Should the NZ Ministry of Health adopt WPATH's SOC 8?

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Abstract

WPATH's Standards of Care (SOC 7) published in 2012 fared poorly in reviews of its quality and it was recently replaced by SOC 8. The launch of the new Guideline was delayed and chaotic and in the days immediately after its publication a correction was published removing all but one of the age limits for medical and surgical treatments. WPATH's medical approach differs from most medicine and science. The scope is far broader than most Clinical Practice Guidelines (CPG). SOC 8 includes intersex people within the transgender and gender diverse (TGD) community despite the two populations lacking common features. It also makes demands of clinicians well beyond the health setting with recommendations going beyond medical considerations to demands for allyship and advice that clinicians seek to influence broader society.

SOC 8 is argued to be evidence based and to be significantly improved. World Health Organisation and the National Academies of Medicine advice on creating CPG guided the development. The National Academies of Medicine use 8 criteria for creating and assessing CPG and the article uses these to assess SOC 8.

The investigation found that the systematic literature review did not find any of the recent independent evidence-based national and sub-national reviews of child and adolescent gender medicine. As WPATH members authors held a uniformity of views about gender identities and the benefits of gender medicine and surgery. The fate of evidence based reviews undertaken to support the Guideline is not clear. Some Guideline Recommendations are duplicated and others have no supporting evidence. There is no evidence that the required independent review took place and nor is there an updating plan. Arrangements for dealing with conflicts of interest are unclear.

Introduction

At its annual symposium in September 2022 the World Professional Association for Transgender Health (WPATH) released the long awaited Standards of Care for the Health of Transgender and Gender Diverse People 8 (SOC 8) (Coleman et al., 2022) replacing the decade-old SOC 7. (WPATH, 2022a)

The NZ Ministry of Health has said that it anticipates it will adopt the updated guidance and that PATHA (the Professional Association for Transgender Health Aotearoa) would update its guidelines following

publication of the new Standard[1 2.] This is despite the increasing number of authorities who are turning away from WPATH's approach.(Fully Informed, 2022)

The Launch of SOC 8

The new Guideline has been keenly anticipated. WPATH has said that SOC 8 is the first 'evidence based' standard of care. The new Guideline's methodology section lists improvements from Soc 7, including, at various stages, using independent advice and processes.

However the reception of the new Guideline has been mixed. Set to be announced in the Northern Hemisphere Spring there were numerous delays throughout 2022 and it was eventually launched to coincide with the symposium.

Anticipating positive coverage WPATH provided exclusive access about the forthcoming Guideline to a New York Times journalist. (Bazelon, 2022) However the journalist published the first article in that paper which confirmed the long-suppressed reality of expert disagreement about the explosion in youth gender medicine. Minimum ages for hormones and surgery, already lowered in the draft, were removed altogether in a correction made days after the launch. This and more caused The Economist to assess the launch as '*a mess*'. (The Economist, 2022)

SOC 8 includes new chapters covering people whose identity is nonbinary or eunuch, chapters on adolescents and people with intersex conditions as well as a chapter that covers issues for transgender people living in institutions.

The purpose of this paper

The paper

- Describes the new WPATH Standards of Care (SOC 8) – also referred to as The Guideline and the way it differs markedly from usual medical and scientific norms.
- Discusses the features of evidence-based, high quality Clinical Practice Guidelines (CPG).
- Describes the extent to which SOC 8 meets the criteria for CPG.
- Describes the ways some specific topics are addressed in SOC 8 that point to concerns.

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[1] PATHA was not formed until a year after the current guidelines were published by Waikato University.

[2] In an OIA response from March 2022 the Ministry wrote: *Our approach to the provision of gender affirming health care will continue to be guided by health professionals and Rainbow communities, including the World Professional Association for Transgender Health (WPATH) Standards of Care Version 8 (SOC8), which is expected to be released in the first quarter of 2022. These updated guidelines will provide updated assessment, support, and therapeutic approaches for transgender and non-binary people. PATHA is expected to update its guidelines for Gender Affirming Health Care following the WPATH release of SOC8.*
https://www.health.govt.nz/system/files/documents/information-release/h202204014_response.pdf

- Assesses whether the Guideline warrants the level of trust that the Ministry is proposing to place in it.

