacts the man's sexual function and destroys his ability to father children, but it also impacts his urinary and endocrine system, two vitally important bodily systems with far-reaching implications for his future health and well-being.

Then there are the "bigenital" surgeries, such as the "phallus-preserving vaginoplasty" and "vagina-preserving phalloplasty," procedures also discussed in the WPATH Files and performed by WPATH surgeons like Satterwhite. These surgeries to create a non-functional second set of genitals come with an extremely high risk of complications. Furthermore, such radical cosmetic surgeries will have a dramatic impact on the patient's health and ability to form long-term romantic partnerships.

Thus, when we compare the detrimental impact that nullification and bigenital surgeries have on a person's sexual identity, which is an intrinsic part of their humanity, coupled with the risks that such surgeries entail, it is clear that the medical crime committed by WPATH-affiliated surgeons is far greater than that of Dr. Robert Smith in Scotland in the 1990s. The NHS Ethics Committee rightly banned Smith from performing further amputations, and we call for WPATH's consumer-driven gender-affirming care to be banned by ethics committees in every town and city across the US and globally.

Another important difference is in the response from the popular press. When the amputations performed by Dr. Smith were revealed, reporting was largely negative. Falkirk and District Royal Infirmary's decision to prevent Smith from carrying out further amputations was in part related to the negative publicity. However, in today's media landscape, non-binary identities are celebrated and gender-affirming care is portrayed as "life-saving." Articles rarely describe the specifics of genital surgeries, but the overall message is consistently positive in today's mainstream press. This helps to increase awareness of these identities and generates desire for genital surgeries. If, in the 1990s, the press had reported favorably about people with innate amputee identities and framed the amputations as a human right and life-saving, it is certainly possible that society would have witnessed an increase in people identifying as amputees and seeking elective amputations.

Both people desiring limb amputation and people desiring abnormal genitalia seek extreme elective surgery to align their bodies with their subjective identity. But, the

275 Lawrence, A. A. "Clinical and Theoretical Parallels between Desire for Limb Amputation and Gender Identity Disorder." [In eng]. Arch Sex Behav 35, no. 3 (Jun 2006): 263-78. https://doi.org/10.1007/s10508-006-9026-6.

origins of that internal sense of self appear to be very different. Apotemnophiles often report seeing an amputee in childhood and, from that moment on, become obsessed with the idea of being an amputee. For many, this obsession then became sexual at the onset of puberty. Similarly, autogynephiles report an obsession with cross-dressing in childhood, beyond the typical dress-up most children engage in, and feeling a thrill of excitement coupled with shame and embarrassment.[276] The sexual element likewise only began at puberty. Even the "eunuch-identified" men described in the bizarre WPATH 2022 Eunuch session were disproportionately likely to have grown up on farms and, therefore, to have witnessed animals castrated. Johnson and Irwig even borrowed language from online apotemnophile communities, describing the men seeking "eunuch calm" as "wannabes."[277]

But those seeking nullification and bigenital surgeries will never have come across people with no genitals or both sets of genitals in their childhood because such a type of person did not exist until WPATH's genre of gender medicine came into being. A parallel cannot be drawn with "intersex" individuals or people with differences of sexual development (DSDs), as such conditions are now known. Individuals with DSDs do not have no genitals or both sets of genitals, and many within the intersex community find the comparison deeply offensive.

While it is not possible to transform a man into a woman by inverting his penis, nor a woman into a man by amputating her breasts and creating a pseudo-penis out of her forearm, such extreme surgeries are at least an attempted remedy, albeit a very misguided one, for a recognized psychiatric disorder. WPATH's non-binary surgeries lack any medical justification and are merely extreme consumer-driven body modifications.

Engineering Children's Height With Hormones

A case study comparing the past scandal of pediatric endocrinologists attempting to correct the height of tall girls and short boys with today's scandal of pediatric endocrinologists attempting to correct gender-nonconformity in children

In the 1950s, pediatric endocrinologists embarked upon an experiment to correct the height of abnormally tall and short children using hormones. This was in the early days of endocrinology when endocrinologists had the air of miracle workers. With the discovery of insulin, this new and exciting branch of medicine had brought diabetics back from the brink of death, and a few short years later, used cortisone to give mobility to crippled arthritics.

