Testimony Summary of Dr. David Bonnet

Proponent of House Bill 68

To Distinguished Chairperson Senator Roegner, Distinguished Vice Chair Antani, Ranking Member Hicks Hudson, and other Distinguished Members and Representatives of the Senate Oversight and Reform Committee, thank you for the opportunity to provide proponent testimony for HB68.

This is a summary of the formal written testimony for easier following. It will demonstrate 3 main points for being a proponent for HB 68, with examples and citations from my main written testimony:

1) There is an ideological push, unsupported by science, underlying the urgency with which "gender affirming" therapies are being marketed.
2) The medical literature with respect to gender-affirming care is incomplete at best, and biased and poor quality at worst, which is leading to harmful and deadly outcomes and consequences/especially for children, thus making true informed consent impossible. In addition, even with adequate informed consent, children have never been regarded as having agency in decisions of this magnitude.
3) This is not a partisan issue. Scientists, child advocates, and physicians of both parties are speaking out. Many of them are socialists, queer or trans themselves, or have been involved in pioneering the development of these treatments, here and abroad. (Kaltiala, McHugh, Hilary Cass)

These arguments span five major categories:

1) History

a. Physicians, regardless of stature or renown, are not immune from falling on the wrong side of medical issues, and very often as a result of assuming knowledge where none or inadequate information exists (Gross, Moniz, Tuskegee Experiment, Codman) or worse, when ethics and contra-ideological information is ignored (Tavistock, Jaime Reed, hypothermia)
b. Transsexualism has been around for a long time, first as a phenomenon of middle age white males from the 50s-90s.
c. After the 1990s the demographic changed, from adult men to gender dysphoric boys, and now to teenage girls, many with severe mental health disorders, as well as significant numbers of autism. This phenomenon has not been adequately explained.
d. In addition to the change in demographic, the volume has increased by twenty-fold or 4000% (GIDS clinic, Tavistock)
e. The number of "gender-affirming" care clinics in the US has gone from 1 in Boston in 2007 to over 100 today. There are no consistent protocols or oversight of these clinics. (Reuters investigation, Washington University, Jaime Reed)
f. Many of these clinics, in the US and elsewhere, were protocolized based on a Dutch study by DeVries et al in 2011.

2) Lack of foundational evidence, misinterpreted conclusions, or misleading information used to support U.S. "gender-affirming care", and which are leading to genuine harm. Also, we have little to no information regarding

long-term consequences of these treatments, both physically and psychologically.

a. An oft-repeated statistic has suggested that non-intervention risks a suicide rate among transgendered of 41%. There is no high-quality evidence supporting this.
b. Multiple studies for supporting data have had to be corrected or retracted, including a groundbreaking American Journal of Psychiatry article asserting great benefits from gender affirming care.
c. An article in Sweden by Dhejne, using multiple generational databases, followed patients thirty years, which is extremely rare. They found a rate of suicide of 19 times the general population and all-cause mortality of three times, not only invalidating Branstrom Journal of Psychiatry data, but also suggesting **serious complications to these treatments may not even be evident until long after the patient is lost to follow up.**
d. Many, if not all, of these clinics are not following the Dutch protocol as it was designed.
e. Significant flaws have been found with the Dutch studies, including bias, loss to follow up, exclusion of contravening data or cohorts (eg "detransitioners"), inadequate study size, and inadequate long term follow-up.
f. Loss to follow up and exclusionary cohorts (ie "detransitioners") are **significant confounders** to a substantial number of gender affirming studies and invalidate the findings.
g. The level of professional disagreement and inconsistency of the literature **is itself** *prima facie* evidence that we are proceeding too rapidly.

3) Examples of severe risk and harm from the literature, as it exists.

a. There is substantial literature suggesting that patients subject to puberty blockers and gender reassignment surgery are at significant higher risk of fertility problems and sterility, heart disease, cognition problems, sexual dysfunction, (specifically anorgasmia), incontinence, repeated surgical revisions and complications, bone density, and liver dysfunction.
b. There does not appear to be evidence that there is a decrease in suicide post treatment.
c. The medicines used to block puberty in transgender individuals are not FDA approved except for precious puberty. Many of them are primarily used for other diseases like bicalutamide for prostate cancer.
d. The FDA has reported a significant number of adverse events for puberty blockers.
e. The makers of many of these puberty blockers have declined to seek FDA approval for them.

4) Testimony and publications of well-regarded scientists and clinicians that are now arguing for these treatments to be stopped until adulthood or only allowed in the context of a well-designed and supervised clinical trial.

a. Paul McHugh, Psychiatrist in Chief of Johns Hopkins, ended these treatments at JH when his own department published a study demonstrating no benefit.
b. Riittu Kaltiala, adolescent psychiatrist in Finland, helped pioneer these treatments, but subsequently led an effort to curtail them (COHERE trial) when data emerged showing harm and flaws of original studies.

c. Hilary Cass, Pediatrician in Chief of the NHS, former President of the Royal College of Pediatrics and Child Health, and one of the most respected clinicians in the UK, was tasked with an independent review of the largest gender clinic in the UK: the Tavistock GIDS clinic. Her independent investigation found shoddy practices and lack of evidence. Tavistock was shut down.

d. Sweden, France, New Zealand, and other countries are now looking carefully at the potential harm.

e. There have been multiple whistleblowers on these treatments, some of whom are gay or lesbian, queer, or trans themselves, scientists, both in the US and UK (Jaime Reed). It cannot be concluded, then, that this is an issue of "transphobia", "science denialism", or "religious dogmatism."

f. Increasing numbers of "detransitioners" are calling for investigations into these therapies, with claims of negligence, inadequate information, and even fraud; among them Chloe Cole, Keira Bell, and others. Ms. Bell brought light to Tavistock when she sued the NHS.

5) That many of the arguments of the transgender movement are internally contradictory, which renders public policy decisions more complex than ideology would prefer, and the lack of consistency and agreement makes it even more important that we proceed slowly, methodically, and carefully and we develop treatments for gender dysphoria.

a. Gender cannot simultaneously be socially constructed and inherent to the individual.

b. Gender identity cannot be simultaneously self-chosen and the product of socialization.

c. Gender identity cannot simultaneously be invisible AND socially verifiable.

d. Gender cannot be both independent of sex and defined with reference to sex.

e. Even as we see the demographic change to disproportionately adolescent females, we see a completely different phenomenon in sports, where transgirls and transwomen engage in sports teams by a significant margin. This is also unexplained.

f. The development of identity is the outcome of a complex interplay of social, physical, cultural, and emotional variables in development. It cannot be considered the beginning of the process, inscrutable and unquestioned, which is what we have established in the US.

g. the origin and history of transgender scholarship, characterized by icons such as Susan Stryker and Rosa Lee, who use in their writing undisguised rage and nakedly political rhetoric, makes it especially appropriate to view the inexplicable urgency of medicating and surgicalising children with a skeptical eye.

To Distinguished Chairperson Senator Roegner, Distinguished Vice Chair Antani, Ranking Member Hicks Hudson, and other Distinguished Members and Representatives of the Senate Oversight and Reform Committee, thank you for the opportunity to provide proponent testimony for HB68.

My name is David M. Bonnet. I am a practicing physician and physician leader, in continuous practice for over 25 years. I trained in the specialties of internal medicine and pediatrics and am board certified and I currently practice in the field of inpatient internal medicine and critical care. For both professional and personal reasons, I am here to testify on behalf of House Bill 68 of the 135th General Assembly. My thoughts and statements are my own, and do not reflect, except by coincidence, any statement of affirmation by either any professional medical society or my employer.

