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Gender-Affirming Care Dossier

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THE RECKONING

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The WPATH Files

The World Professional Association for Transgender Health (WPATH) is considered the world's leading scientific and medical organization for transgender health care. However, the WPATH Files published by Environmental Progress destroys any semblance of WPATH's reputation as a respectable medical organization and show its true colors: an activist organization willing to manipulate medical standards to perform experimental, life-altering procedures on the most vulnerable people.

The WPATH Files began when an anonymous source leaked internal WPATH communications exposing the medical experimentation and flouting of medical and mental health standards of care practiced among its members. Many of the posts involve children, adolescents, and people with special needs who have borne the cost of WPATH's activism.

Environmental Progress compiled the internal communications into a 241-page document and published it as "The WPATH Files." They invited other journalists to report on the contents of the document. And that's exactly what we did.

This document has two main goals. The first is to expose WPATH as an illegitimate medical organization. To that end, we have highlighted some of the most shocking stories from the WPATH Files that expose WPATH's continual violation of medical standards of care and consent — not only the standards for basic medical practice but even the flawed standards the organization members have written for themselves. On that point, we listed the main "cast of characters" of corrupt professionals behind the internal communications we have highlighted. Many of WPATH members have contributed to WPATH's current standards of care (SOC8).

The second aim of this document is to call you to action to hold WPATH accountable for its actions. At the end of this document, you will find a pre-written letter that you can email to the American Academy of Pediatrics (AAP), the American Psychological Association (APA), the American Medical Association (AMA), and the Endocrine Society. You will find the contact emails for the respective organizations listed on the back.

We also solicit your help in exposing these bad actors on social media. Copy the letter on X, tag WPATH, the AAP, APA, AMA, and and the Endocrine Society to demand that they are held accountable for their actions. It's time to bring the reckoning to WPATH.

Call to action: Send this letter to hold WPATH accountable

Subject Line: Please Ditch WPATH Standards

To Whom It May Concern:

The World Professional Association for Transgender Health (WPATH) enjoys the reputation of being the leading scientific and medical organization devoted to transgender healthcare. WPATH claims that its standards of care, followed by healthcare providers worldwide, are based on the best available evidence and that gender-affirming care is both safe and life-saving. Every major American medical association endorses WPATH's approach to gender medicine.

However, a recent report by Environmental Progress revealed that this prestigious reputation is neither deserved nor accurate. Based on leaked files from WPATH's internal messaging forum, as well as a leaked internal panel discussion, the WPATH Files report reveals that the world-leading transgender healthcare group is neither scientific nor promoting ethical medical care. Instead, the internal communications show that WPATH advocates for an unregulated experiment to be conducted on some of the most vulnerable people in society.

The WPATH Files have proven that WPATH members have no regard for medical ethics and knowingly submit their young and vulnerable clients to irreversible medical interventions without obtaining informed consent. Their haphazard, ideologically driven approach to medicine has resulted in the sterilization of otherwise healthy adolescents, genital atrophy, and even the surgical creation of second sets of genitals for people who identify as non-binary. They have failed to provide substantial evidence that these interventions offer any benefit that could outweigh the costs.

A month after the damning findings of the WPATH Files report were made public, the final report of the UK's Cass Review was released. The result of a four-year investigation into England's youth gender service, the 388-page document confirmed that there is no good quality evidence to support the puberty suppression experiment, leading to the NHS England restricting access to puberty blockers and hormones for adolescents to the strictest of clinical trial settings. This is in line with the findings of the recent systematic reviews conducted by Sweden and Finland.

Despite WPATH's claims that each patient is carefully evaluated prior to receiving puberty blockers, cross-sex hormones, or surgical intervention, the WPATH files show that far too many professionals seek to eliminate safeguards, considering caution to amount to discriminatory "gatekeeping." Instead, they discuss internally how to fast-track patients, providing assessment and referral letters for treatment despite severe psychiatric comorbidities such as major depressive disorder and schizophrenia. This has resulted in the doling out of life-altering and risky medical treatments to minors as well as vulnerable adults with disabilities or extreme mental health concerns.

Many European nations have now abandoned WPATH's affirmative model of care for young people suffering from gender distress in favor of a cautious, psychotherapeutic approach due to the worrying lack of evidence to support medicalization. Ignoring these important developments and failing to condemn the pseudoscientific, harmful medical practices endorsed by WPATH will have far-reaching consequences beyond the field of gender medicine. When major medical associations advocate for a treatment protocol completely lacking in sound scientific evidence, this erodes the public's trust in these institutions. To preserve your reputation as trustworthy sources of evidence-based, ethical providers of medical information, we call on you to publicly condemn the reckless practices of WPATH and to reject their published Standards of Care in light of the unfolding evidence that they are, as the president of WPATH admits, "arbitrary."

American Academy of Pediatrics (AAP)

- Click HERE to go to their general contact form.
- Social media: copy and paste this letter into X, tag @AmerAcadPeds and @WPATH, and be sure to use the hashtag #DitchWPATH

American Psychological Association (APA)

- Email: executiveoffice@apa.org
- Social media: copy and paste this letter into X, tag @APA and @WPATH, and be sure to use the hashtag #DitchWPATH

American Medical Association (AMA)

- Email of the AMA President: Jesse.Ehrenfeld@ama-assn.org
- Social media: copy and paste this letter into X, tag @AmerMedicalAssn and @WPATH, and be sure to use the hashtag #DitchWPATH

Endocrine Society

- Email: governance@endocrine.org
- Social media: the Endocrine Society does not have an account with X.