So when synthetic estrogen (DES) was developed, and scientists found a way to extract human growth hormone (hGH) from the pituitaries of cadavers, pediatric endocrinologists got swept up in the excitement of discovery and turned their attention to "correcting" the height of tall girls and short boys.

Initially, this experiment was confined only to those suffering from medical conditions such as gigantism and dwarfism. But, soon, endocrinologists broadened their patient pool to include healthy children who didn't measure up to the height standards of the day.

Despite imprecise height prediction methods, a paucity of research into the psychosocial benefits, and a complete absence of evidence about long-term safety and effectiveness, thousands of healthy children were subjected to this treatment. The treatments weren't lacking opposition, though, with some questioning whether abnormal height was a medical problem or just a social impediment.

The media played a role in spreading the word about this new and exciting solution to the woes of being either too tall or too short. Australian pediatrician Norman Wettenhall spearheaded the experiment to correct the height of girls destined to be tall. In 1964, Australian media uncritically reported his success in treating twenty-five tall girls. The Sydney Sun ran a front-page story featuring "two of Australia's growth-controlled girls," who were described

276 Lawrence, A. A. Men Trapped in Men's Bodies: Narratives of Autogynephilic Transsexualism. Springer Science & Business Media, 2012.

277 Ibid (n.221)

as "happy, pretty teenagers who have been prevented from growing embarrassingly tall" by estrogen therapy.[278] This article and others neglected to mention the often debilitating side effects of the treatment, which included weight gain, depression, intense nausea, ovarian cysts, and spontaneous lactation. What ensued was a surge of parents seeking treatment for their daughters, many of whom were mothers who were unhappy with their own tall stature.

While Wettenhall was conducting his experiment in Australia, a group of researchers in the US, headed by Alfred Wilhemi, a chemist at Yale, were crudely processing pituitary glands harvested from morgues, grinding the glands in a blender and then drying them into a powder that would later be injected into short children, the majority of whom were boys. The Food and Drug Administration (FDA) allowed this experiment, and the NIH established and funded a national pituitary collection program. An unlikely coalition of parents of short children and commercial airline pilots worked together to gather pituitaries from coroners and fly them, stored in acetone and on dry ice, to the processing plant.[279]

But then, in 1984, tragedy struck. Those who had been treated with hGH started to die of Creutzfeldt-Jakob disease (CJD), a devastating fatal illness caused by a prion that had gone undetected during processing.[280] It was discovered that fears that hGH injections could spread CJD had been ignored for years.[281] Pituitary-derived hGH was swiftly removed from the market and replaced by a synthetic form, although many pediatric endocrinologists initially thought the ban was too severe and an overreaction. Some parents even acquired pituitary-derived hGH from other sources after being informed of the risk.[282]

There was now unlimited supply of synthetic human growth hormone, and some pediatric endocrinologists began experimenting with a combination of puberty blockers and hGH to give the child more time to grow.

Genentech, the drug company that won FDA approval for synthetic hGH, set about expanding its off-label use to treat healthy children of short stature, financing a journal, funding studies on growth, sponsoring symposiums, courting pediatric endocrinologists and funding height screening programs in American schools.[283] This eventually led to Genentech becoming the first drug company in history to face criminal prosecution by the FDA for illegally promoting off-label, resulting in one of the largest financial penalties ever paid in the industry.[284,285]

At the same time, the harmful effects of estrogen therapy were being exposed, with links to cancer and disorders of the reproductive system.[286] In 1976, the New York Times ran an article downplaying the dangers, quoting a pediatric endocrinologist who claimed the therapy was safe for tall girls because they typically took the hormone for a shorter period of time and another saying, "the choice is to be overly tall or to take a risk that is almost nonexistent."[287,288]

278 Cohen, S., & Cosgrove, C. Normal at Any Cost: Tall Girls, Short Boys, and the Medical Industry's Quest to Manipulate Height, 32. Penguin, 2009.

279 Ibid (n.278 p.78)

280 "National Hormone & Pituitary Program (Nhpp): Information for People Treated with Pituitary Human Growth Hormone." National Institute of Diabetes and Digestive and Kidney Diseases 2021, https://www.niddk.nih.gov/health-information/endocrine-diseases/national-hormone-pituitary-program.