I have detailed below how I will outline this testimony. But first I would like to share a story to illustrate the greater importance of this issue:

At the 1876 Centennial Exhibition in Philadelphia, there was at the time an odd exhibit by a British surgeon named Joseph Lister, outlining an elaborate and time-consuming procedure called "antisepsis", that would protect surgical and other patients from previously unknown "microorganisms". Despite 11 years of data from Britain and the rest of Europe showing plummeting surgical mortality, American surgeons scoffed. One American surgeon, Samuel Gross, remarked, ***"Little, if any, faith is placed by any enlightened or experienced surgeon on this side of the Atlantic in the so-called "treatment" of Professor Lister."*** He continued, ***"The whole theory of antisepsis is not only absurd, it is a positive injury."***

But Dr. Gross wasn't just any doctor. He was the President of the American Medical Congress, the precursor of today's American College of Surgeons, and arguably the most famous surgeon in the US at the time.

Dr. Gross, if you could ask him today, would have told you he was protecting people by his statement and actions. **But he was wrong.** And Dr. Lister's "absurd theory" of antisepsis is now the standard of care in every competent healthcare facility and surgical suite in the world. (49) (50) (51) (52) (53)

In 1914, a surgeon named Ernest Codman proposed to his colleagues at the Massachusetts Medical Society that they should do reviews of their surgeries to ensure standardization and quality. For his trouble, he was expelled from the MMS, lost his position at Mass General, and although subsequently created his own hospital using his own fortune, he ultimately died penniless. Nevertheless, his work and opinions are now the basis of modern quality improvement and have improved the care of millions of people. Indeed, the highest award the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) gives is called the "Codman Award". (54)

In 1932, six hundred sharecroppers from Macon County, Alabama, with the promise of free medical care, were recruited to study syphilis, which at that time had no cure. In order to track the disease's full progression, researchers provided no effective care as the study's African American participants experienced severe health problems including blindness, mental impairment—or death. Those researchers were not only wrong but had wrong motivations as well. It is now known, infamously, as "The Tuskegee Experiment."

There are many other examples, but I trust the point is clear: in each of the three examples given, if asked, the clinicians involved would have assured you that they were protecting people......helping people.

And in every case, history has proven each of them tragically, spectacularly wrong.

So too, I believe, with the more recent modern phenomenon of "gender-affirming care". News about the transgender movement seems to be everywhere these days. It seems daily we hear stories of teachers and activists using public classrooms or social media to influence, or perhaps propagandize, children on its behalf; or for state legislatures to enact laws that are purportedly to "protect children" by criminalizing their parents for not "affirming" what is an incompletely studied emerging science. Most notably, it appears to this clinician that the medical industry and related institutions are becoming co-opted by this movement to promote a dangerous and false narrative: that the only compassionate solutions for transgender and gender dysphoric children involve what is euphemistically referred to as "gender affirming care", which increasingly involve both off label use of puberty blocking drugs or permanently disfiguring surgery at earlier and earlier ages. And I believe this movement is and has been relying on false narratives, poor and incomplete science, and even increasingly deceptive and bullying tactics towards those who would oppose them to do so, which I will detail below.

It is for these and other reasons that I chose, as a citizen, as a father, and as a practicing physician for 25 years, to speak out against this barbaric and unscientific trend and in support of House bill 68 which proposes to ban these practices in children who cannot possibly understand the long-term implications (or potential complications) of what they are agreeing to in the near and especially long term. In this testimony I would like to demonstrate several points:

1) I will dispute the notion that this care is inherently "compassionate" and by converse, that withholding it or not pursuing it constitutes "hate", "phobia" or "lack of compassion". Indeed, I will demonstrate that the lack of foundational evidence of these therapies invariably results in documented disproportionate ***avoidable harm***, physically and emotionally, and that even when implemented by well-meaning people, is the opposite of compassion. It is indeed crueler than any discrimination.
2) I will demonstrate that the science that underlies these treatments are often shoddy in quality, with significant confounders which would invalidate the validity of their conclusions. Conversely, I will also demonstrate that far superior studies which would refute the previous conclusions of efficacy are often ignored or hidden, not only by the transgender movement, but by media as well.
3) I will give examples of how the arguments for the movement itself lack internal logical consistency, leading to the negation of the premise, but also tangibly negative and incoherent policy decision which affect things like women's sports, and safe spaces, and achievements.
4) Our European colleagues, many of whom pioneered these treatments, are rapidly hitting the brakes and sounding the alarm on these treatments as the lack of supporting evidence becomes clearer, even as we in the US are rapidly expanding access to them.
5) Although tangentially related, the history of this movement is relevant, as its original proponents own politically charged words belie an agenda that is counterintuitive to its claims of altruism and compassion, while simultaneously explaining why, to the casual American observer, there

has been an inexplicably urgent movement from a vanishingly small group of individuals on the fringe to a sudden priority of the mainstream in some of the oldest institutions.

I have tried, wherever possible, to use the highest quality peer-reviewed data (where available---data for many of the claims of these treatments is limited at best, thus underscoring the point) and accurate sources, as well as direct quotes from individuals with sources. In addition, because this is an emerging area of medicine, there is variable agreement on definitions, but for purposes of clarity, I have included some of the most misunderstood definitions here:

1) "Gender dysphoria"- the condition whereupon one believes their "physical" self or identity does not match their "perceived" self or identity.
2) "Transgender"- a person with gender dysphoria whom has taken steps, (from adjusting pronouns and clothing all the way to gender reassignment surgery), to rectify the perceived discrepancy between their physical and perceptual selves
3) "Confounder"- in research, is a variable or other piece of information, that, by its inclusion AND exclusion, can affect, often negatively, the validity of data and conclusions of studies. (55)

There are two other points before beginning which are extremely important: the first is that gender dysphoria is real and transgender people are real, and their experience of suffering is agonizing and heartbreaking, for them and their families. For many, this seeming discordance drives many to drugs and alcohol and even suicide. But they are in deep need of compassion, community, dignity, belonging, and solutions, not drugs and surgery, as I will show. It is imperative that as we seek out solutions for them, we remember that this is a group of people in need, but that affirmation does not necessarily equate to compassion.

The last point may be in many of your minds: why should the government be involved in this? Why shouldn't this be a decision between a healthcare professional and their patient(s)?

The answer is simple—because doctors make mistakes, both scientifically and ethically. In fact, in between many amazing and dramatic successes for humanity, as I noted above, we have peppered within them spectacular harmful failures: malarial therapy, deep sleep therapy, insulin shock therapy, cardiazol therapy, and psychosurgery, all of which would be viewed today as terribly harmful, and appropriately so. As Mary Shelley so deftly and cleverly themed in her famous allegorical novel Frankenstein; when science is stripped of its ethical and moral boundaries, tragedy, sorrow, and monsters result—figuratively and literally. The doctor-patient relationship, while unique and intimate, has never been, is not now, and should NEVER be a cover for the propagation of harmful therapies. Oversight and accountability are REQUIRED, just as we would require in any other industry, especially if the area involved is emerging or with limited data.

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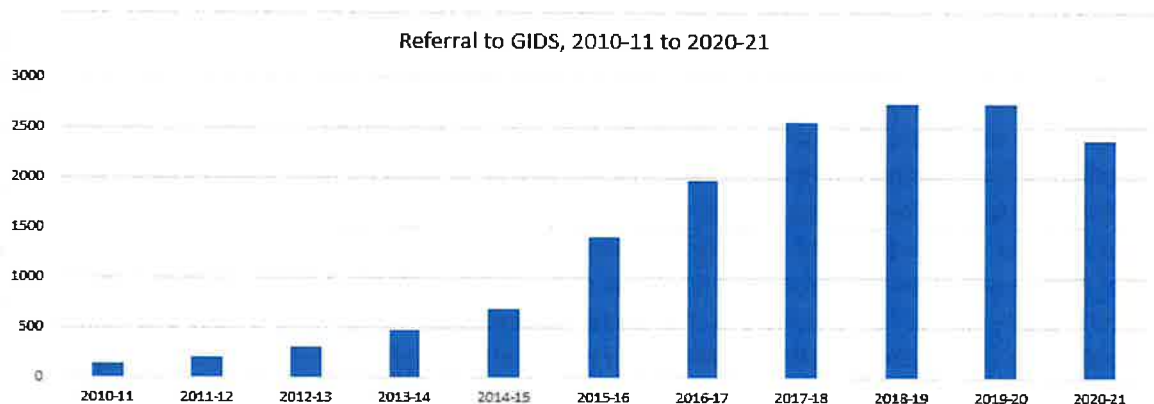
In order to understand how we have arrived to be faced with these decisions, it is critical to understand a little of the history and thought processes that underlie this complex issue, both here and in Europe.