Cast of Characters

The majority of the names in the WPATH Files have been redacted, but here are the few unredacted people, many of whom have a public persona. You will see their names come up in some of the posts that our research team has highlighted in the following section.

It's also important to note that many of these figures are not only practicing so-called "gender-affirming care," but moreover, they are setting the WPATH guidelines for their own standard of care. This is important to note because these "health care" practitioners change pre-existing standards of care for other conditions like mental health to justify their experimental treatments. It becomes clear that WPATH is not a legitimate health care organization but a corrupt network of activist-driven doctors who are attempting to legitimize their own dangerous, non-reversible treatments on our children.

We took the time to list them and their bios so that they can be held accountable and you can avoid their practices or any of their affiliates.

Thomas Satterwhite (Man)

A plastic surgeon cashing in on mentally unwell patients.

Dr. Satterwhite, MD is a board-certified Plastic and Craniofacial Surgeon. At his practice in San Francisco, Align Surgical Associates, Dr. Satterwhite "works exclusively with trans women, trans men and non-binary patients seeking Gender Confirmation procedures."

Marci Bowers (Man)

WPATH President and surgeon once described as "the Beyonce of bottom surgery."

Outside of his role as the President of WPATH, Marci has served on the board of GLAAD and the Transgender Law Center. He is considered a "pioneer in the field of

gender affirmation surgery." He was the first transgender person to perform a transgender surgery.

Christine N. McGinn

Former service member and “unintentional media darling.”

Christine runs the Papillon Gender Wellness Center in Pennsylvania. According to MSNBC, he "has also become an unintentional media darling, garnering headlines after successfully breastfeeding her [his] twin babies and offering free surgery for transgender Navy veterans. She [he] consulted on the film ‘The Danish Girl’ for surgery scenes, and has appeared as a transgender advocate on ‘The Dr. Oz Show’, CNN and more."

Dan H. Karasic

Professor Emeritus and SOC8 Contributor.

According to his bio: "Dan Karasic, MD, Professor Emeritus, Psychiatry, UCSF Weill Institute for Neurosciences, has been a UCSF professor since 1991, and opened a telepsychiatry private practice in 2020. He received his M.D. from Yale University and trained in psychiatry at the UCLA Neuropsychiatric Institute."

Dan led the development of the Mental and Behavioral Health Conditions in Adults, chapter for WPATH's Standards of care Version 8.

Daniel D. Dugi

"Gender-affirming" surgeon

In 2012, Daniel co-founded the OSHU Transgender Health program. According to his bio:

> *He is the program’s Director of Surgical Services, one of the most comprehensive and highest volume gender programs in the nation. He is the Fellowship director for OHSU’s Gender-affirming and Genitourinary*

Reconstructive Surgery fellowship. He is active in advocacy, education, and research.

Rajveer S. Purohit

"Best doctor in New York City."

According to his bio, Dr. Purohit has performed "over 1000 complex reconstructive surgical procedures including urethroplasty for urethral strictures, repair of fistula, and gender affirming surgery including vaginoplasty, metoidioplasty and phalloplasty."

He is the director of Reconstructive Urology and a Professor of Urology at The Mount Sinai Hospital. New York Magazine listed him as one of the "best doctors in New York City."

Exposing WPATH: An activist organization targeting the most vulnerable

The below stories are internal communication posts compiled in the WPATH Files that demonstrate how the organization violates basic standards of care and consent to perform ethically compromised transgender treatments.

A 14-year-old boy seeks a vaginoplasty

One of the posts uncovered in the WPATH files is from a doctor seeking guidance concerning his 14-year-old patient who requested male-to-female (MtF) surgery. According to the post, the boy "started transition since she (he) was 4," and the doctor, understandably, expressed hesitancy to perform such a surgery on so young a patient. The doctor writes:

> *"She (he) wants to have gender affirming surgery MtF….but I have never done this on such a young patient."*

Dr. Christine N. McGinn chimed in. Dr. McGinn also transitioned from a male to female and rose to staredom for successfully breastfeeding and offered to perform free transition surgeries for Navy veterans. He replied:

> *I have performed about 20 vaginoplasties in patients under 18 in the past 17 years…*none of these patients have regretted their decisions that I am aware of.

McGinn isn't "aware" because there aren't any long-range studies about the effects of these interventions on young people. Even WPATH's own Standards of Care admit this:

> *Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible.*

Dr. McGinn went on to say,

> *For well prepared patients, I feel the ideal time in the US is surgery the summer before their last year of high school.*

Moreover, Dr. McGinn recommended having a "fact-finding" appointment to tell the 14-year-old about the surgery, adding that "penoscrotal hypo plasma is also an important topic to discuss early."

He likely misspelled "penoscrotal hypoplasia," which essentially means "small penis." Why would Dr. McGinn mention this? A small penis could cause complications for the surgery due to the amount of tissue needed to construct a new "vagina" through the inversion of penile tissue According to the National Library of Medicine, these complications are not uncommon:

> *Importantly, complications associated with penile inversion vaginoplasty are not uncommon and can be life-threatening.*

These complications are especially acute with the underdeveloped penises of male children or older teenagers who have been put on puberty blockers that stunt penile development. Even the WPATH Standards of Care admit this:

> *Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).*

But Dr. McGinn thinks we should go ahead and get that life-threatening surgery out of the way before high school — and make sure to talk to the mentally unstable 14-year-old about the implications of a small penis being "turned into" a "vagina."