281 Ibid (n. 279 p.275)

282 Ibid (n. 279 p.143)

283 Ibid (n.279 ch.8)

284 Conrad, P., & Potter, D. "Human Growth Hormone and the Temptations of Biomedical Enhancement." Sociology of Health & Illness 26, no. 2 (2004): 184-215. https://doi.org/10.1111/j.1467-9566.2004.00386.x.

285 Ibid (n.279 p.188)

286 Herbst, A. L., Ulfelder, H., & Poskanzer, D. C. "Adenocarcinoma of the Vagina." New England Journal of Medicine 284, no. 16 (1971): 878-81. https://doi.org/10.1056/nejm197104222841604. https://dx.doi.org/10.1056/nejm197104222841604.

287 Ziel, H. K., & Finkle, W. D. "Increased Risk of Endometrial Carcinoma among Users of Conjugated Estrogens." [In eng]. N Engl J Med 293, no. 23 (Dec 4 1975): 1167-70. https://doi.org/10.1056/nejm197512042932303.

288 "The Use of Estrogen as a Growth Inhibitor in over-Tall Girls Is Being Questioned." The New York Times, 1976, https://www.nytimes.com/1976/02/11/archives/the-use-of-estrogen-as-a-growth-inhibitor-in-overtall-girls-is.html.

However, this turned out to be false. An investigation into the Tall Girls scandal began in 2000. Researchers tracked down hundreds of women and found higher rates of infertility,[289] and increased risk of endometriosis. The researchers saw cancers in the group as well, but due to the small sample size, they couldn't conclude the effects of the treatment on cancer risk.[290]

As well, while short-term follow-up studies [291,292] had shown high rates of satisfaction in the girls who had undergone treatment, the investigation in 2000 revealed that 99.1% of the women who had not received treatment were happy they hadn't taken the hormone, compared to a regret rate of 42.1% for those who had, with the researchers concluding that 56% were "less than satisfied."[293] Many of the parents expressed profound guilt at what they had done to their daughters.

While the tall girls were still dealing with fertility issues and disorders of the reproductive system, and those treated with pituitary-derived hGH were still living with a potential death sentence hanging over their heads, the field of pediatric endocrinology moved on to its next reckless experiment, once again using hormonal interventions to mold children into gender-stereotype norms. This time, their attempt involved a whole rewrite of what it means to be human and a complete disregard for biological reality. However, the new adventure was eerily similar to its predecessor.

At the center of both scandals, there are healthy children who are different, who don't measure up to what is considered "normal" for the culture of their particular time and place, and there is a medical world willing to embark upon an experiment to engineer normality. Gender nonconformity is no more a medical condition than being taller or shorter than the average height. Of note, in both scandals, adults who are unhappy with aspects of their appearance are the ones calling for children to be experimented on.

As well, there are off-label drugs being prescribed to healthy children without any knowledge of the drugs' safety, effectiveness, or benefits. However, the height-manipulation therapy experiment occurred long before the development of evidence-based medicine when it was common for doctors to test out ideas on patient groups without prior controlled testing. Neither for DES nor hGH were there any controlled trials or long-term follow-up studies before the drugs were rolled out for widespread use, but this was normal for the era.

It is the same for the puberty suppression experiment, which was rolled out into general medical practice based on the questionable results of a deeply flawed study of just 55 adolescents, with psychological data only available for 32 participants. This is reminiscent of Wettenhall's claims of success with just 25 tall girls, which led to the widespread adoption of estrogen therapy to correct height.

In the original Dutch paper, sponsored by Ferring Pharmaceuticals, a maker of puberty blockers, de Waal and Cohen-Kettenis even discuss the opportunity to "manipulate growth." Regarding height, the researchers point out that while a natal female's growth spurt will be hampered, the fusion of the growth plates will also be delayed. "Since females are about 12 cm shorter than males, we may intervene with growth-stimulating

289 Venn, A., Bruinsma, F., Werther, G., Pyett, P., Baird, D., Jones, P., Rayner, J., & Lumley, J. "Oestrogen Treatment to Reduce the Adult Height of Tall Girls: Long-Term Effects on Fertility." The Lancet 364, no. 9444 (2004): 1513-18. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)17274-7/fulltext.