What we today refer to as "transgenderism", was since the 1950s or 60s, up until the 2000s referred to as "transsexualism", and was disproportionately a phenomenon of adult middle-aged white males. (1)

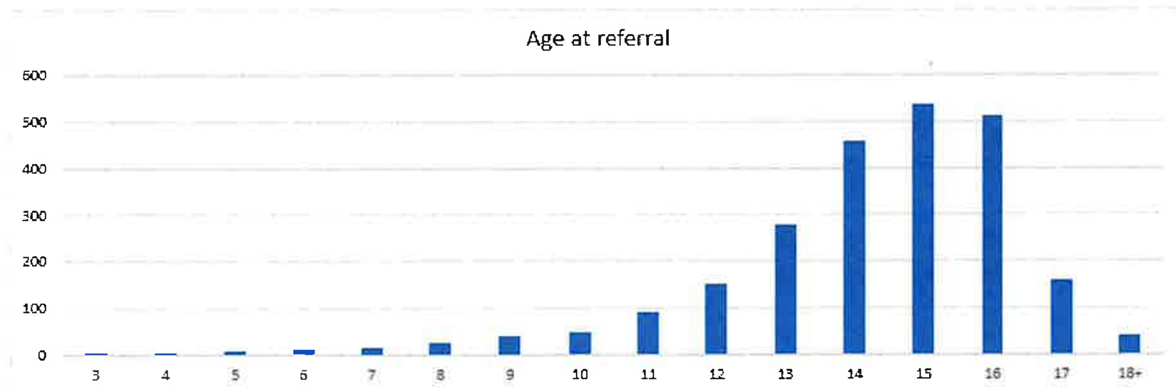
Indeed, In the 1960s, a British survey demonstrated almost all (>90%) transsexuals (now transgender) were adult white males (2) There are no reports or studies of gender dysphoria in children for this period in history, although more recently, there have been retrospective efforts to classify historic individuals, like the teenage Roman Emperor Elagabalus, as such. (3) however, there were notable examples of transsexuals, such as Alan Hart, the first recorded transman in the US to receive a hysterectomy. (104)

However, over the intervening years, that demographic started to morph, for reasons still unclear, from disproportionately adult male to pediatric age gender dysphoric boys with no comorbid mental health problems, and then, by 2012-15, to disproportionately teenage girls, many of whom had severe mental health disorders accompanying gender dysphoric thoughts. (4)(5)(6). Indeed, there was hardly any scientific literature before 2012 on girls ages 11 to 21 ever having developed gender dysphoria at all. Yet of the young people described in Lisa Littman's 2018 seminal paper on young people (4), 82.8% were now female. Nevertheless, this population was still comparatively small as of 2018. (7) *{Citation #7 presented the results of North American studies using short (one to three item) self-reports of gender identity and its variance. The studies suggested that 0.17%–1.3% of adolescents and young adults identified as transgender. This is notable because it was authored by one of the earliest advocates of pediatric gender care, Dr. Riittakerttu Kaltiala, one of the most respected adolescent psychiatrists in Finland, and a respected academic in this field, and who is now speaking out about the dangers of these practices.}* (8)

In addition, it should be noted that besides a complete shift in age and sex demographic, across the world there has been a twenty fold rise in those seeking transition, again without adequate study or explanation for the trend: The UK's Gender Identity Development Service at Tavistock (which has now been shuttered, due to corrupt and poor practices—see below) reported a twenty-fold increase in referrals over the course of the last decade: (1) (2)



The above surge was driven primarily by adolescent girls with a mean age of 15 (2):



New Zealand, (9) Finland, (7) Sweden, and Canada (10) have recorded similar dramatic exponential increases.

So we have established that over an approximate 50 year period, a substantial demographic change occurred in transgenderism, from that of white adult males to that of adolescents, disproportionately female, without adequate explanation, although there have been many theories. This realization came not out of study, but rather direct observation: these were the people seeking out care and transition in particular. (1) (9) (7) (2) (10)

But how did we get from there to advocacy for largely unproven and risky treatments which would be likely be permanent modifications in children? The answer is multifactorial, but there are a couple of prominent arguments, both current and historic. As demonstrated above, for decades the primary transgender demographic was adult white males. Because these individuals had already undergone male puberty, evidence of this was permanent and difficult to hide, making seamless integration into society as the opposite sex difficult, if not impossible, and as such, these individuals were quite regrettably subject to ostracization, (11), isolation, and even violence. (12) (13). Therefore, the argument went, if intervention could occur **earlier**, either before the permanent changes of sexual development were completed, or ideally, even before they began and interventions were started to match (and in the United States to "affirm") the perceived vs. biologic gender, then not only would the worst of the punitive isolation, prejudice, and violence that transgender individuals were unfortunately subjected to would be mitigated, it would also would lessen incidence of suicide and depression. This would be achieved specifically with therapy, and possibly puberty blocking drugs, ultimately leading to cross gender hormone therapy for life, and even sex reassignment surgeries. (14)

However, the scientific evidence to support the risks of non-intervention has been both overstated and misrepresented. (15) (16) (17) (18) (19) (20) (21). Conversely, the evidence used to assess risk, both short and long term, and been understated or ignored, to the extent it exists at all. *** (26) Indeed, multiple lawsuits, from individuals who feel they were misled on the evidence supporting these treatments' efficacy, are now starting to arise. (25) (27) In addition, even when successful protocols have been developed for purposes of scientific assessment, frequently the components that made them successful have not been followed. (23) (28) Indeed, in converse to a successful Dutch protocol developed for gender dysphoric boys where no puberty blockers were given before 6-18 months of intensive psychiatric therapy, a recent Reuters investigation demonstrated that at some U.S.

clinics, *puberty blockers were given as quickly as after 1-2 visits, and at least a few were prescribed immediately after the inaugural visit.* (22) (23) (28) At one institute, Washington University in St. Louis, a case manager, Jaime Reed, herself a queer woman, became a whistleblower to the Missouri State Attorney General, decrying sloppy practices and concerns of unscientific treatments and complications. (22) (23), and whose account was vindicated by the New York Times. (24)

*** ***This list of citations here supporting the severe risk of these treatments and "gender-affirming care" is substantial. I will provide details, by category, in a subsequent section.***

Nevertheless, out of these above demographic observations was developed one of the first protocols, by DeVries and Co, in the Netherlands in 2011. Consistent to that written above, it established that if young people with gender dysphoria were able to avoid natural puberty by blocking it with pharmaceuticals, followed by cross-gender hormones, they could start living their "authentic lives" earlier, more safely, and more credibly. (29) It became known as the "Dutch protocol" (8) and was the template for the development of multiple treatment centers and clinics, all over the world, including many in the United States. While the first gender care clinic was inaugurated in Boston in 2007, that number, following the Dutch protocol, expanded dramatically from a few before 2011, to over 100 today (30). However, it is important to recognize that the "Dutch protocol" study cohort involved almost exclusively young boys, carefully selected, high functioning and with no history of psychiatric problems. And DeVries and Co's analysis and data suggested that with early intervention, these boys thrived as the opposite sex. (29).

However, over time, several things started to occur all at once. After the Dutch Protocol became the gold standard of pediatric gender care and there was an explosion of gender clinics all over the world based on their treatment plan and increasing demand for therapies, severe criticisms of the validity Dutch's data began to emerge.(8) (30) **Specifically, a high risk of bias, incompleteness of evidence of regarding physical health risks, poor generalizability and applicability to current cases that clinicians were seeing worldwide.** (31) To quote one of the authors of this devastating critique.