Even Marci Bowers, the president of the WPATH board of directors, had to step in on this one and say:

> *I would not do it…tissue too immature. Dilation routine is too critical. Age 16 is the youngest I've EVER done.*

Marci Bowers is a transwoman — a man — and it's interesting that he said that in the chat, given that WPATH's own Standards of Care (Version 8) don't seem to make any hard and fast rules about age (pg. 548). Instead, they use "Tanner Stage 2" of puberty as a marker. According to the NIH, girls can enter this stage between 8 and 15. For boys, it's 10 and 15.

Marci did admit:

> *Currently our standard is 18, though I do agree this number is arbitrary. Decision should be individual based on maturity.*

Let that sink in: The president of the board of WPATH said that the age standards for performing these permanent genital surgeries on minors is "arbitrary."

Here is our big takeaway: WPATH has no idea what age is appropriate and refuses to put hard and fast rules on it for fear of "gatekeeping" — a phrase that came up A LOT in these discussions.

Why stop at genitalia? WPATH appears to condone amputation to accommodate BIID

If doctors believe they can mutilate perfectly healthy genitalia to accommodate patients' beliefs that they are a different gender, what would prevent them from amputating perfectly healthy limbs if that's what a patient wanted? The WPATH Files exposed that these are the kinds of conversations that are already happening in the world of transgender treatment.

"Body integrity identity disorder" or BIID, according to the National Institutes of Health, is an "extremely rare phenomenon of persons who desire the amputation of one or more healthy limbs or who desire a paralysis." Rather than encouraging patients suffering from BIID to seek psychiatric care, a person posted this, according to the WPATH Files:

> *There seems to be little research about this condition. … It does seem that amputation has provided relief for several clients.*

The person went on to say:

There has been a change in the portion of the body causing distress.

So we should condone amputating an arm today and a leg tomorrow to accommodate a patient's mental disorder? As absurd as this sounds, we shouldn't expect anything different from WPATH. It is consistent with the organization's own logic.

One commenter said:

> *It is clear these individuals do display some characteristics similar to trans people. … I fear one may have here a group of particularly unfortunate individuals to whom medical science is as hostile as it once was to trans people.*

If these people get their way, cutting off limbs will be a requirement to, as one commenter put it, "align the bodies of people with BIID with their minds." *If the minds are sick, then the bodies will be too.*

WPATH hosted a discussion board post titled "Initiating Hormone Therapy in the Midst of Trauma"

A gender "expert" posted about his internal struggle about whether or not someone with extreme mental health challenges can truly consent to the injection of sex hormones for the sole purpose of "aligning his body with his mind." He says:

> *I'm struggling with a patient dx [diagnosed] with PTSD, MDD [Major Depressive Disorder] with well documented, and observed associations … schizoid typical traits … psychiatry is recommending holding off [hormone therapy] the patient is becoming more and more frustrated with me not moving forward with HRT … 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.*

But the real shock isn't in the question; it's in the answer. Dan H. Karasic, who lead the development of the Mental and Behavioral Health Conditions and Adults chapter for WPATH's Standards of Care Version 8 (SOC8) responded to the question saying:

> *I'm missing why you are perplexed? Does the mental illness impair ability to give informed consent? 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?"

Let's pause here and break down the "informed consent" model as described in the WPATH Files Overview:

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. 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 consent has been secured. 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.

WPATH members don't even come close to clearing the bar for true, ethical, informed consent.

Another commenter chimed in:

I've had patients/clients with diagnosed DID, MDD, bipolar, schizophrenia, etc., who do just fine on HT [hormone therapy] ... would you deny a cisgender patient with the same psychiatric dx hormone therapy if they were hypogonadic [a condition in which the male testes or the female ovaries produce little or no sex hormones]? This is harm reduction and so doing nothing is not a "neutral option."

"Harm reduction" is a term that comes up often in the WPATH files. Another commenter said:

As gender affirmative practitioners, we also consider harm reduction as a our primary lens- In other words, what will happen to these patients if they do NOT undergo their affirmative treatment, which is also a medical necessity?

She said she has only declined writing one letter (for approval for medical intervention) 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.*

Here's what we can conclude from this conversation: Unless a patient is hallucinating in her session, the doctor will approve permanent, life-altering "gender affirming" treatments.

Many of the people on the WPATH forum are very worried about "gatekeeping." It's a term they use often, and it refers to the measures in place to protect the patient from undergoing these permanent treatments if they will regret it later. One person posts:

> *We as mental health professionals have been put inappropriately into gatekeeper roles. I'm not aware of any other medical procedure that requires the approval of a therapist. I think requiring this for trans-clients is another way that our healthcare system positions gender-affirming care as "optional."*

Gatekeeping is another way of saying "safeguarding." WPATH members don't want to safeguard their patients — not even those patients suffering from a mental illness.

