# WPATH FILES EXCERPTS: EXPOSING THE REALITIES OF GENDER MEDICINE

# PREFACE

WPATH, and gender clinicians and activist groups more generally, insist that gender medicine is "settled science." They present puberty-blockers, cross-sex hormones and genital surgeries as "evidence-based" life-saving care and suicide prevention. Rachel Levine, the US Assistant Secretary for Health, claims there is "no argument among medical professionals – pediatricians, pediatric endocrinologists, adolescent medicine physicians, adolescent psychiatrists, psychologists, etc. – about the value and the importance of gender-affirming care."

But when gender clinicians and lobbyists think no one else is listening, what they say can be quite different – and shocking. They:

1. Make clear they give cross-sex hormones and surgeries to people with limited or no capacity to consent, including people with major mental illnesses and minors
2. Acknowledge that minors do not understand the long-term consequences of "gender affirmation," including sterility
3. Discuss extreme body-modification surgeries, such as removing genital organs entirely or creating a neovagina alongside a penis, with no medical justification
4. Frame detransition and post-treatment regret as trivial
5. Claim that minors should be given life-changing hormones and surgeries because otherwise they will kill themselves – despite no evidence that such interventions make suicide rarer
6. Describe serious side effects (including fatal ones) and common sub-optimal outcomes

All the quotes come from WPATH members, in posts on the WPATH members' forum or during internal panel discussions. The full materials will be made available to journalists.

## An Unethical Approach to Consent Among Adults with Comorbidities

**Patients with dissociative identity disorder are regarded as having the capacity to consent to hormones:**

> *"One client who had [dissociative identity disorder], we worked on all alters giving consent to HRT before it was started. They had alters who were both male and female gender and 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 could be sued later, if they decide HRT or surgery was not in their best interest."*
>
> Gender therapist

**So are patients with severe mental health issues.**

**In reply to a nurse practitioner who is struggling with how to handle a patient with PTSD, major depressive disorder, observed dissociations, and schizoid typical traits who wishes to go on hormone therapy:**

> *"I'm missing why you are perplexed… 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…So why the internal struggle as to 'the right thing to do?'"*
>
> Dr. Dan Karasic, lead author of WPATH Standards of Care 8 mental health chapter

**Mentally ill and homeless people are regarded as suitable for referring for genital surgery:**

> *"I have also intervened on behalf of people who have been diagnosed with major depressive disorder, cPTSD, homeless and got at least an orchiectomy… In the last 15 years I had to regrettably decline writing only one letter, mainly b/c 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."*
>
> Gender therapist

**There is a lack of concern regarding young people regretting sacrificing their fertility:**

> *"Some of the Dutch researchers gave some data about young adults who had transitioned and [had] reproductive regret, like regret, and it's there, and I don't think any of that surprises us."*
>
> Dr. Daniel Metzger, Canadian endocrinologist

## Minors Offered Life-Changing Interventions They Cannot Fully Understand

**Concerning whether is it reasonable to expect children and young adolescents to grasp the effects of "gender-affirming care:"**

*"[It is] out of their developmental range to understand the extent to which some of these medical interventions are impacting them. 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."*

Dianne Berg, child psychologist and co-author of the child chapter of WPATH Standards of Care 8

*"We're often explaining these sorts of things to people who haven't even had biology in high school yet."*

Dr. Daniel Metzger, Canadian endocrinologist

**Dr. Christine McGinn, American plastic surgeon, reported performing about 20 vaginoplasties on patients under 18 over a 17-year period and confessed that:**

*"not all… had perfect outcomes"*

**On the complexity of discussing fertility preservation with children and adolescents during an internal panel discussion:**

*"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. They'd be like, ew, kids, babies, gross…*

*"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…' So I think, you know, it doesn't surprise me…*

*"Most of the kids are nowhere in any kind of a brain space to really talk about [fertility preservation] in a serious way."*

Dr Daniel Metzger, Canadian endocrinologist

## Extreme Body Modifications with No Medical Justification

*"I've performed mastectomies without nipples, or have created chests with varying degrees of remaining breast tissue, or created incision patterns specific to my patient's wishes. For bottom surgery, I've performed minimal-depth vaginoplasties (vulvoplasties), phallus-preserving vaginoplasties, and nullification procedures. I'm quite comfortable tailoring my operations to serve the needs of each patient."*

Dr. Thomas Satterwhite, California surgeon

*"How do we come up with appropriate standards for non-binary patients? What best practices and standards are you following in your experience? I've found more and more patients recently requesting 'non-standard' procedures such as top surgery without nipples, nullification, and phallus-preserving vaginoplasty."*

Dr. Thomas Satterwhite, California surgeon

*"[Gender clinicians should provide care for] 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."*

Activist law professor

*"I think we are going to see a wave of non-binary affirming requests for surgery that will include non-standard procedures. I have worked with clients who identify as non-binary, agender, and Eunuchs who have wanted atypical surgical procedures, many of which either don't exist in nature or represent the first of their kind and therefore probably have few examples of best practices…"*

Doctor

## Detransition and Suicide Prevention

**In reply to a post about a detransition study:**

> *"acknowledgment that de-transition exists even to a minor extent is considered off limits for many in our community,"*
>
> WPATH President Marci Bowers

> *"individuals are entitled to make their own mistakes, and while medical systems and professionals can and should help them avoid mistakes, the power dynamic between a gender specialist and their patients, and between cis and trans people more generally, means that some mistakes are valued higher than others."*
>
> Researcher

> *"What is problematic is the idea of detransitioning, as it frames being cisgender as the default and reinforces transness as a pathology. It makes more sense to frame gender as something that can shift over time, and to figure out ways to support people making the choices they want to make in the moment, with the understanding that feelings around decisions [may] change over time."*
>
> Researcher

**In reply to a therapist concerned about a 13-year-old "nonbinary" natal female with an eating disorder who is requesting testosterone, a pediatric endocrinologist recommended the child "be living as the other sex for 6-12 months" and have "at least one supportive parent." She added:**

> *"it is very difficult to ask that they wait until 16 because by then they will be dealing with menstrual periods and complete breast development. Waiting appears to increase the rate of suicide attempts."*

## Serious side effects and common post-surgical complications

**An exchange between two doctors about the severe, potentially fatal, side effects of testosterone use in natal females (testosterone is a known carcinogen):**

> *"[16-year-old female patient] 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… We are prepared to support the patient in any way we can (e.g. top surgery when medically stable, etc)."*
>
> Doctor

> *"I have one transition friend/collegue [sic] who, after about 8-10 years of [testosterone] developped [sic] hepatocarcinoma. To the best of my knowledge, it was linked to his hormone treatment… it was so advanced that he opted for palliative care and died a couple of months later."*
>
> Doctor

**Speaking of a "young patient" who developed pelvic inflammatory disease after three years of testosterone:**

> *"has atrophy with the persistent yellow discharge we often see as a result."*
>
> Nurse practitioner

**And describing young natal females developing:**

> *"pelvic floor dysfunction, and even pain with orgasm."*
>
> Doctor

> *"I used to have bleeding after penetrative sex. It would hurt to have an orgasm… My uterus atrophied also."*
>
> Trans-identified female emergency medical technician (paramedic)

**Natal male patients on estrogen are described experiencing:**

> *"[erections] feeling like broken glass."*
>
> Registered nurse

**Poor outcomes are accepted as a fact of life:**

> *"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…if the patient can't follow the dilation schedule, they may lose depth, but as long as they're capable of making that decision of sound mind while informed of the risks, then that may be all you can do."*
>
> Doctor