> "What the studies ***failed*** to show, however, is that these physical changes resulted in meaningful psychological improvements significant enough to justify the adverse effects of the treatment—including the ***certainty*** of sterility." (30) (31)

Emphasis the authors. In addition to this severe rebuke of the now (circa 2011-2015) standard of care, it also noted a tendency, particularly in American clinics, to dismiss notions of scientific uncertainty and understate health risks. In contrast to the European physicians, who felt that identity formation was the outcome of a complex and healthy developmental process, the American physicians were arguing that the ***assertion*** of identity was the ***beginning*** of the process, and the assertion itself was not subject to scrutiny. Again the authors: (30)

"As a result, a false narrative has taken root. It is that "gender-affirming" medical and surgical interventions for youth are as benign as aspirin, as well-

studied as penicillin and statins, and as essential to survival as insulin for childhood diabetes—and that the vigorous scientific debate currently underway is merely "science denialism" motivated by ignorance, religious zeal, and transphobia (Drescher et al., Citation2022; McNamara et al., Citation2022; Turban, Citation2022). This highly politicized and fallacious narrative, crafted and promoted by clinician-advocates, has failed to withstand scientific scrutiny internationally, with public health authorities in Sweden, Finland, and most recently England doing a U-turn on pediatric gender transitions in the last 24 months (COHERE (Council for Choices in Health Care), Citation2020; Socialstyrelsen [National Board of Health and Welfare], Citation2022; National Health Service (NHS), Citation2022a). In the U.S., however, medical organizations so far have chosen to use their eminence to shield the practice of pediatric "gender affirmation" from scrutiny. In response to mounting legal challenges, these organizations have been exerting their considerable influence to insist the science is settled (American Medical Association (AMA), Citation2022). We argued that this stance stifles scientific debate, threatens the integrity and validity of the informed consent process—and ultimately, hurts the very patients it aims to protect." (31)

Also happening at the same time was a dramatic increase in a demographic completely unlike the cohort in the Dutch protocol; that of teenage girls, many of whom had pre-existing or comorbid psychiatric issues. In one study, 48% of children and young people who were seen in GIDS (Gender Identity Development Service of Great Britain) and whose parents completed the social responsiveness scale (SRS), a quantitative measure of autistic behaviors in children and young people, **scored in the mild to severe range.** (32) In another in the British Medical Journal, around 35% of young people referred to GIDS, presented **with moderate to severe autistic traits.** (33)

As one can see, a disturbing pattern was beginning to emerge; even as demand for these services skyrocketed worldwide: greater and greater observations of gaps in scholarship were being made (31), confounders in previously unscrutinized papers were being identified (data points that by their inclusion and especially by omission invalidate the conclusion from data) (31) (32) (33) (34), and it was becoming undeniable that conclusions based more on ideology than on scholarship were being made (31).

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So we have established dramatic unexplained changes in demographics over time, along with new interest in explaining the phenomenon, (1) (2) (35), shown the establishment of a gold standard for gender care worldwide, as well as demonstrated that the underpinnings of that same standard were starting to be questioned, even as demand for the services exploded.

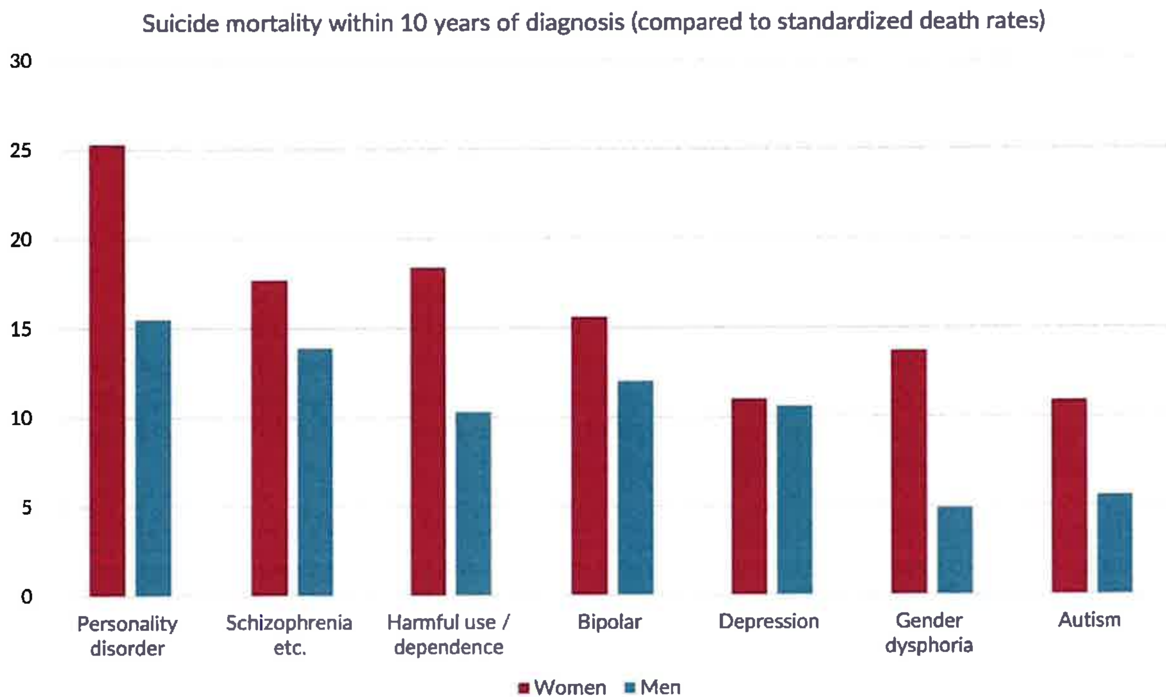
That last phenomenon seemed to then be characterized by a sense of urgency that had not previously been experienced. These discussions and observations also became characterized by an increasing hostility to any criticism, as well as a tendency to overstate risks of non-intervention (such as suicide) and both overstate benefits of intervention, as well as minimize short- and long-term physical risks:

Let's look at a couple of notable examples of these patterns:

One notable example of this is the incidence of suicide in these patients. This is a key point because the risk of suicide is frequently cited as one of the underlying reasons used to support the risk/benefit ratio of being aggressive with gender care. An oft repeated statistic in gender clinics and in the media, is that the suicide rate of transgender youth is 41% (15) (36) and is taken from the National Transgender Discrimination Survey. (16) However, a 2021 paper (17) observed that the participants were recruited through transgender advocacy organizations and subjects ***were asked to "pledge" to promote the survey among friends and family.*** This recruiting method yielded a large but highly skewed, ***and unscientific*** sample. By targeting transgender advocacy groups, the survey underrepresented the experiences of transgender individuals who are not politically engaged. Also, a very high number of the survey participants (nearly 40%) ***had not transitioned medically or socially*** at the time of the survey, and a significant number reported no intention to transition in the future, thus invalidating the conclusion.

Also, it is often overlooked, in the ideological interest of not classifying gender dysphoria as a mental illness or delusion, that people with psychiatric and neurodiverse conditions are much more likely to die of suicide than gender dysphoric people:

A Swedish study observed that suicide rates for personality disorder, schizophrenia, substance addiction, bipolar and (among males) depression and autism were all higher than suicide rates for gender dysphoric people: (37)



These high rates of completed suicides were subsequently confirmed by another study (38) which put the lifetime risk of suicide death for schizophrenics at 5.6%. This study also found that "the absolute risk of suicide in different psychiatric disorders to vary from 2% to 8%, higher for men than for women and highest for men and women with bipolar disorder, unipolar affective disorder, schizophrenia, and schizophrenia like disorder."

Lastly on this particular subject, there is a competing notion used by clinician advocates that argues that converse: that earlier intervention decreases suicide. That, too, has been found not only to be unsupported in the medical literature, but rather, that the opposite was likely true.

Indeed, one of the most influential studies on the value of treating gender-dysphoric patients with "gender-affirming" care, by Bränström et al in a 2019 article for the American Journal of Psychiatry, (40) had to be corrected. (39) The Bränström study reanalysis in 2023 was instigated by severe criticism of the study by multiple clinicians from around the world, including Paul McHugh, who was Psychiatrist in Chief at Johns Hopkins, and whom both pioneered these treatments at Hopkins, but also ended them when his own department published literature demonstrating no benefit to the care. The reanalysis noted that neither "gender-affirming hormone treatment" nor "gender-affirming surgery" reduced the need of transgender-identifying people for mental health services.