Here are some more examples of WPATH folks saying the mentally ill have the right to cut off their reproductive organs like the rest of us:

> *I'm concerned that denying necessary surgical care (even for the severely mentally ill) encroaches strongly on a patients autonomy–presuming the patient in question has capacity to make their own medical decisions.*

But how can you tell if the patient has that capacity? It seems pretty arbitrary. One commenter even said:

> *There is not a clear line … it's a clinical judgment from the best I can tell.*

Again, they have no clue, so they have to fudge it a bit:

> *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 between you, the patient, the surgeon, and any other resources/family you can recruit …*

Here’s another jaw-dropping post:

> *Withholding care is more problematic when compared to the provider's feelings about the potential for stability after surgery and/or difficulty with following through with aftercare instructions.*

The aftercare for a gender reassignment surgery can be extensive, so to say that a provider shouldn't let concern about a patient's ability to do proper post-surgical care stop them from doing surgery is a kind of insane risk/benefit analysis.

A patient experiences ejaculation from his new “vagina” post-surgery

A doctor posts:

> *I have a transgender patient who underwent full depth vaginoplasty a year ago. Penile inversion technique. She [he] notices an ejaculate with orgasm that smells like semen and is bothersome. Is there a solution?*

Dr. Daniel D. Dugi jumped in with the super helpful answer:

> *I don’t think there is a remedy.*

A close second in the race to be utterly unhelpful is from this “woman of trans experience” who had “bottom surgery” 40 years ago:

> *I say enjoy the ride. In my experience, it’s the ultimate physical sign of orgasm..what’s not to like?*

This is essentially what these “experts” are saying about ejaculation from a “neo-vagina:” “Your patient doesn't like it? That's weird. I loved it. Oh well, it can't be fixed.” Talk about “professional” care.

A 16-year-old develops tumors from hormone therapy

A doctor posted about a 16-year-old girl who developed a type of tumor called “hepatic adenomas” from her hormone therapy, which included testosterone and contraceptives. These tumors began developing on her liver:

> *Wondering if anyone else has had to navigate the development of hepatic adenomas in a young person treated with testosterone and/or oral contraceptives. … Our team has a 16 yr old patient … found to have two liver masses –Hepatic adenomas. – ... the oncologist and the surgeon have both indicated that the likely offending agents are the hormones.*

According to the NIH, these tumors are most often associated with oral contraceptives:

> *Hepatic adenomas, also called hepatocellular adenomas, are rare but benign epithelial tumors of the liver frequently associated with oral contraceptive pill use.*

In response to the doctor’s post, another member offered this terrifying anecdote about a “transition friend” who was on “T” (testosterone) for 8-19 years and then developed “hepatocarcinoma” (liver cancer):

> *To the best of my knowledge it was linked to his [her] hormonal treatment..unfortunately I don’t have much more details since it was so advanced that he [she] opted for palliative care and died a couple of months after.*

Not everyone on hormone “therapy” will die of liver cancer. However, there are many other possible side effects that are discussed among the WPATH members:

> *I have a young patient on testosterone x 3 years. … he [she] has atrophy with persistent yellow discharge we often see as a result.*
>
> *Some patients have developed pelvic floor dysfunction and even pain with orgasm.*
>
> *I developed vulval lichen planus* [essentially a horrible, itchy rash on the vagina] *and lichen sclerosis* [a chronic condition that causes thin, white patches of skin, usually in the genital area] *20 years after commencing testosterone treatment*

and 17 years after hysterectomy. I had splits in the skin which bled and were excruciating.

I used to have bleeding after penetrative sex… It would hurt to orgasm… My uterus atrophied also…

They (men on estrogen) *will go to have a erection and that tissue usually causes pain that many patients refer to as feeling like broken glass.*

Many people in the WPATH comments discussed their own experience with their medical “transition.” Often, it was negative. It makes one wonder, are these “experts” just playing out their traumatic experiences on their patients in an attempt to normalize what happened to them? If lots of people have, for instance, vaginal atrophy, then maybe they wouldn't feel as bad about their own. It may not be a conscious dynamic, but it could be a factor.

No help/support for patients who choose to detransition

One WPATH member posted about a patient, a 17-year-old girl who regrets transitioning to a male and began the detransition process. The girl says she felt “angry” and “brainwashed” into making permanent alterations to her body:

We have a patient, 17 yrs, Ftm, that just graduated from highschool and decided to detransition…He [she] is very distraught and angry. He [she] reports that he [she] feels he [she] was brainwashed and is upset by the permanent changes to his [her] body…per mom, they are feeling very validated by ‘right wing groups and Matt Walsh.’

Considering how obsessed this community is with validating everyone's self-expression, isn’t it odd that this commenter kept using male pronouns, even though the patient is a woman, who is detransitioning because she felt brainwashed into pretending she’s a man? The commenters interestingly didn't seem to apply their usual level of unquestioning affirmation to this particular turn in the patient's “gender journey” saying things like this:

Based on their admiration of Matt Walsh, they might simply be making claims that support their narrative.

How un-affirmative of them. Then, in a brilliant twist of irony, one commenter perfectly described what's happening — sarcasm implied:

> *I think it's important to critically consider what goes into truly brainwashing someone. I'm sure you'd agree that it's unlikely that an entire network of mental and health care professionals over the span of this youths adolescence have created a system sophisticated enough to collaborate in brainwashing a child into transitioning.*

And yet, that is exactly what has happened.