Setting the scene

Assessments of the 2012 SOC 7 Guideline

Reviews of SOC 7 cast doubt on its quality. It was rated poorly in a 2021 systematic review of transgender medicine clinical practice guidelines. A team of researchers found that it was not 'gold standard' and none could recommend its use after assessing it against the Advancing Guideline Development, Reporting and Evaluation in Health Care (AGREE) criteria. (Brouwers et al., 2010) Reviewers had to abandon a proposed comparative analysis with other transgender health guidelines because of the lack of recommendation statements and a poor evidence base.(Dahlen et al., 2021) A review by some of the WPATH SOC 8 authors, was apparently published to point to improvements that could improve SOC 8. The authors found that it was based on lower-quality evidence such as observational studies and expert opinions and that it lacked any rating of the quality of the available evidence or the strength of recommendations. They also noted that there was no description of how expert contributors are selected to participate in the process of developing the guidelines.(Deutsch et al., 2016) In an apparent response to these negative assessments the methodology section of the new Guideline lists several improvements from Soc 7.(Coleman et al., 2022)

WPATH and its origins

The Harry Benjamin Gender Dysphoria Association was formed in 1979 and was the forerunner to WPATH and it was under that name that the first 6 SOC were produced. Benjamin was a German medical doctor who moved to the USA but he had visited Dr Magnus Hirschfeld's Institut für Sexualwissenschaft and was influenced by his ideas. He is said to have coined the term transsexual and was among the early adopters of the idea that sex (biology) could be differentiated from gender (feelings related to opposite or same sex-stereotyped behaviour). In his writing he appeared to conceive of transsexualism as a kind of intersex condition of the mind and in his medical practice he provided hormone treatment and arranged for surgery for his clinic's patients. WPATH's early standards of care have been based on his case studies even though Benjamin noted his patients associated poor mental health preceded treatment and was almost ubiquitous afterwards. But his 1966 book was prescient in that it anticipated many of the issues that are still at the heart of WPATH(Benjamin, 1966)

An outlier from usual scientific and medical approaches

The existence of a gender identity is not universally accepted and there is no diagnostic proof that such a thing exists. Treating people who are uncomfortable in their bodies does not require the creation of terminology that draws everyone into a contested world view But WPATH does this and their definition of Gender identity is described in the Guideline as 'An individual's …. internal identification and

experience' (SOC 8 s31). With its underpinning of gender theory, which regards gender as being more significant than sex, and as a spectrum (Esses, 2022) it contradicts the usual medical explanations of sex – as a binary of male and female. Even the understandings of evolutionary biology where biology and sex are the basis of natural selection and humans are understood as specialised mammals are countered by gender theory.[3](Joyce, 2021). Unlike other illnesses of perception (e.g., anorexia, self-harm, psychosis) gender medicine is unique in promoting lifelong medical and surgical treatment to address an internal belief. In addition psychology usually regards societal experiences as preeminent in identity formation rather than a psyche that emerges from within let alone a gendered psyche that may have been created in a 'wrong body'. (Consider for example whether it is acceptable to consider disabled or anorexic people to have also been 'born in wrong bodies'). In a further unusual difference from normal medical practice the Guideline reports that it eschews the normal population terms like prevalence and incidence because doing this will 'preclude inappropriate pathologizing' of the transgender and gender diverse (TGD) community. It does however use these statistical terms in the eunuch and intersex chapters. SOC 8 does not demand diagnoses of gender dysphoria or gender incongruence unless local rules mandate it.

In summary led by Benjamin's thinking, the branch of medicine that WPATH has developed is at odds with usual medical practice.

The use of Clinical Guideline Standards in creating guidelines

Guideline development in medicine is assisted by various sets of standards development guidance that provide schema and checklists. WPATH says that it used two: one from the World Health Organisation (World Health Organisation, 2014) and another published by the National Academies of Medicine (National Academies, 2011) One of the reviews of SOC 7 mentioned above used AGREE - a third set of standards.(Brouwers et al., 2010) Other more specialised tools can guide specific aspects of guideline creation. There are guides to generating research questions, conducting literature reviews, implementing and adapting guidelines, assessing, and weighting the quality of evidence for guideline recommendations for example.

The National Academies Guideline

This paper uses the National Academies eight point schema below to assess the SOC 8 Guideline. Some quotes from the AGREE and WHO Clinical Practice Guideline development tools are used to describe specific points. The National Academies of Medicine Clinical Practice Guideline (CPG) describes how using it can enhance clinician and patient decision-making '*by translating complex scientific research*

[3] Joyce describes how Magnus Hirschfeld's view of sex as a spectrum, contrasted with Darwin's. Evolutionary theory that has been the basis of all subsequent biological science. I.e. that there are two sexes whose genetic mixing has driven natural selection and evolution and which determines the way sex differences are important in the practice of medicine.

findings into recommendations for clinical practice that are relevant to the individual patient encounter'. The key features are