The authors of the critique, led by Van Mol, (41) made several very important critiques of the article, starting with the increasingly common issue of researchers being unable to reproduce the findings of any particular study- a "crisis of irreproducibility"—a term coined by no less a figure than Frances Collins, director of the NIH. To quote the authors:

"Perhaps nowhere in medicine and psychology is this problem of irreproducibility worse than in studies of people who claim to have a mismatch between their sex and their internal sense of being male or female." (39)

The authors continued, identifying major flaws in the studies, including but not limited to the overlooking of the key data points of completed suicides, health care visits, prescriptions, and hospitalization for the litany of other medical or psychological diagnoses potentially related to gender affirming treatments. In addition, they noted, all of these things were available to the researchers through multiple registries because Sweden has a Nationalized Healthcare System with sophisticated data analytics. Yet they were not utilized for unclear reasons.

More concerningly, existing readily available data, also from Sweden, and better designed, not only showed no benefit to gender affirming interventions, but also showed ***much higher morbidity and mortality*** in the 2011 Dhejne study. The Dhejne team made extensive use of numerous, specified Swedish registries and examined data from 324 patients in Sweden over thirty years who underwent sex reassignment. They used population controls matched by birth year, birth sex, and reassigned sex. ***When followed out beyond ten years, the sex-reassigned group had nineteen times the rate of completed suicides and nearly three times the rate of all-cause mortality and inpatient psychiatric care, compared to the general population.*** These important findings could have easily been updated by Bränström and Pachankis to the more current time frame, but they were not. (45)

Similarly, multiple other studies support similar conclusions to Dhejne. (47) One such study noted that after sex reassignment surgery, one study showed that adult transsexual clients were 4.9 times more likely to have made a suicide attempt and 19.1 times more likely to have died from suicide, after adjusting for prior psychiatric comorbidity (44) Yet another study in the European Journal of Endocrinology demonstrated that suicide rates among transgender male-to-females were 51% higher than the general population. (46)

We can therefore see the problem with these studies: one of the most influential scientific supports for the argument for early aggressive gender therapy not only had to be retracted for incomplete data and probable bias, but similar and superior studies ***show exactly the opposite.*** This level of uncertainty and incongruity make dogmatic claims such as "the science is settled" extremely questionable. (43) Thus, if **one** aspect of **one** risk factor of gender-affirming care can have such widely variable results, how can we legitimately argue that we have intellectual scientific standing to assess risk and informed consent of these and other procedures?

As noted above, the aforementioned is *one* aspect of *one* dimension of psychiatric risks for transgender patients. But what of the potential physical risks, of which the evidence demonstrates that there are many? Some would argue that the risks of intervention and regret are minimal in comparison to the risks of non-intervention (48). However, as we have shown, some of these arguments are based on clinical literature like the influential Bränström study above, which had to issue a correction, if not a total retraction.

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So let us walk through some of the potential physical implications of these treatments and their supporting data. While the literature in this area is still emerging and incomplete, early studies are extensive. For that reason, I have decided to arrange a number of these potential risks topically for ease of reading as well as reference. I have attempted to use the best available studies to underscore my points.

Fertility:

-One study in 2023 found that long-term testosterone exposure, as seen in transgender men undergoing gender-affirming therapy, could potentially compromise fertility by negatively affecting ovarian follicle growth, health, and DNA integrity. The research indicated that testosterone was linked with decreased follicle growth activation, poor follicle health, and increased DNA damage, suggesting possible impacts on fertility. (56)

-Another wide-ranging study found that gender-related drug regimens place patients at risk of infertility. On surgeries, the study noted that cross-sex surgery that includes hysterectomy and oophorectomy in transmen or orchiectomy in transwomen results in permanent sterility. (57) The authors remarked:

> *"Suppression of puberty with gonadotropin-releasing hormone agonist analogs (GnRHa) in the pediatric transgender patient can pause the maturation of germ cells, and thus, affect fertility potential. Testosterone therapy in transgender men can suppress ovulation and alter ovarian histology, while estrogen therapy in transgender women can lead to impaired spermatogenesis and testicular atrophy. The effect of hormone therapy on fertility is potentially reversible, but the extent is unclear."*

Surgical Complications:

Female-to-male genital reconstruction surgery has a high negative outcome rate, including urethral compromise and worsened mental health:

-The results of a 2021 international survey (58) of 129 female-to-male patients who underwent genital reconstruction surgery support anecdotal reports that complication rates following genital reconstruction are higher than are commonly reported in the surgical literature.

-Complication rates, including urethral compromise, and worsened mental health outcomes remain high for gender affirming penile reconstruction. In total, the 129 patients reported 281 complications requiring 142 revisions.

-Another paper (59) found a 70% complication rate in one type of female-to-male genital reconstruction surgery.

-Even with the "radial forearm free flap" method of creating a synthetic penis — "considered by many as the gold standard for phalloplasty" (60) — there are high rates of complications, with up to 64% urethroplasty related complications (61)

Vaginoplasty can result in fistula, necrosis, stenosis, prolapse, and even death.

-Male-to-female genital surgery (vaginoplasty) is associated with significant long-term complications: there is a 2% risk of fistula, 14% risk of stenosis (abnormal narrowing), 1% risk of necrosis (tissue death) and 4% risk of prolapse (62)

-One systematic review found an overall complication rate of 32.5%. (63)

-A Dutch study of 55 (out of an original 70) adolescents treated with puberty blockers, cross sex hormones, and genital surgery, showed that among 22 male-to-female patients who underwent vaginoplasty, one adolescent died as a result of necrotizing fasciitis after the surgery. (64) ***** these are the authors of the original "Dutch protocol"***

Also, approximately 1 in 5 vaginoplasties results in corrective surgery:

-A systematic review of neo-vagina surgeries found a re-operation rate of 21.7% for non-aesthetic reasons. (65)

-A Brazilian paper found a somewhat lower, but similar, reoperation rate of 16.8%. (66)

Incontinence:

There is evidence that up to a quarter of transgender genital surgeries result in incontinence.

-A systematic literature review found that 21% of male-to-female patients and 25% of female-to-male patients suffered from incontinence as a result of transgender genital surgery. (67)

-One recent study estimates the number of post-operative transsexuals suffering stress incontinence to be 23%. This study was not a literature review, and almost all of the participants were male-to-female. (68)

Sexual Function:

Genital surgeries tend to reduce the capacity for orgasm in males and may do so in females.

-One study showed that around 30% of male-to-female genital surgeries result in the inability to orgasm. (69)

-Figures on female-to-male transitioners are less clear. However, a clinical follow-up study of 38 transmen – 29 of whom had received phalloplasty, and 9 metoidioplasty – found that reported loss of orgasmic capacity was more marginally common than reported gain of orgasmic capacity. (70)

-The negative intrapsychic and interpersonal consequences of anorgasmia (the inability to climax) is well-documented and applies equally to transgender individuals (71)

Feminizing hormones reduce sexual function in males.

-Feminizing hormonal treatments lead to a lessening drive, erectile dysfunction, and shrinking of testes and penis, significantly compromising sexual function. (71)

-A Belgian doctoral thesis study found that 69.7% of transwomen reported a decrease in sexual desire — while the opposite effect is found in transmen. (72)

Suicide:

Mentioned above:

-There is no high-quality evidence that transgender youth have a suicide risk exceeding 41% (45) (40) (39)

-Similarly, the 2011 Dhejne study, which studied a cohort of patients for thirty years, demonstrated a risk of suicide of 19 times the general population. ***(Obviously, this studied an adult vs. pediatric population, but the point remains the same- that is, the impact on children of these treatments is potentially catastrophic later in life)* (46)

Also, in contrast to the Branstrom study, there is little evidence that medical transition decreases suicidality.