Desperate to avoid any blame for what happened to this poor girl, one commenter described an "AFAB" (assigned female at birth) patient who is detransitioning as not really detransitioning at all:

> *Instead of using the term 'detransition' he [she] is simply describing this as a turn in his [her] gender journey.*

Another commenter questioned if the family was supportive enough, saying:

> *I have, at times, been seen as the instigator of the individuals decisions–even up to renunciations of family or family values and beliefs.*

Here are more folks desperate to avoid blame:

> *We don't have to see it (detransition) as a mistake that was made.*
>
> *What is problematic is the idea of detransitioning, as it frames being cisgender as the default and reinforces transness as a pathology.*

Inverting your penis, cutting off healthy breasts, it's all just part of everyone's "gender journey." Besides, since all of this "care" is "client-centered," isn't it *really* the patient's fault anyway? This WPATH commentator seems to think so:

> *In the end, 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. That mistakenly not providing care to a trans person in case they regret it*

> *is assumed to be less harmful than granting a mistaken request for treatment, is just a symptom of that power dynamic.*

Marci Bowers jumped into the chat, saying:

> *As you know, acknowledgment that detransition exists to even a minor extent is considered off-limits for many in our community.*

Bowers concluded with more patient-blaming:

> *Patients need to own and take active responsibility for medical decisions, especially those that have potentially permanent effects.*

Keep in mind that some of these patients who need to "take active responsibility" are minors, people with a disability, or those who are mentally unwell. As another WPATH member described, these are people "who seem to feel they should be allowed to switch back and forth merely at their request."

These experts "support" their patients when they sign up for treatment. But if the patient regrets it? They tell the patient to "own" their mistakes.

The effects of puberty blockers

A doctor posted a question about the effects of putting a 10-year-old girl on puberty blockers — before she has even had her first period:

> *I've recently received a question from an AFAB pre-menarche [referring to a patient who hasn't had a period yet] 10 y/o patient about whether blockers will stunt his [her] growth. I understand blockers can slow the rate of growth.*

Haven't we been told that puberty blockers are safe, effective, and reversible? Even this doctor admits that there is a possibility of stunted growth.

Marci Bowers responded to a question in the group about how puberty blockers affect fertility:

> *The fertility question has no research that I'm aware of as puberty onset allows for fertility options while blockers preclude those opportunities. I'm unaware of an individual claiming ability to orgasm when they were blocked at Tanner 2.*

Tanner 2 is when the Standards of Care say a patient can begin taking puberty blockers. Here, Marci seems to be saying that if you block puberty in that stage, then the adolescent will never orgasm. But he really doesn't know, because, as he admits:

> *Puberty blockade is in its infancy [...] we do not fully understand the orgasmic response and blockers make this a major question.*

WPATH dismisses the consent model of care

WPATH is actively attempting to manipulate its own "consent model of care" because the normal safeguards in current consent models are too restrictive and preventative of their treatments. One doctor posted:

> *I have been thinking more about what it means to obtain fully 'informed consent.' I was wondering to what degree, if any, other mental health providers discuss actual rates of surgical complications with client when providing assessments for surgical care. e.g. pain or loss of sensation, need for additional surgeries, necrotic tissue, infection, hematomas, strictures, implant-related complications, etc.*

Essentially he is asking, "Before we sign off on these risky surgeries, should we maybe tell the patients they could cause internal bleeding and kill off their body tissue?"

But some WPATH "experts" don't even want that level of "gatekeeping" because informed consent is too "cisnormative."

> *I'd also look at the vast literature on the uselessness and dehumanizing nature of the assessment process. The "traditional" model has had no real evaluation and does not appear to be grounded in much more than 'commonsense' cisnormativity.*

The fact that this organization is attempting to reject all standard consent models should tell you everything you need to know: It's an activist group with a scalpel.

Insurance: Bypassing safeguards to get coverage

WPATH members, even though the organization is largely an ideological sham, use the organization's gravitas when submitting letters for insurance:

> *I have made an effort not to use a diagnosis when sending information to insurance companies. And so far, I haven't been contacted and asked for a diagnosis. Instead, my letter reads 'X meets the recommended World Professional Association for Transgender Health Standards of Care guidelines for the type of surgery he is pursuing.*

WPATH members say that requiring two letters before amputating healthy breasts seems like "gatekeeping:"

> *I'm writing a letter for a 17-year-old for gender affirming top surgery…the surgeons office is requesting two letters…seems extra extra gatekeeping.*

The members jumped in the comments agreeing that this was totally "gatekeeping," and many made offers like this one:

> *I believe there are quite a few of us who are willing to provide a session and letter pro bono if that's what's in the best interest of the client.*

This person is happy to blindly rubber-stamp this approval process to ensure this 17-year-old doesn't need two whole letters before removing her breasts. A commenter "on the surgeon side of things" also advised about how to write these letters, saying:

> *With a 17 yr old, I also find it helpful to include….why starting university with top surgery done is imperative.*

"Imperative" ... interesting choice of words. It's imperative that we not send this girl to college with healthy breasts? And that's not the only insurance gatekeeper.

Another WPATH member bemoaned insurance for denying to cover FFS (facial feminization surgery) because the patient needed to be on HRT (hormone replacement therapy) for a year first:

> *Is there any way around this policy or wording…I certainly don't agree with an insurance plan telling her (him) she (he) must be on HRT to obtain medically necessary surgery for her (his) physical and mental health, along with safety.*

These internal communications prove that WPATH members are actively manipulating and bypassing the few safeguards around children before they make the permanent decision to alter their bodies and dissect their healthy organs and tissue.