1. Transparency
2. Management of conflicts of interest
3. A systematic review
4. Guideline development group rules
5. Establishing evidence foundations for guideline recommendations
6. Articulation of recommendations
7. External review
8. Updating (National Academies, 2011)

The WHO guideline lists additionally such things as:

- expert group composition
- instructions for group processes to achieve consensus among experts
- taking into consideration potential harms and benefits, end user's values and preferences
- minimum standards for reporting. (World Health Organisation, 2014)

WPATH's challenge in developing the SOC 8

The task facing the WPATH Guideline creators is complex. Most health guidelines cover one health condition or the use of a single technique or medical appliance. Examples would be post-operative sepsis or diabetes care. In contrast WPATH SOC 8 covers two almost entirely separate populations - transgender and 'intersex' people meaning those with disorders of sexual development – a hugely varied group with each condition requiring specific interventions. The transgender, and gender non-conforming populations are complex too, with different age cohorts appearing to have differing causation. For example the recent explosion in numbers of mainly post-pubertal young women and there is a massively increasing number of people overall seeking treatment. Other differences relate to the personalised treatments demanded by patients and offered by SOC 8. According to the Guideline patients may want 'medically necessary' (i.e. treatment that insurance companies will pay for) medical and / or surgical intervention or not; they may have mental health issues or not; children and young people (or parents on their behalf) who may seek social transition and / or puberty blockade or not. Interestingly these decisions are often, but not always, based on personal perceived need or a preference for particular bodily characteristics and not medical necessity as usually understood. This complexity surely raises questions about whether a single guideline is appropriate to cover the many populations and medical interventions involved. The wide coverage of The Guideline means that it contains only very cursory information about surgery for people who want to more closely fit their self-perception and does not differentiate between different disorders of sexual development.

Assessment of compliance with the National Academies Clinical Practice Guideline

This section assesses SOC 8 against the National Academies for Medicine criteria. It uses the 8 features described above to assess The SOC 8 Guideline.

Transparency

The National Academies advice stresses the relationship between transparency and the creation of trust in the resulting guideline. This relates mainly to transparent procedures. The WPATH Guideline raises numerous transparency issues related to the methods used; information that appears to be missing and problems with categories and definitions.

Missing and contradictory information

An ethics chapter available for comment in the draft version was removed from the final document. The reason given was surprisingly that

> *In the course of writing the chapter, it was later determined topic of ethics was best placed external to the SOC8 and required further in-depth examination of ethical considerations relevant to transgender health*.(p248 para 3.2).

And elsewhere a statement titled 'ethical approval' states

> *This manuscript does not contain any studies with human participants performed by any of the authors.(WPATH, 2021a)*

Despite claims that the Guideline was reviewed for consistency across chapters there are multiple instances where statements made in one chapter are contradicted elsewhere. For example, the size and nature of the transgender and gender non-conforming population; the recent rise in numbers and the change of cohort (from mainly male and pre-pubertal to mainly female and post-pubertal). The need for counselling is in some places required to understand the causation of gender dysphoria, but elsewhere it is optional and it is even implied it may be effectively akin to a conversion practice. The research evidence on initiatives that either improve or are worse for TGD people's rates of self-harm, overall wellbeing and suicidality are also described in ways that are inconsistent between chapters. In any case much of the evidence for these claims is based on low quality surveys of self-selecting populations or research with small populations.

Conflicts of interest

According to the WHO Handbook for Guideline development that WPATH argues it has followed there are tables that cover what should happen to mitigate different kinds of conflicts of interest, workflows to guide the assessment process and approaches to mitigate the impacts of funding and other

relationships that represent conflicts of interest. (World Health Organisation, 2014) WPATH reports that there is a requirement for a conflict of interest notification but it provides no information detailing how conflicts were managed, nor about how these notifications impacted the research or the selection of participants.

While no research has been carried out for the current Guideline an examination of the SOC 7 found that many of the authors received income based on recommendations in the guidelines; work at clinics or universities that receive funds from advocacy groups; foundations, or pharmaceutical companies who heavily favour a certain treatment paradigm.(MacRichards, 2019) As with Soc 7 several are based at the University of Minnesota where recurrent funding from the Tawani Foundation (a transgender advocacy organization) is provided for the role held by Professor Eli Coleman, who is also the WPATH Guideline Steering Committee Chair and a Professor of Gender Studies in the Institute for Sexual and Gender Health, Department of Family Medicine and Community Health, at the University's Medical school (Tawani Foundation, n.d.) The Guideline itself says that SOC 8 is part funded, the TAWANI Foundation.