290 Ibid (n.279 p.345)

291 Crawford, J. D. "Treatment of Tall Girls with Estrogen." Pediatrics 62, no. 6 (1978): 1189-95. https://doi.org/10.1542/peds.62.6.1189.

292 De Waal, W. J., Torn, M., De Muinck Keizer-Schrama, S. M., Aarsen, R. S., & Drop, S. L. "Long Term Sequelae of Sex Steroid Treatment in the Management of Constitutionally Tall Stature." Archives of Disease in Childhood 73, no. 4 (1995): 311-15. https://doi.org/10.1136/adc.73.4.311. https://dx.doi.org/10.1136/adc.73.4.311.

293 Pyett, P., Rayner, J., Venn, A., Bruinsma, F., Werther, G., & Lumley, J. "Using Hormone Treatment to Reduce the Adult Height of Tall Girls: Are Women Satisfied with the Decision in Later Years?". Social Science & Medicine 61, no. 8 (2005/10/01/ 2005): 1629-39. https://doi.org/https://doi.org/10.1016/j.socscimed.2005.03.016.

treatment in order to adjust the female height to an acceptable male height," they theorized at the time.[294]

The girls who were given DES experienced high rates of fertility issues many years later and an increased risk of endometriosis. These side effects were not foreseen by the endocrinologists who gave the hormone to these previously healthy girls.

It is possible, but surely unlikely, that the Dutch researchers who first embarked upon the adolescent sex-trait modification experiment also did not foresee the impact the treatment would have on the fertility and sexual function of their patients. However, the WPATH documents reveal that gender-affirming medical and mental health professionals today are well aware of the detrimental impact of puberty blockers and hormones on this important aspect of their young patients' lives. From the discussions about vaginal atrophy as a result of prolonged testosterone use and descriptions of natal males having erections that feel like "broken glass," to Bowers's comments about natal males facing a lifetime of being infertile and anorgasmic, the documents clearly show that WPATH members know that the cross-sex hormone therapy their professional association endorses negatively affects a patient's fertility and sexual function.

Just as Wilhemi and his fellow researchers did not anticipate that their treatment might pose a potential threat to the lives of their previously healthy patients, the Dutch researchers likewise did not foresee that suppressing puberty would result in the tragic death of one of the original study participants.[295] Like their predecessors administering contaminated hGH to healthy children, gender doctors had been aware of what Bowers refers to in the files as "problematic surgical outcomes" since at least 2005, but this was not enough to halt the experiment.[296]

Also reminiscent of the CJD crisis, the anecdote in the WPATH Files about the natal female who appears to have died of liver cancer brought on by prolonged testosterone use, as well as the Lancet case study of the 17-year-old with liver cancer, raise serious concerns. Just as the CJD nightmare didn't surface until decades after the children had been treated, we may face another such catastrophe in the coming years as the risks of prolonged testosterone use in females begin to manifest.

In both scandals, there is a lack of good quality long-term research. During the height-modification scandal, clinicians conducted short-term follow-ups and reported high satisfaction rates. However, follow-up studies done before the women had reached the age that they might start to regret compromising their fertility have only limited worth. The long-term follow-up study conducted in 2000 found much higher rates of regret and dissatisfaction among the women.

There is the same lack of adequate long-term data for the hormonal interventions for adolescent sex-trait modification. Today's experiment has a much greater detrimental impact on the young participants. Discussions in the files show that WPATH is aware that this treatment protocol is creating a generation of sexually dysfunctional young people.