WPATH members ignore the one-year waiting requirement for a 79-year-old wanting a limited-depth vaginoplasty

A WPATH member posted about a 79-year-old who wanted to forgo the 12-month "lived-gender requirement" before undergoing his limited-depth vaginoplasty. The requirement entails living as your "new gender" for an entire year before undergoing gender transition surgery. In this case, this 79-year-old man would have to "present" as a woman for a year:

> *Patient does not meet 12 mo lived gender requirement of WPATH SoC version 7…does anyone know whether SoC V8 will soften the 12 mo lived gender requirement?...at age 79, time is of the essence.*

This is when WPATH members said the quiet part out loud: The standards are, let's just say, "flexible." Some would say they aren't standards at all.

> *(I) interpret the 12-month lived gender requirement in a much looser way.*
>
> *The SoC7 are meant to be flexible guidelines.*

WPATH members not only make their own standards to justify their ethically problematic treatments — they can't even comply with the standards that they set. It's clear this isn't a legitimate medical organization.

Nonstandard procedures: Do you want a penis *and* a vagina, or none at all?

Thomas Satterwhite posted about a series of recent requests for what he deems as “non-standard” procedures:

> *I’ve found more and more patients recently requesting ‘non-standard’ procedures such as top surgery without nipples, nullification, and phallus preserving vaginoplasty.*

For context, top surgery is either the removal of breasts on a female or the construction of breasts on a male. Either procedure can be done with or without nipples. “Nullification” is a procedure that removes the genitalia altogether, essentially making the patient a eunuch. A “phallus preserving vaginoplasty” is the construction of a “neo-vagina” on a male while preserving his penis. Since “neo-vaginas” are typically constructed through scrotal tissue, this particular “neo-vagina” is likely made from grafted tissue, especially from the colon.

In a follow-up post he added:

> *From my perspective as a surgeon, I am quite comfortable performing procedures that are of ‘low frequency.’*

You would like to think that people would have jumped into the chat to tell this man to stop doing abstract art on people’s bodies. But no, quite the opposite. He was policed for his idea that there is even such a thing as “non-standard” like in this response:

> *I’m not sure whether we need new standards of care or just a different way of looking at gender that’s not through a cisgenderist gaze.If adult patients have body autonomy, what is the issue with having top surgery without nippples, for example? Surgical tattoos can help if the patient changes their mind later.*

After being battered by discussions of “gatekeeping,” Thomas apologized:

> *I had written my initial question too hastily and too thoughtlessly. With every patient I operate on…I let the patient lead the journey. Not me…Gender identity has nothing to do with ones gender expression and choice of surgical procedures.*

But even after this apology, the people did not relent:

> *Is 'non-standard' procedures the best term to use? They may become standard in the future.*
>
> *The entire field of gender care is going to be inevitably overhauled by younger people–thankfully–and we will need to adjust our lens regarding interventions being responsive to the poorly defined 'gender dysphoria.'*

Thomas tried to regain their favor by saying that he operates on his clients with specific incision patterns at their request:

> *I've performed mastectomies without nipples, or have created chests with varying degrees of remaining chest tissue, or created incision patterns specific to my patients wishes…*

But he got one-upped by the next commenter who turns people into eunuchs:

> *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.*

These are radical medical experiments based on an increasingly nonsensical ideology that insists that although sex, gender, gender identity, and gender expression are all constructs of the mind, the body must be molded to fit any whim and fantasy. There are no limits and no rules. As long as these surgeons, "gender specialists," and "mental health providers" keep making their money, they'll cut up mentally unstable people any way they would like and force insurance to pay for it as if it were chemotherapy saving their patients' lives. They think they're the good guys:

> *Why do people seek out trans health? It's to have a body that feels comfortable to them, that feels like them, that feels like home–or at least close to it as possible. Trans health is not and should not be about creating bodies that are*

> *socially acceptable, bodies that do not challenge cisnormativity….conservatives are scary and I understand the fear that non-standard surgeries will be weaponized against access to care…if we reject those surgeries for being ‘"weird’ or politically unpopular can we trust ourselves to stand up for the other subgroups that religious conservatives target?*

It's important to keep in mind that they see challenging “cisnormativity” as virtuous, and human bodies are the instruments they use to mount that challenge. They want us all to “reject the binary” of sex, and to bend the public's minds in that direction, they need to change more of the public's bodies. The aim is the obliteration of norms. That’s why none of their standards hold — because standards imply norms, which the ideology of radical transgenderism must reject.

More gender nullification surgeries

Rajveer S. Purohit jumped into the WPATH chat to teach a fellow “expert” about gender nullification surgeries:

> *What I have done in the past is a total penectomy with neurovascular pedicle preservation and burial of a ‘neoclitoris’ so patients can continue to have orgasms-if they wish- a segment of the bulbar urethra remnant is preserved and brought out as a perineal urethrostomy and sutured to a u-flap posteriorly. Anatorialy, the skim above the phallus is developed as a flap and mobilized down to the.*

Unfortunately, that’s where the screenshot cuts off, so if you were following along, you’ll just have to make the rest up. I’m pretty sure that’s what Rajveer is doing anyway. If you haven’t put two and two together already, gender “nullification” surgeries are essentially turning patients into eunuchs while still maintaining the ability to orgasm — cutting off a penis and constructing a “neo-clitoris.”