Guideline development group rules

The Guideline Development advice from the US National Academies is that they should provide for '*comprising a variety of methodological experts and clinicians, and populations expected to be affected by the CPG.*'

The SOC 8 chapter authors and their teams are listed on the WPATH website. Only WPATH members were permitted as authors and chapter leads creating an immediate bar to diversity of thinking. Many of the Guideline authors, perhaps the majority, are also cited multiple times in the Guideline itself. There is no evidence of critical or cautious voices on any of the committees. The rules preclude anyone who may be involved with the Society of Evidence Based Gender Medicine, Genspect, the award nominated Transgender Trend or those people in the English, Swedish, Finnish and Floridian health systems who were working to take a more cautious approach to puberty blockers unless they are also WPATH members. No specifically intersex stakeholder organisations are listed as having been consulted about whether their inclusion was acceptable to them.

In the end to end process of some 3 ½ years there was a 2 week public consultation phase in late 2021 which was extended, without explanation, to six-weeks over the Christmas / New Year period for the public to comment. The time scale meant it was almost impossible for organisational submissions to be consulted and finalised. Submitters were warned against making their own copies of the drafts and were advised that no changes to the recommendations would be made as a result of the consultation. In any case many elements of the final document were missing from the draft chapters. (WPATH, 2021b)

There are some participants whose inclusion throws doubt onto the values and actions of the organisation. One of the authors of the children's chapter is Susie Green, former head of Mermaids, a UK support charity for transgender children, which is currently under investigation by the Charities Commission (Hargrave, 2022) and mired in numerous scandals.(BBC News, 2022)

Prior to the launch, an independent investigative journalist found that the Eunuch chapter contained links to a pornographic website – the Eunuch Archives - which contained thousands of pornographic stories including fantasies about carrying out castrations, including on children. Later it was revealed that the lead author was himself a participant in the Archives and also used it anonymously to carry out his research. The journalist wrote that he was one of two authors had written a paper '*justifying the pedophilic fantasies amongst castration fetishists*'. In a 2015 paper titled *"The Sexual Side of Castration Narratives*" where fictional child sexual abuse material was called "therapeutic" and helpful for those with eunuch ideations."(Gluck, 2022) However in his presentation to the conference the speaker on this topic made clear that he was more sympathetic to the eunuchs who hated their genitals or who might emulate those who historically have held special functions (such as the placid and infertile males in political and religious leadership roles). He said that those who had an extreme fetish or paraphilic disorder were not included). (Johnson, 2022)

In the last year, senior members of the association have become whistle-blowers against WPATH's own practices calling them lazy. (Shrier, 2021) One has spoken out against the often quoted 'rather a live daughter than a dead son' thinking (Biggs, 2018) saying there is no evidence that failure to provide rapid access to child gender medicine will cause suicide. (Genspect, 2021)

The Systematic review

Research Methodology

The SOC 8 methodology is described in one of its appendices, and the improvements over SOC 7 are outlined but to gain a full picture the reader needs to do quite some detective work. The WPATH website (not the Guideline) lists the chapter authors and their brief biographies and information about the development of the Guidelines. PROSPERO, a database containing a register of systematic reviews, contains information about the status of the literature reviews responding to the research questions that had been formulated by WPATH. However these funded reviews are not identified in the Guideline document itself (although one is included as a cited reference) nor are they on the WPATH website. PROSPERO shows that two reviews were listed as being funded by WPATH in 2019 and which were therefore presumably initiated to become the evidence base of SOC 8 but nowhere is this explicit.(National Institute for Health Research, 2019) One titled *Effects of hormone therapy in transgender people* (Baker et al., 2021) was published. A second set of proposed literature reviews *Effects of gender-affirming surgeries for treatment of gender dysphoria in transgender people* was due for release in October 2019 but has apparently not been published and, if the PROSPERO record is correct, barely progressed beyond initiation stages.(National Institute for Health Research, 2019) No explanation for this, or the implications for the Guideline of it not having been completed, is provided.

Literature review

AGREE II describes an evidence search [4]

- *Systematic methods were used to search for evidence.*
- *The criteria for selecting the evidence are clearly described.*

WPATH's search strategy and databases are listed in Appendix A 3.6 and the 'independent systematic literature reviews' mentioned above were begun. This process was reported as complete by September 2019 in the SOC 8 appendix A3, more than three years before the Guidelines were released. At least 600 additional references were added after 2019 that the text says were added on the basis of '*background literature searches and search updates*'.[5] Research papers was excluded and other material was added through searches of '*additional databases as deemed appropriate*' however these decisions were based on criteria which are not described.