-When it comes to gender dysphoric children, there is little evidence that medical transition decreases suicide rates. There is little evidence to assert that puberty blockers are necessary to prevent suicide (73)

-After sex reassignment surgery, one study showed that adult transsexual clients were 4.9 times more likely to have made a suicide attempt and 19.1 times more likely to have died from suicide, after adjusting for prior psychiatric comorbidity. Similarly, an Australian paper notes that many patients have poor outcomes, which puts them at risk of suicide. (44) (47)

-A prominent study claiming that medical transition alleviated suicidality had to be corrected, to clarify that it proved "no advantage of surgery" in this regard. (40) (39)

Puberty Blockers:

There is limited evidence that medical transition leads to positive outcomes. Several different studies have noted the paucity of good quality evidence for transition.

-An Australian paper states that most available evidence indicating positive outcomes for gender reassignment is of poor quality. (47)

-A German study "found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition", adding that "[t]his lack of studies shows a gap between current clinical practice and clinical research." (76)

-A British review (77) conducted by the National Institute for Health and Care Excellence (NICE) graded certainty of evidence for puberty blocker use as "very low" in every category, including impact on

gender dysphoria, mental health, body image, global functioning, psychosocial functioning, cognitive functioning, bone density and adverse effects. (77)

-A chapter in an edited volume details the low evidence base for treatment pathways employed at the UK's Gender Identity Development Service, demonstrating how negative evidence was "ignored or suppressed". (78)

-Finally, a systematic review commissioned by the World Professional Association for Transgender Health (WPATH) to "systematically review the effect of gender-affirming hormone therapy on psychological outcomes among transgender people" noted that, in some areas, there was low quality or insufficient evidence. (79)

Bone Density:

Puberty blockers and cross-sex hormones negatively impact bone health in a significant number of cases.

-There is little long-term evidence on bone mass density in relation to puberty blockers. However, in a significant minority of cases of long-term puberty suppression related to gender identity, bone mass density scores qualify as "low for age". Low bone mass density increases risk of osteoporosis and fractures. (80)

-Adolescents who enter puberty at an older age have persistently lower bone mass density than their peers: in one case study, an adolescent had a bone mass density -2 standard deviations below the mean after three years of blocking puberty. (81) (82)

-It has also been noted that:

> *"In early-pubertal transgender youth, BMD [bone mass density] was lower than reference standards for sex designated at birth. This lower BMD may be explained, in part, by suboptimal calcium intake and decreased physical activity– potential targets for intervention."* (83)

-Bone metabolism is also decreased as a result of taking cross-sex hormones, for both males and (in later life) females. (84)

-A British study found that puberty blockers used to treat children aged 12 to 15 who have severe and persistent gender dysphoria had no significant effect on their psychological function, thoughts of self-harm, or body image. However, as expected, **the children experienced reduced growth in height and bone strength by the time they finished their treatment at age 16**. (85)

Heart disease:

Transmen are four or five times as likely as females in general to suffer a heart attack.

-A 2019 study found that post-operative female-to-male transgender people were 4.9 times as likely to suffer a myocardial infarction (heart attack) than women in general. (86)

-Another study also found a somewhat smaller yet still large discrepancy, concluding that transmen were 3.69 more likely to suffer a heart attack than women in general. (87)

Liver toxicity:

Bicalutamide is a medication used to treat metastatic prostate cancer, and one of its side effects is that it feminizes the bodies of men who take it, including the appearance of breasts. The Washington University center prescribed this cancer drug as a puberty blocker and feminizing agent for boys. As with most cancer drugs, bicalutamide has a long list of side effects, and this patient experienced one of them: liver toxicity. (88) It is also not only not recommended for children, and its use as a puberty blocking agent is not FDA approved. (89)

Off label use:

-Endo International plc and AbbVie Inc dominate the U.S. market for puberty blockers. The only FDA-approved use for these drugs in children is for central precocious puberty, a condition in which children begin to sexually mature before age 8 or 9 because of pituitary gland dysfunction. (28)

-One side effect in children who take these drugs can be a decline in bone density, which is often treated with vitamin D or calcium supplements. Studies have shown that bone density can return to normal once therapy ends, but also that for some transgender girls, it may not. (83) (84) (85)

-In September of 2023, the FDA published a study that found "no evidence for an increased risk of fracture" for precocious puberty patients who take leuprolide, the generic name for AbbVie's Lupron and similar drugs. *However, the FDA study didn't review cases of children who took the drug for gender dysphoria.*

-In a 2018 study published in the medical journal Clinical Pediatrics, *researchers at Yale University noted a sharp increase in the off-label use of puberty blockers and said these drugs "have not been thoroughly investigated in populations with normally timed puberty."* (89)

-Another concern about puberty blockers emerged in 2016, when the FDA ordered drugmakers to add a warning about psychiatric problems to the drugs' label as a treatment for children with precocious puberty. **On its label for Lupron, AbbVie says: "Psychiatric events have been reported in patients" taking puberty blockers. Events include emotional symptoms "such as crying, irritability, impatience, anger and aggression." (28)**

-The FDA pursued the label change after receiving 10 reports through its adverse event reporting system of children who had suicidal thoughts, including one suicide attempt, according to a Dec. 5, 2016, agency report reviewed by Reuters. One of the cases involved a 14-year-old patient taking Lupron for gender dysphoria, the records show. In the report, the FDA said suicidal ideation and depression are "serious events," and there is "enough evidence to warrant informing prescribers, even in the face of uncertainty about causality." (28)

"A Dec. 17, 2020, adverse event report to the FDA describes a 15-year-old patient taking Lupron for gender therapy. The patient had a history of "major depressive disorder" and a family history of

depression. The patient experienced "mental health deterioration" while on Lupron and attempted suicide twice. AbbVie wrote in the report to the FDA that "there is no reasonable possibility" that the adverse events were related to Lupron. The company did not elaborate." (28)

"Dr Brad Miller, division director of pediatric endocrinology at the University of Minnesota Medical School and M Health Masonic Children's Hospital, expressed surprise at the number of adverse event reports Reuters found. He said he was particularly concerned because doctors prescribe puberty blockers for transgender children, who are already at higher risk of mental health problems. **Miller and several other doctors told Reuters they had repeatedly asked AbbVie, Endo and other makers of puberty blockers to seek FDA approval for the drugs in treating gender dysphoria in children and to conduct clinical trials to establish the drugs' safety for such use. They said the companies always declined.** "They would say it would cost a lot of money to get approval," Miller said. "And they were not interested in going there because (transgender treatment) was a political hot potato." (28)

The list, while extensive, could continue exhaustively, but the point should be sufficiently clear: while much is known about the impact of gender affirming care, there is even more that is unknown. And even what is known appears to be disproportionately harmful, as well as the subject of robust professional disagreement.

So much so, in fact, that even many of the stalwart early advocates of these therapies began to change course. In 2015 Dr. Kaltiala asked a national body, called the Council for Choices in Health Care (COHERE), to create national guidelines for treatment of gender dysphoria in minors. In 2018 I renewed this request with colleagues, and it was accepted. COHERE commissioned a systematic evidence review to assess the reliability of the current medical literature on youth transition. In 2016, because of several years of growing concern about the harms of transition on vulnerable young patients, Finland's two pediatric gender services changed their protocols. Now, if young people had other, more urgent problems than gender dysphoria that needed to be addressed, we promptly referred those patients for more appropriate treatment, such as psychiatric counseling, rather than continuing their gender identity assessment.