Thomas Satterwhite added that he gets insurance to pay for this insanity:

> *This is a procedure we perform in our practice –Align surgical Associates. We’ve been able to consistently get insurance coverage for many of our patients.*

Daniel D. Dugi said:

> *We also offer this [nullification surgery] at OHSU Portland. Incision/scar pattern depends on patient choice of approach..haven't had a problem getting insurance coverage so far.*

A 13-year-old girl on "T"

A doctor seeks guidance on a self-identified non-binary 13-year-old girl who wants to start taking testosterone:

> *I have an incoming 13yo–soon to be 14yo–who has identified this past year as non-binary, referred to me for assessment to start testosterone, per child's request. Thoughts?*

One response said:

> *The current SOC [standards of care] actually removes the age requirement altogether and recommends not starting until the adolescent is reasonably able to provide informed consent, the age of which will be different person to person.*

Here is another example of WPATH's incredibly loose standards of "informed consent." There is no standard. It differs from "person to person," even if that person is a 13-year-old girl.

One commenter said,

> *I usually recommend that the person be living as the other sex for 6-12 months.*

That defies WPATH's own "standards." The standard governing these doctors, in all practicality, is to do whatever the patients want.

> *After much experience as a pediatric endocrinologist I would not rule out treating if the person is…convinced that transition would be correct for him [her].*

Let that sink in. This doctor said that the decision to treat a 13-year-old girl is based on if the girl is "*convinced that transition would be correct for [her].*"

WPATH members have no clue what they are doing

In one back-and-forth, a WPATH member said:

> *I have a nonbinary patient…who had questions regarding the use of finasteride to prevent bottom–clitoral–growth.*

Just to prove they see this as a big experiment, one responder said:

> *I haven't had any experience with this…but will be interested to see if others have tried using it.*

Another response said:

> *We have not been able to find any evidence for this but it is clearly something that is being discussed in the community.*

According to Medline, Finasteride (Proscar) is used:

> *Alone or in combination with another medication (doxazosin [Cardura]) to treat benign prostatic hypertrophy (BPH, enlargement of the prostate gland)... Taking finasteride may increase the risk that you will develop high-grade prostate cancer (a type of prostate cancer that spreads and grows more quickly than other types of prostate cancer) or breast cancer. Talk to your doctor about the risks of taking finasteride.*

What is the response from WPATH's members? Hey, let's give it a whirl. There is no "evidence-based" standard behind this pseudo-medical organization.

Can a developmentally delayed 13-year-old provide informed consent?

This question was posed as an “ethical inquiry:”

> *In a developmentally delayed 13yo adolescent, currently on pubertal suppression that may not reach the emotional and cognitive developmental bar set by SOC within the typical adolescent time frame, if at all, what is the ethical approach to care?*

Here were the replies:

> *I think the judgment is left up to individual teams.*

> *This is how I would approach this…: a guiding principle would be weighing harm of acting vs not acting.*

How would one weigh the “harm of acting vs not acting?” Would you want the doctor enabling a 13-year-old developmentally delayed girl to undergo this treatment to be in charge of that judgment?

Autogynephilia isn’t real … right?

A doctor enquired about autogynephilia:

> *I would appreciate hearing from my mental health colleagues who have treated AMAB clients who present with traits associated with Autogynephilia.*

The term autogynephilia was coined by Dr. Ray Blanchard and refers to the psychological condition of men who “transition” to female who are sexually aroused by the idea of themselves as female.

According to the Journal of Homosexuality:

> *Ray Blanchard's Autogynephilia Theory suggests that the association between sexual orientation and autogynephilia among male-to-female transsexuals is clinically important and the association is always (or almost always) present.*

Interestingly, Lia Thomas (the male swimmer who raced against Riley Gaines) is rumored to have autogynephilia, based on some unearthed social media posts.

What was WPATH's response? Pretend autogynephilia doesn't exist.

> *Blanchard's theory of autogynephilia is no longer widely accepted in trans health–if it ever was– and is widely considered transmisogynistic.*
>
> *...long been debunked…for several reasons including concerns about its validity and potential stigmatization of transgeder individuals.*
>
> *Bogus concept of autogynephilia…*

Of course, a self-described "gender doula" entered the chat:

> *As a gender doula, I work with folks who are feeling confused and/or distressed about the way their gender intersects with their erotic life. I find that folks of many genders, including cis het folks find various forms of gender affirmation to be extremely erotic. Pathologizing this as a 'phillia' is not helpful.*

On page 219 of the WPATH Files, a person posted about a very weird case of a patient who "*identifies solely as a heterosexual man with autogynephilia."* He takes hormones on and off, kind of in the style of a drug addict trying to get sober, then going on a bender. After nine weeks of hormones, he will *"sexually gratify himself"* then "*have clarity…and seek out anti-trans activists as a form of self punishment"* (according to the WPATH member) Then the process starts over. He says:

The patient is admittedly staunchly conservative and religious, and is part of legislative bodies that work with 'anti-grooming' groups in an attempt to 'de-trans' children.