Despite the independence of the original reviews there are some serious limitations. The apparent non appearance of the surgical literature review is of course the first. Much of the research that calls into doubt WPATH's social transition, medical and surgical approaches has not been included. Neither were they captured in the background processes that the methodology section says found additional relevant resources. Amongst the sources not identified by this process and thus not examined were:

- Several recent, evidence-based, national reviews by independent assessors which show that the evidence base for puberty blockers and adult medical and surgical interventions is 'very low'.(SEGM, 2021a, NICE, 2020, Brignardello-Petersen & Wiercioch, 2022 , Canadian Gender Report, 2020, Cass, 2022) By ignoring them there has been no need to rebut the issues that they have raised about the poor quality of evidence.(Esses, 2022)
- The research of Dr Michael Biggs which has been fundamental in reversing gender medicine practice in England. (Biggs, 2020)
- The legal findings related to the limits of Gillick Competency in relation to informed consent in the Keira Bell trial (High Court of Justice, 2020)
- The extensive coverage of British academics in the edited volume Inventing Transgender Children and Young People (Moore, 2019)
- Research that demonstrates the unusually high burdens of trauma faced by children who report as transgender was also missing. (Kozlowska et al., 2021)
- Animal studies that showed that pubertal suppression in sheep had measurable effects (Hough et al., 2017) were explicitly excluded from evidence reviews. (National Institute for Health Research, 2019)

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[4] AGREE II criteria are used here as they are a similar framework for developing Guidelines but the detail of what is required is succinct. It is the same approach used in Dahlen et al's assessment of SOC 7.

[5] The references show that about 215 new articles were cited from 2021, 300 from 2020 and 55 from 2022. Presumably other earlier articles were also cited as the text was developed.

- FDA listed notifications about puberty suppressants and the broader research datasets on the medications that point to serious iatrogenic health impacts. (Food and Drug Administration (FDA), 2022) (Lesbians United, 2022)
- Material that discusses the basis for 'informed consent'. It is, in NZ at least, the means by which unauthorised medicines (whose use would otherwise made illegal by the Medicines Act) can be prescribed.

With none of this important background evidence having been included and therefore not considered thoroughly by independent experts the Guideline is able to report that

> *'There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care (Version 8), in TGD people in need of these treatments (s18)*

But when large amounts of high quality research that casts doubt on WPATH's affirmative approach are not included (and it appears that the surgical literature review was never reported) is there not a severe danger that the medicine cart is being pulled by a horse that is heading in the wrong direction? The Cass report provides a salutary example of what happens when services embed ideological rather than medical priorities.(Cass, 2022)

The development of recommendations

Clinical Practice Guidelines (CPG) development tools including The National Academies Clinical Practice Guideline, World Health Organisation Handbook and AGREE all require recommendations to arise from evidence. But this is not the case for SOC 8. The Guideline advises in the methodology section that *'this evidence is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion*'. (S247) But expert opinion, even when it is consensus based is not the same as research evidence. A review in the British Medical Journal of SOC 8 noted that in the adolescent chapter

> *that the quality and quantity of the evidence on effectiveness of treatments in adolescents renders a systematic review "not possible" but at the same time that the evidence "indicates a general improvement in the lives of transgender adolescents" who receive medical treatment.* (Block, 2022)

In its place WPATH provided a '*short narrative review'* even though its research strategy failed to report the systematic national level reviews mentioned above whose findings should have dented their optimistic assessment.

It seems that throughout a lack of evidence is no bar to proposed treatment if expert opinion argues that it should happen. Other commentators have unpicked aspects of the guidelines identifying

examples where the evidence base does not support the claims made. (Ayad & O'Malley, 2022, Clark 2022)

Formulation of recommendation statements

The methods for formulating recommendations are clearly described in the AGREE guideline.

- *The health benefits, side effects, and risks have been considered in formulating the recommendations.*
- *There is an explicit link between the recommendations and the supporting evidence*(Brouwers et al., 2010)

But a submission to the draft Guideline noted that, despite the claims in the methodology section, that the draft document's recommendations lacked

- *strength of recommendation or certainty of evidence attached to them.*
- *justification about the balance of desirable and undesirable consequences for each of the recommendations.*
- *evidence synthesis attached to each of the recommendations.*
- *values and preferences, which shape the recommendations* (SEGM, 2022)

The final Recommendations still do not have these missing elements. Small sample sizes or survey results from self-selecting surveys are rarely mentioned as lessening levels of certainty. A proper process would be expected to be provided in a structured or tabulated format against each recommendation to assist understanding. But the narrative making the case for each statement is unstructured as is the balancing of positives and negatives. Often alternative views present in the literature are simply brushed away. For example D'Angelo's criticism of an article by Turban that it seeks to undermine ethical psychotherapy by conflating it with conversion therapy(s53) is simply negated by repeating more information from the criticised research and missing the point that conversion practices and exploratory therapy to identify causation are not the same by saying

> *'this should not detract from the importance of emphasizing efforts undertaken a priori to change a person's identity are clinically and ethically unsound.'*

Since many of the recommendations are not based on clear cut evidence SOC 8 appears barely more effective than SOC 7.