In June of 2020, the Finnish COHERE review released its findings: It concluded that the studies touting the success of the "gender-affirming" model were biased and unreliable—systematically so in some cases. The authors wrote: (90)

*"**In light of available evidence, gender reassignment of minors is an experimental practice."** The report stated that young patients seeking gender transition should be instructed about **"the reality of a lifelong commitment to medical therapy, the permanence of the effects, and the possible physical and mental adverse effects of the treatments."** The report warned that young people, whose brains were still maturing, lacked the ability to properly **"assess the consequences" of making decisions they would have to live with for the "rest of their lives." (90)***

The authors concluded that for all these reasons, **gender transition should be postponed "until adulthood." (90)**

While this was occurring in Finland, similar conclusions were being drawn in the UK and Sweden. In the UK, no less a figure than Hilary Cass, Pediatrician in Chief of the NHS, former President of the Royal College of Pediatrics and Child Health, and one of the most respected clinicians in the UK, was tasked with an independent review of the largest gender clinic in the UK: the Tavistock GIDS clinic. (91)

The report **highlighted a profound lack of evidence and medical consensus** about the best approach to treating gender dysphoria in children. Yet the NHS's specialist Gender Identity Development Service (GIDS) **takes a child's expressed gender identity as the starting point for treatment.** This "affirmative approach" leaves little space for exploration of the potential relationship between their dysphoria and neurodiversity or psychosocial needs, including those arising from childhood trauma or internalized hostility to same-sex attraction. GIDS has compounded this lack of evidence with its own failure to track patient outcomes. (91) (92)

The report also noted several other points:

-The Tavistock clinic had been applying the affirmative model in a looser form than in the Netherlands, (The Dutch Protocol" where it was conceived, and to a patient group whose characteristics have changed dramatically from those for whom it was developed – teenage girls, whose gender dysphoria has manifested in adolescence rather than in early childhood. (91)

-The majority of young people now referred to GIDS had other complex mental health issues or neurodiversity, including autism, but GIDS had failed to assess these needs in the round. (91)

-The review was also clear about the lack of evidence about one of the affirmative model's treatment pathways: puberty-blocking drugs, which, for the vast majority of children prescribed them, function as a precursor to cross-sex hormones. The long-term health consequences of puberty blockers are unknown, and the Cass report noted clinical confusion about their purpose. **It was unclear whether children progress to cross-sex hormones because their gender identity was already settled, or whether puberty blockers interfere with the natural resolution of gender dysphoria. (91)**

-Young people's gender identity can remain in flux until their mid-20s, so the risk of regret following irreversible treatment needed to be understood, **but there was a lack of data on regret**. The report notes the lack of services and support for young detransitioners like Keira Bell, **who took the trust that runs GIDS to court, and who played a vital role in drawing attention to their inadequate care. (91)**

In June of 2023, Tavistock was shut down and puberty blockers banned in the UK until adulthood. (92)

Similar findings and conclusions were drawn in Sweden, the Netherlands, New Zealand, Australia, and France. Germany is now reviewing these practices as well. (93) (94)

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So, what can be concluded from these findings? That these opponents are ignorant? That they are religiously motivated bigots? That they are "MAGA conservatives"? That they are "phobic"? By no means. Because to do so would be palpably absurd.

Even as these findings were being published, in the US, we were demonstrating startling ignorance both of the foundations of the arguments in Europe and of the basic science involved.

In the name of protecting children by providing public funding for hospitals to distribute puberty blockers, California state legislators lambasted their opponents in defense of a transgender healthcare bill (AB 2218) in a Senate hearing in 2020. Senate Health Committee members complained about receiving hundreds of calls from voters telling them not to support a bill that "sterilizes children". Author Assemblyman Miguel Santiago (D-Los Angeles) accused the opposition of misleading constituents and "fearmongering for good sound bites."

However, according to informed consent forms acquired by Michael Laidlaw, a pediatric endocrinologist from Rocklin, CA, the Children's Hospital of Los Angeles (CHLA) confirmed that puberty blockers and cross-sex hormones the hospital gives to prepubescent minors could likely prevent them from having "biological children," later in life. **AB 2218 specifically was intended to fund medical facilities handing out these gender transitioning drugs**. A copy of the informed consent form is below:

Risks of Puberty Blockers

- The side effects and the safety of these medicines are not completely understood. There may be long-term risks that are not yet known.
- If your child starts puberty blockers in the earliest stages of puberty, and then goes on to gender affirming hormones, they will not develop sperm or eggs. This means that they will not be able to have biological children. *This is an important aspect of blocking puberty and progressing to hormones that you should understand prior to moving forward with puberty suppression.* If your child discontinues the use of blockers, and does not go on gender affirming hormones, they will continue their pubertal development about 6-12 months after stopping the medication, and fertility would be maintained.
- While on puberty blockers, your child's bone density will go back to developing at a pre-pubertal rate. While the clinical impact of this is not yet known, we will obtain bone density

-From Children's Hospital of Los Angeles informed consent form for puberty blockers

Despite this glaring and obvious statement about the risks, California legislators continued to insist that there was "nothing about sterilization" in the bill, presumably because the bill does not mention "sterilization":

"Unfortunately, people have been misled about this bill," Santiago told Health Committee members. Let me be very clear and set the record straight. Nothing in this bill. Nothing, I will repeat, talks about sterilizing kids. Nothing, I will repeat, in this bill points to anything to do with children." -Miguel Santiago (D-Los Angeles)

Senator Connie Leyva (D-San Bernardino) expressed pity for her callers. *"We received hundreds of calls to vote no on this bill,"* Leyva said in committee. *"I felt bad for the people who were calling to ask us to vote no because I do think they were misled.* ***There is nothing in this bill that talks about sterilizing children. It really talks about health care for individuals who identify as transgender."***

"I got hundreds and hundreds of calls asking me not to support something that sterilizes children," Senator Susan Rubio (D-West Covina) told the committee. *"So after those calls, I decided to read the bill very, very carefully and I didn't find anything about sterilizing children."*

While a tangential point, this discussion is relevant to the level of discourse in the United States: despite reading it "very, very carefully", a duly elected legislator could not seem to make the connection between a bill that funding off label puberty blockers for children with the potential for sterilization, despite an informed consent form that categorically classifies sterilization as a risk. And this underscores why robust support for HB 68 is so necessary.

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I will briefly cover two final topics which, although tangential to the medicoclinical discussion, are relevant. The first is the inherently dyssynchronous arguments surrounding transgender issues, the lack of coherence around which complicate, and indeed indicate a need for caution, in proceeding rapidly with potentially permanent and lifechanging treatments. The second are the words of a few of the founders of the transgender movement, words which, while individually spoken, indicate a much broader goal----one for which medical safety is a secondary priority.

The American Psychological Association (APA) defines sex as "a person's biological status ... typically categorized as male, female, or intersex (i.e., atypical combinations of features that usually distinguish male from female." It defines gender as "the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex." (101)

Gender identity refers to:

[a] person's deeply felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender non-conforming, boygirl, ladyboy) which may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics. Since gender identity is internal, a person's gender identity is not necessarily visible to others. (101)

On the surface, these definitions appear quite reasonable. However, they mask a series of deep contradictions that tend to occur when people talk about gender as a social construction. If we are going to be able to have constructive conversations about gender and society, it is important to unmask these contradictions. Here are a few:

1) **Gender cannot simultaneously be socially constructed and inherent to the individual.**

In the APA definition, sex refers to the biological reproductive anatomy, while gender refers to cultural expectations and norms. Drawing on this distinction, when people say that gender is socially constructed, they tend to assert that sex is independent of gender.

However, if gender is an arbitrary creation of society, how is it possible for gender identity to be an "internal" and "inherent" sense of self? It is not possible for gender to simultaneously be an arbitrary product of culture and an inherent experience of the individual. If gender comes from the culture, how can it also be an inherent property of the individual person? (100)

2) **Gender identity cannot be simultaneously self-chosen and the product of socialization.**

The idea that gender is socially constructed generally means that gender identities are the product of socialization. This statement stands in contradiction to the idea that gender identities arise from the process of self-identification—that it is the individual who decides upon gender identity.

3) Gender identity cannot simultaneously be invisible AND socially verifiable.