Many of the short-term studies with reported high patient satisfaction rates are cited by gender-affirming clinicians as proof that sex-trait modification procedures are beneficial. But these are just as inadequate as the short-term studies during the height-modification scandal. For the data to be worthwhile, gender doctors need to follow up with their patients long into adulthood, when the true impact of sacrificing their fertility and sexual function is felt. But we are already seeing a trend similar to the tall girls

294 Ibid (n.157)

295 Ibid (n.74)

296 "Consensus Report on Symposium in May 2005." gires, 2005, https://www.gires.org.uk/consensus-report-on-symposium-in-may-2005/.

experiment: the longer the follow-up period, the higher the regret rate for sex-trait modification interventions.[297,298] The preliminary findings of the Dutch long-term follow-up already indicate that fertility regret is significant.[299]

During inquiries into the CJD tragedy, a British court found that the UK Department of Health should have taken action in the summer of 1977 after warnings about CJD contamination were sounded, and an Australian investigation set the cut-off date at 1980. It's difficult to pin down exactly when gender-affirming doctors should have been aware that their puberty suppression experiment was causing harm. Very early on, it was noted that all, or almost all, children were progressing to irreversible cross-sex hormones,[300] and the "problematic surgical outcomes" were recorded in scientific literature as early as 2008.[301] However, a firm line can be drawn with the findings of Sweden, Finland and England's systematic reviews in 2019 and 2020.[302,303,304] Each of these pre-dated the comments made by Bowers in the forum and those of the panelists in the Identity Evolution Workshop.

One of the most striking differences between the two scandals is the impact of the therapy on the young person's future chance of forming long-term romantic partnerships. The parents signing their children up for height-modification hormone therapy did so out of the well-intentioned belief that it would increase the chances that their children would find a romantic partner, lasting love, and marriage.

Conversely, the parents signing their children up for today's sex-trait modification hormone therapy don't seem to consider the fact that they are potentially ruining their child's future ability to form intimate relationships. Or, more likely, they do consider it, but they are coerced into agreeing by the transition-or-suicide lie that gender-affirming medical and mental health professionals tell reluctant parents.

The length of time the young people were to take hormones is also vastly different. For the height-modification experiment, the children could be on hormones for years, but as soon as they reached their final adult height, treatment immediately stopped. WPATH advocates for pediatric endocrinologists today to turn adolescents into lifelong medical patients, dependent on wrong-sex hormones for the rest of their lives, without any evidence that this treatment protocol is safe.

The clinicians in the 1950s and 1960s couldn't foresee a world where being tall would be socially acceptable for women and even admired, or the possibility that very tall or very short adults could develop resilience to conquer their perceived social disadvantage. Today, WPATH members cannot foresee their adolescent patients growing up, reconciling with their birth sex and no longer identifying as transgender, but the ever-growing number of detransitioners suggests this is not a rare occurrence. However, the young people having their bodies permanently altered by WPATH-influenced clinicians are not able to turn back the clock and undo the damage.

297 Hall, R., Mitchell, L., & Sachdeva, J. "Access to Care and Frequency of Detransition among a Cohort Discharged by a Uk National Adult Gender Identity Clinic: Retrospective Case-Note Review." BJPsych Open 7, no. 6 (2021). https://doi.org/10.1192/bjo.2021.1022. https://dx.doi.org/10.1192/bjo.2021.1022.

298 Boyd, I., Hackett, T., & Bewley, S. "Care of Transgender Patients: A General Practice Quality Improvement Approach." Healthcare 10, no. 1 (2022): 121. https://doi.org/10.3390/healthcare10010121. https://dx.doi.org/10.3390/healthcare10010121.

299 Ibid (n.48)

300 Ibid (n.294)

301 Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. "The Treatment of Adolescent Transsexuals: Changing Insights." [In eng]. J Sex Med 5, no. 8 (Aug 2008): 1892-7. https://doi.org/10.1111/j.1743-6109.2008.00870.x.

302 "Gender Dysphoria in Children and Adolescents: An Inventory of the Literature." Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019, https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/.

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CONCLUSION

As this report has shown, WPATH is not a medical organization. It is not engaged in a scientific quest to discover the best possible way to help vulnerable individuals who are suffering from gender-related distress. Instead, it is a fringe group of activist clinicians and researchers masquerading as a medical group, advocating for a reckless hormonal and surgical experiment to be performed on some of the most vulnerable members of society.

It would be criminal for a surgeon to sever the spinal cord of a person who identified as a quadriplegic or to blind a sighted patient who identified as blind. It is just as unethical to destroy healthy reproductive systems and amputate the healthy breasts and genitals of mentally unwell people. To do so without first even attempting to help the person overcome their mental illness, without realistically preparing the individual for the grueling post-op period or warning of the life-long negative effect that the procedures will have on their long-term health and ability to form intimate relationships amounts to medical negligence of the highest order.