Other analysis noted that:

> *The combined group of 119 committee members, including medical professionals, researchers, and community stakeholders, used the Delphi method to approve all wording, requiring agreement from at least 75% of members. (Block, 2022)*

But the Delphi method is regarded by experts as of most use in social science. It is regarded as a poor tool for clinical research as it relies on opinions and not evidence. Although anonymous it provides no protection against groupthink and serves to prioritise expert opinion over the use of research evidence.(Barrett & Heale, 2020)

Another problem with the WPATH Recommendations is that many are not clinical advice. The language is often more political than would usually be expected in a clinical guideline. Many recommendations are injunctions to act as champions for transgender people including beyond the medical context. For example recommendation 2.5 lists principles for clinicians which consist, for the most part, of moral persuasion, and which appear to place clinicians and policy makers in the role of transgender ally rather than medical provider. Others relate to the commissioning of services. The Institutions chapter makes the case for males identifying as transgender to be housed in women's facilities and the arguments deployed are similar to those used in advocating for self-identification in law. Thus it appears that WPATH is seeking to implement an extra-legal form of self-identification in institutions beyond the few countries that have implemented self-id like NZ and Canada.

Many of the guidelines, because of their very wide scope are properly directed at legislators or policy makers. For example the introduction says

> *…. health care professionals who provide care to TGD people are called upon to advocate for improved access to safe and licensed gender-affirming care while respecting the autonomy of individuals. (s5)*

Other sections make similar demands for health care professionals to intervene in other professional areas including in government and education. For example introduction and following recommendations say

> *…. health care professionals who provide care to TGD people are called upon to advocate for improved access to safe and licensed gender-affirming care while respecting the autonomy of individuals. (s5)*
>
> *Statement 4.1 We recommend all personnel working in governmental, nongovernmental, and private agencies receive cultural-knowledge training focused on treating transgender and gender diverse individuals with dignity and respect.*
>
> *Statement 6.4 We recommend health care professionals work with families, schools, and other relevant settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.*

The text is frequently punctuated by repeated discussion of transgender stigma, victimisation, discrimination, oppression and the need for additional human rights, including rights to bodily autonomy as well as the effects of minority stress. Thus it appears emotional claims are made and expert opinion is frequently deployed in place of research evidence to start or to continue treatment

even though if the other more cautious evidence-based material had been included the advice would have differed.

For example the in the hormone chapter Recommendation 12.21 about continuing with hormones during an episode of poor mental health says

> *Mediators and moderators of mental health disparities unique to transgender people include experiences of discrimination, victimization, misgendering, family rejection, and internalized transphobia*

But it is one of almost two dozen times throughout the Guideline's where these issues are mentioned. The term 'minority stress' is used 34 times throughout the document.

There are frequent poor instances of poor proof-reading. Several guideline statements are duplicated, sometimes even in the same chapter, for reasons that are not clear.(See 6.1b and 7.2 about gaining theoretical and evidenced-based (sic) training in child and family medicine, 15.4 and 18.5 about smoking cessation, 16.5 and 18.10 about reparative therapy, 5.1c and 5.3c about investigating reasons for possible gender incongruence and 15.1 and 15.2 about preparing for surgery.) In Appendix A the methodology section the bibliographic link to The National Academy of Science CPG that was used is missing and the WHO CPG guideline reference is made to the wrong document. In other places proof-reading leaves sentences that are extremely hard to parse. See for example sentences 1, 2 and 3 from the Intersex chapter.)(s93) Four paragraphs into the Adolescent Chapter a sentence beginning

> *A chapter dedicated to transgender and gender diverse (TGD) adolescents, distinct from the child chapter, has been created for this 8th edition of the Standards of Care*

which seems oddly self-referencing then repeats verbatim, information from the chapter summary. Some sentences are lacking proper punctuation making understanding difficult.

Reviews

Pre-publication SOC 8 provides nothing to indicate that an independent pre-publication review has taken place. If it had surely reviewers might have noticed the missing literature and the heavy reliance on expert opinion for example.

Post publication Neither are details of a post-implementation review plan or period noted although WPATH acknowledge on their website that this is a requirement and it says

A new edition of the SOC (SOC-9) will be developed in the future, when new evidence and/or significant changes in the field necessitating a new edition is substantial.(Appendix A 4)

But such a statement is not adequate to the purpose envisaged.