This particular argument is extremely relevant to public policy, specifically women's sports and single sex spaces. As an example, Jessica Yaniv (sometimes known as Jonathan) is a Canadian transgender activist. Yaniv is a pre-surgical transgender (male-to-female) individual who self-identifies as a woman. Yaniv achieved notoriety by seeking Brazilian wax services from aestheticians in Vancouver, British Columbia. In salons that provide such services, Brazilian waxing is performed on females and involves the removal of pubic hair from the vulva, labia, perineum and anus. In Canada, an individual who self-identifies as a woman gains legal status as a female. After making an initial appointment with a salon, Yaniv would then reveal that the requested services would be performed on a woman—namely Yaniv—who also happened to have a penis, testicles and scrotum. When salon owners indicated that they did not perform such procedures, or felt unqualified to perform them, Yaniv would threaten legal action. In 2019, the Tribunal rejected her complaints and ruled Yaniv had racist motives. In following years, Yaniv has gone on to make additional complaints of discrimination, libel and privacy breach. (99)

Yaniv's actions put aestheticians in a difficult position: they were being asked to manipulate a penis and scrotum in a service that has typically been understood as something performed by women on women. Their discomfort and unwillingness to do so is something that is likely to be appreciated by people across the political spectrum. Nonetheless, a prescription in which self-identification is the only criterion that defines a person's gender as "man" or "woman" raises difficult issues about whether salon owners are legally obligated to perform Brazilian waxing procedures on individuals with male genitalia.

Apart from these incidents, Yaniv has been accused of engaging mid-teen girls in sexualized chat. Yaniv has recently been arrested for brandishing a legal weapon—a taser—on social media. Yaniv has taken "selfies" in public bathrooms with women, **apparently without their consent**, appearing in the photos. In public chat discussions, Yaniv has discussed the appropriateness of approaching young girls in locker rooms for the purpose of requesting tampons from them. It should go without saying that Yaniv's behaviors are deeply atypical of people who identify as transgender. I would agree with the assertions of those who feel that Yaniv's actions do not represent the transgender community and do not advance the agenda for transgender rights.

Yaniv's actions should not be taken to be representative of transgender individuals. Nonetheless, Yaniv's actions illustrate the deep conceptual problems that arise when we think of gender a form of "self-identification." As we have learned in history, people who wish not to be scrutinized, whether for prurient or predatory reasons, **will seek out places where they are not subject to scrutiny, for reasons of legal protection or power differential.** This presents a potential public danger to women and a challenge to public policymakers. (96) (97) (98)

If, as the APA definition maintains, gender identity is something that is not necessarily visible to others, how can we ever verify a person's claim to a given gender identity? A social identity is not the kind of thing that can be determined by a solitary self. Social identities are verified and validated in social relations. *If this were not the case, we would be compelled to accept any identity claim made by any individual exclusively on the basis of self-assertion alone.*

4) Gender cannot be both independent of sex and defined with reference to sex.

The APA defines gender identity as one's sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender. To say that one's experience of self may not comport with one's assigned sex is to make a distinction between sex and gender. However, the capacity to discriminate sex from gender does not make one independent of the other. Just as this testimony requires my perceived thoughts, it is made possible by the fact that I have opposable thumbs, biologically, in order to write it. Human experience is simply not divided into separate biological and socially constructed parts.

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Lastly, although we continue to hear the transgender issue put in terms of "compassion" and "rights", there has been a historical and fiercely political component, independent of the medical components.

In the late 1980's, a group of academics, including Susan Stryker, Rosa Lee, Judith Butler, Gayle Rubin, and Sandy Stone, helped establish the disciplines of "queer theory" and "transgender studies". These academics believed gender to be a "social construct" (see above), used to oppress racial and sexual minorities, and denounced the traditional classification of man and woman as a false binary used to support an oppressive system of "heteronormativity". This system, they argued, needed to be "ruthlessly deconstructed".

Susan Stryker, a male-to-female transgender professor currently at the University of Arizona, in their best-known essay, "My Words to Victor Frankenstein above the Village of Chamounix: Performing Transgender Rage", Dr. Stryker contend that the transsexual body is a "technological construct" that represents a war against Western society.

"I am a transsexual", Stryker writes, "and therefore I am a monster". And this monster, Stryker contends, is destined to channel its "rage and revenge" against the "naturalized heterosexual order", against "traditional family values"; and against the "hegemonic oppression of nature itself". (102)

It is clear from this and other transgender scholarship that the movement is inherently political. Similarly, some trans activists even view their movement as the future of Marxism. Rosa Lee, an activist writer contends in the book *"Transgender Marxism",* trans people can serve as the new vanguard of the proletariat, promising to abolish heteronormativity in the same way that orthodox Marxism promised to abolish capitalism:

"In a different era," Lee writes,

"Marxists spoke of the construction of a "new socialist man" as a crucial task in the broader process of socialist construction. Today, in a time of both rising fascism and an emergent socialist movement, our challenge is transsexualising our Marxism. We should think [of] the project of transition to communism in our time—communisation—as including the transition to new communist selves, new ways of being and relating to one another."

Though, as noted before, these items regarding the origin and history of transgender scholarship may seem esoteric and tangential to the ethical and medical debate; however, seen through the above lens of undisguised rage and nakedly political rhetoric, it seems especially appropriate to view the

inexplicable urgency of medicating and surgicalising children with a skeptical eye.

In closing, as I have demonstrated, ideology has no place in the practice of medicine. And it is indeed, I fear, exactly that which is driving the implementation of these harmful therapies, destructive surgeries, and empty promises. I have shown you how much of the data supporting these aggressive and permanent therapies are based on incomplete data at best, and shoddy or cherry-picked data at worst. I have given you extensive, although not exhaustive examples, with sourced citations, as to the potential harms of these therapies, both short-term and long term, which in themselves draw into question whether true informed consent, given the lack of data, is adequate or possible. I have shown you how this is not a partisan issue, with many of the most outspoken critics of these therapies being either victims of them themselves, sexual minorities, or part of the group that first pioneered them. Listen to the words of Keira Bell, Chloe Cole, Izabella Ayar, Kobe, or countless others as they describe their state of mind and how they feel misled. Listen to them describe Many of them, including These individuals and groups are uniquely qualified to raise the alarm, and are dramatically hitting the brakes on these therapies, even as the United States is hitting the gas as quickly as possible.

Further, I have walked you through the inconsistency of current pro-transgender argumentation, and how this lack of resolution of its logical inconsistency will negatively impact public policy.

Lastly, I have given you a glimpse into the extremely partisan, polarized view of some of the founders of this movement in the United States, which underlies the ferocity of the activism, despite lack of scientific grounding, and which is translating into true harm.

It is for these reasons that this clinician recommends passing HB 68. There is little question that these therapies have the capacity to cause great harm and our knowledge of the long-term potential impact is limited at best. Proponents of these therapies would have you believe these are issues of compassion or bigotry. They are not. Let us remember also:

"Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience." C.S. Lewis

As for those who would make the appeal to the authority of "science", I would remind them that "science" is an activity undertaken by human beings, flawed and biased. Great harm has been perpetuated in the name of the greater good by science. Antisepsis was opposed in the United States by the biggest names in medicine of the day. Minorities in this country were purposely exposed to infectious diseases to learn how to treat them. Everything we know about treating hypothermia was derived from the work of Josef Mengele. And less than 100 years ago, one of the most celebrated treatments for mental illness was a frontal lobotomy, for which the pioneering surgeon received the 1949 Nobel Prize for Medicine.

And until it was abandoned in the 1980's, an estimated 150,000 of those procedures were performed worldwide, including Ruth Kennedy, the sister of John F. Kennedy.

And each surgeon would have told you that they were helping people, if asked.

Today we would view the above examples with horror, and rightly so. But the rhetoric in support of them at the time is eerily similar to that which we hear today: "the science is settled", "we must act now or else". "More harm will come from not acting". Or worse, "it is for the greater good". Science is not immutable, nor infallible.

Transgender individuals are human beings who are uniquely suffering, along with their families. They deserve solutions, not fads or ideology. We do them no favors by making false or grotesquely optimistic promises with potentially devastating physical and emotional consequences—especially children whom society has never assumed to have agency for decisions of this magnitude.

Let us not repeat the mistakes of the past, especially for our children.

Yours Sincerely,

David M. Bonnet MD, MBA; Diplomate, American Board of Internal Medicine

Footnotes:

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