Thus, there can be no doubt that we are currently witnessing one of the greatest crimes in the history of modern medicine. The scandal of WPATH's gender-affirming care combines all the elements of the four past medical misadventures outlined in our case studies.

Doctors cannot be trusted to regulate themselves. They, too, are human and possess the same inherent biases and vulnerabilities as the rest of us. This is especially true when groupthink takes hold and dissent is silenced. When a doctor stakes his or her reputation on a given treatment, it can lead to powerful conflicts of interest and confirmation bias, preventing even the most well-intentioned and competent physician from seeing the obvious harm being inflicted on patients. Bowers's claim in the New York Times, that the field of transgender medicine is "every bit as objective- and outcome-driven as any other specialty in medicine," demonstrates how blind WPATH's leadership is to the reality of the organization's unethical approach to medicine.

We have regulatory bodies to maintain ethical standards, and we therefore call on medical ethics boards across the US and the rest of the world to conduct urgent, unbiased, transparent, and rigorous reviews of the sex-trait modification interventions WPATH endorses. We also call on the APA, the AMA, the AAP, and The Endocrine Society to set politics aside and condemn the pseudoscientific, unethical medical practices of WPATH.

Furthermore, we call upon the US government to launch an official non-partisan inquiry into how an organization with such disregard for medical ethics and the scientific process was ever granted the authority to establish global standards of care in a field of medicine. We advocate for this drastic action due to the unwarranted prestige, undue influence, and resulting danger posed by WPATH.

WPATH serves no purpose, contributes nothing beneficial to the field of gender medicine, and leads medical and mental health professionals astray. Several European nations have already abandoned the group's guidelines, indicating the extent to which WPATH has become obsolete.

Political activism and medicine should never mix. An organization in pursuit of political goals is one not in pursuit of patient health. The WPATH Files contain abundant evidence that the organization is an activist group, not a scientific one. From the Alberta professor stating that trans health care is about challenging cisnormativity to Satterwhite and his supporters ignoring the ethical concerns of non-binary surgeries and focusing on the importance of using politically correct language, it is clear that WPATH prioritizes politics over science.

The medical world self-corrects by open discussion, scientific debate, and diligent investigation. None of these factors is present within the WPATH Files. Instead, there is political discourse and policing of language. When one

clinician posted a study about detransitioners, WPATH's president cautions that "acknowledgment that de-transition exists to even a minor extent is considered off limits for many in our community." Given the complexity of gender medicine, the controversy surrounding the treatments, and the drastic, life-altering effects of the hormonal and surgical interventions endorsed by WPATH, it is especially disconcerting that the Ontario family physician was the lone dissenting voice in all the files.

A medical organization that cannot face up to the devastating harm its treatments are causing is a danger to the patients it claims to serve. The unwillingness to acknowledge the victims of this medical scandal, the refusal to recognize the growing body of evidence showing that the risks of gender-affirming care greatly outweigh any supposed benefit, and the extreme beliefs of many of its members indicate that WPATH will never be able to correct its course. The internal communications demonstrate that the organization is corrupt to its core.

Currently, lawmakers, judges, insurance companies, and public health providers are duped into trusting WPATH's guidelines as a result of the broken chain of trust. These stakeholders are not aware that the political activists within WPATH are promoting a reckless, consumer-driven transition-on-demand approach to extreme body modification, even for minors and the severely mentally ill. It is for this reason that we believe the medical world must reject WPATH's guidelines.

Gender dysphoria is a complex psychiatric condition, and there is no easy answer as to the best way to ease the pain of those afflicted. It is beyond the scope of this report to attempt to find such a solution. However, it is possible to state with unequivocal certainty that the World Professional Association of Transgender Health does not advocate for the best possible care for this vulnerable patient cohort, and the detrimental impact of WPATH's actions over the past two decades has rendered the organization irredeemable. It is now imperative to usher in a new era in gender medicine, one that prioritizes the health and well-being of patients as its foremost objective.