One commenter offered this advice:

> *Perhaps, figuratively speaking, without abandoning them (him) you need to 'stick your professional foot out' and trip this person up. Perhaps a religious approach may work. 'This confusion in your life, do you think this is what God wants? There is a physical and genetic component to trans. It's not a defect. It is part of God's biology. It cannot be wrong to explore that!'...type of logic/reasoning. I am a 'devout bead rattling catholic' and have no problems between me and God, simply because I have good self-talk that I am convinced He has given me…*

> *Whatever keeps this poor soul going around in circles has to be a lie. Your job is to figure out what that lie is, and the usual culprit is someone else is feeding them this religious crap…i very rarely speak about my faith or God, but as you said, religion and conversion crackpots are part of this puzzle.*

Keep statements like this in mind when considering that these people's individual judgment is substituting for medical standards.

Creating a sexual crisis for an autistic patient

This story is particularly monstrous. A doctor posted about an 18-year-old autistic patient about her increased sexual arousal on testosterone:

> *I have a freshly turned 18 yr old transmale (female) client with autism who just started testosterone…and they (she) can't stop being 'horny.'...I plan to do some sex education and human anatomy lessons as the client is new to anything related to sex, intimacy, arousal, etc.*

Here's our translation: They medicated an autistic young person with no sexual experience to the point that she developed an uncontrollable libido, putting her in a potentially dangerous and an absolutely confusing situation.

How do they recommend helping this poor girl? They don't say to take her off of her meds. Instead they say:

> *I have a resource for transmen who specifically have sex with other men.*

We checked out the resource and found that it was pornographic and widely inappropriate. The first page is a picture of two bare butts in some kind of bondage style-straps lying on a bed.

Here are some excerpts:

> *Some of us take drugs, such as cocaine, heroin, amphetamine (speed, meth) and ketamine ("Special K"), with needles.*
>
> *Some trans men work as sex workers full-time, or part-time to supplement their income.*

> *Make sure your BDSM is risk-aware, consensual kink (RACK). is applies to any BDSM activity, ranging from a 24/7 BDSM relationship to only being interested in some occasional spanking.*

Remember, a “health care professional” is recommending this pornographic resource to an 18-year-old autistic girl.

Here’s another horrifying comment from this thread:

> *Masturbation education is key, encouraging that it is completely natural and normal to self satisfy and soothe.*

A fully mentally aware adult who will teach an autistic teen about masturbation should tell you everything you need to know about the credibility of WPATH. For people so worried about power dynamics, how could they possibly support something like this? How is this young autistic girl supposed to say no if she's uncomfortable?

> *It’s important for them to explore their sexuality now at this stage providing psychoeducation that sexuality is fluid.*

A voice of reason? Not for long

In response to a post promoting the idea that “lengthy gender assessments” before medical intervention (blockers, hormones, surgery) is “gatekeeping,” a voice of reason came in the form of a “woman assigned male at birth and a clinical social worker:*”* He says:

> *[Lengthy gender assessments] are not necessarily to impede or delay care. it is to weigh with the patient the potential risks and benefits of their receiving gender affirming medical interventions…I would contend that many professionals providing gender affirming care have not received the training required to meet these standards of care.*

Someone commented,

> *thanks for sharing your take on this…but therapists aren't required to assess folks who need hip replacement surgery–larger regret rate– or nose jobs.*

This is where the rubber meets the road. On the one hand, WPATH members are demanding we treat their patients as if they are in need of medical intervention the same way as someone whose hip is broken — as if removing healthy breasts or inverting a penis were a “repair.” But the question they can't escape is: What's broken? They can't say the mind of a “gender non-conforming” patient is broken — that's “pathologizing.” So what's left to be broken? The body. The baseline assumption is that perfectly healthy bodies are broken and in need of unnatural interventions. It’s the original sin of the flesh taken to its most extreme, but here there is no redemption unless the patients pay up and put their health on the line to “fix” themselves.

The voice of reason replied:

> *We have a novel population now, like it or not. If we are not careful, the rollbacks on care at the government levels, in response to a loss or lack of gatekeeping/ proper assessments by the system will lead to a loss of service for consenting, fully-informed adults. Individuals under 18–really under 26, in my opinion–are unknown, especially those with what appears to be adolescent onset Gender Dysphoria…so the sloppy approach to delivering this care will come back to bite us all, I am sure. Either we do a better job at the healthcare level or we put ourselves at risk of having politicians make these decisions for us.*

“Gatekeeping,” as this person correctly describes, is another word for “safeguarding.” If there are no safeguards, how could they possibly keep their patients safe?

Gender-affirming care: The not-so-secret cash cow

According to research published in 2022 by the Journal of Law, Medicine & Ethics, the amount of money being raked in by doctors performing transgender “treatments” is astounding. These procedures often create life-long patiens, requiring regular and long-term medical care following their “gender-affirming care.” The financial incentive to push these treatments on potential patients is clear.

	Average per-person cost for all related procedures	**Average health insurance plan paid**	**Average per-person out-of-pocket cost**
Bottom Surgery / Phalloplasty	$137,893	$133,911	$3,982
Bottom Surgery/ Vaginoplasty	$56,269	$53,645	$2,624
Bottom Surgery/ Hysterectomy	$16,167	$14,538	$1,629
Bottom Surgery/ Orchiectomy	$8,177	$6,927	$1,250
Top Surgery/ Mastectomy	$14,924	$12,680	$2,244

	Average per-person cost, annually	Average health insurance plan paid, annually	Average per-person out-of-pocket cost, annually
Testosterone	$161	$121	$40
Estrogens + Anti-Androgens	248	$153	$95
GnRH (Puberty Blockers)	$2,623	$2,410	$214