Case studies

The following brief descriptions demonstrate how WPATH's process is creating a lack of clarity in how the Guideline is working and whether the approach has been adequate.

Usability

There is nothing that orients the user to how it might be used with an individual patient in a clinical setting as the National Academies CPG says is the purpose of the Guideline. Some of SOC 8's Recommendations are available only to those who meet specific criteria. But the criteria are not outlined in the information supporting the Recommendation. Instead it may be contained in one or two other chapters of SOC 8 as well as in an Appendix to The Guideline. This means that using The Guideline in a practical setting would be next to impossible.

Age limits correction

As mentioned above there was a surprising about face when a correction (WPATH, 2022b) to the guideline was published mere days after it was released which removed all but one of the age limits for treatment which had been in the draft policy.(Nainnggolan, 2022) Questions about how "Years of rigorous scientific effort" could end with such a big change in the closing stages of the process were asked but initially no explanation was forthcoming either to the media or in the Guideline itself.(Lane, 2022) With the downsides of puberty blockers becoming more apparent WPATH makes the case to treat younger and younger children with cross sex hormones.

WPATH subsequently blamed the publisher for the mistake,leaving the reasons WPATH made them open to speculation. However, the decision leaves responsibility for how old children have to be to be eligible for life-changing surgery and medicine, entirely in the hands of individual clinicians and will be one the Ministry will be under pressure to adopt.(WPATH, 2022b) A few days into the symposium, a speaker described the thinking behind the change – that the removal of age limits would protect clinicians from being sued. When her comments were reported, accurately, in the media and on social media, (Buttons, 2022) (Wright, 2022) WPATH resorted to an extraordinary media release saying the comments were being misrepresented and constituted dangerous misinformation.(WPATH, 2022c)

Binding, Tucking and Menstrual suppression

Two recommendations taken from the adolescent chapter demonstrate how the acceptance of expert opinion plays out in practice. They are suggestions rather than recommendations but Statement 6.6 advocates education on breast binding in girls and young women and penis and scrotal tucking in boys and young men to avoid dysphoria with advice about risks and safe practice. **There is no evidence at all presented that doing this is desirable or beneficial** and the references provided are to sales blurbs and transgender advocacy sites. So 'expert opinion' rather than evidence has been used to bolster the idea that practices with known harms are presented to patients giving the impression they are potentially beneficial and can be deployed safely. Nowhere is there a warning that the approach is really one of

harm minimisation by people already involved in dangerous behaviour since none of the evidence cited demonstrates that either practice is of proven benefit.

Statement 6.7 recommends providers 'consider prescribing menstrual suppression agents for 'adolescents experiencing gender incongruence' for break-through bleeding despite there being 'no formal research evaluating how menstrual suppression may impact gender incongruence and/or dysphoria."

Intersex conditions

The Guideline says that 'the term transgender and gender diverse was chosen with the intent to be most inclusive and to highlight the many diverse gender identities, expressions, experiences, and health care needs of TGD people' which appears to validate the inclusion of intersex. So SOC 8 includes all people with 'intersex' conditions as people who are transgender and non-gender conforming. Is this warranted?

In SOC 7 the inclusion of intersex people included only the small numbers of them whose 'gender identity' differed from their sex, often for reasons associated to their medical condition or to early 'corrective' surgery. The great majority of people with intersex conditions are male or female people with reproductive system conditions who need to manage the associated health impacts. Disorders of sexual development are entirely different to being transgender and people with actual intersex conditions are never self-defined as other TGD groups are (although the Guideline discusses a group of people who 'identify' as intersex while having no underlying condition). The case for including them appears weak.

The Guideline says 'People with intersex conditions are also far more likely than the general population to be transgender' but the references are to a single condition (CAH) observed in neonates (S 102) and the paper does not support the claim made. The chapter focusses on the idea of bodily integrity and addresses surgical interventions as a potential undermining of it which is sometimes true. Hence, the chapter makes broad generalisations about the undesirability of surgery before the age or majority. This is done despite minor surgical procedures to correct some conditions being routine and uncontroversial. Thus SOC 8 approach for the Intersex Chapter is in complete contrast to the removal of age limits for young people expressing gender identity issues.

Rainbow vs transgender

The Guideline argues that the transgender community and therefore treatment should be

> *be as broad and comprehensive as possible in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth.(S23)*

SOC 8 regards Intersex people as transgender or part of the gender identity and expression non-conforming community (despite the category issues this raises). Does SOC 8 also regard same-sex attracted people as being subsumed under the rubric of this wide definition of gender non-conformity?

Frequent references are made to gay and lesbian people under the heading of LGBT in the text and in references citing research that only includes them. For example in showing that conversion practices are harmful SOC 8 uses 2 retrospective studies of lesbians and gay men (and a third whose findings are acknowledged in the Guideline to be contested – Turban, Beckwith et al s176).

Lesbians and gay men are gender non-conforming, in their choice of sexual partner, and often more broadly in their personality and preferences and may well consider they differ from gendered expectations. This is important because there is strong evidence that same-sex attracted people are particularly vulnerable to a belief (and to pressure) that they are transgender and homophobia may be a cause of a decision to transition. (Littman, 2021) (Vandenbussche, 2021) Increasingly schools are addressing gender issues in teaching with even very young children and teaching bodily dissociation by teaching that sex change is an option for any child.(Resist Gender Education, 2022) This uncertainty raises serious ethical issues about how clinicians should treat gender confused people when same sex attraction may be masked. [6]All of New Zealand's detransitioners whose stories have appeared in the public domain are lesbian women from which it could be inferred that people with same sex attraction are being channelled into medical and surgical transition. (Rewoman, 2021) (Lane, 2019) (Z, 2020) (Paul, 2022)

Detransitioners

Following the launch two incidents cast light on the adequacy of the evidence base (or even whether the resources that were available were accurately used). Throughout SOC 8 the evidence is argued to point to detransitioners being rare. However a researcher whose paper was referenced in the Guideline, complained that his paper (Expósito-Campos, 2021) was completely misrepresented as it said that detransition levels were low.(Expósito-Campos, 2022)

A few weeks after the launch, another author whose 2021 research was summarised in SOC 8 as saying of detransitioners that

> *This process of identity exploration should not necessarily be equated with regret, confusion, or poor decision-making because a TGD [transgender] adult's gender identity may change without devaluing previous transition decisions.(S41)*

has recently posted on social media about the plight of detransitioners telling an entirely different story:

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[6] The recent NHS Cass review uses the concept of 'overshadowing' to explain how proper assessment is not only for same-sex attracted people but to uncover all kinds of causative factors that may underlie a transgender identity.

- *Detrans TikTok influencers have told me they receive several private messages per week of folks questioning their transition & looking for support and community.*
- *Many of these folks are young (OFC, it's TikTok!). Many AFAB, many w unmet mental health care needs.*
- *What else does the comment section of detrans TikTok reveal?:...vitriol and public shaming:*
- *We need to come together to offer support and care; not cast them out.* (McKinnon, 2022)

These sudden post-publication concerns about the Guideline's interpretation of detransition as low and not synonymous with regret is just one example that raises concerns about the quality of research inputs and their interpretation. Pressing concerns about the growing number of detransitioners and their predicament has been growing in other analyses for years.(SEGM, 2021b) (Griffiths, 2021)

Discussion

There seem to be significant reasons for doubting whether SOC 8 is a high quality Clinical Practice Guideline. But more importantly WPATH is wedded to a philosophy of human biology that differs from the consensus in believing that that there are humans where sex and gender are misaligned. It appears there are issues with all 8 of the National Academies criteria. From the literature review to the development of recommendations there are significant indications that the Guideline appears to deviate from good practice. Although the Guideline is argued to be evidence based many of the recommendations are based on expert opinion or on moralising pressure. The Guideline frequently seeks to influence far beyond clinical issues into politics and the broader public sphere. The Standards where conflicts of interest have previously been identified and the current arrangements appear to be similar. Some WPATH members who believe that WPATH's approach is extreme have broken ranks with their organisation. Others have connections that appear outlandish. There is nothing to indicate how the conflicts of interest were handled despite leading members of the authorial team either being dependent on funding from a charitable foundation with a vested interest in specific kinds of outcomes or earning income from sources where rules that are favourable to them could benefit them financially or professionally.

There is no systematic programme for a review of content. Despite the new Guideline containing recommendations some of these have some problems in relation to the lack of evidence, how they might be applied in practice, the frequent use of expert opinion instead of evidence. Numerous Recommendations are unusual in that they attempt to influence beyond the health sector and others are duplicated. The Delphi mechanism to endorse recommendations does not avoid the danger of groupthink. The evidence search misses much of relevance that would have that reined in the enthusiasm for medication and surgery and there was an intended set of literature reviews that it appears did not progress. The guidelines are already creaking to take account of a growing segment of the ever expanding rainbow – detransitioners and it is impossible to discern whether lesbians and gay men are also part of the Transgender and gender non-conforming cohort. All of these issues serve to

create the impression that WPATH is using a systematic review as legitimization device to implement a Guideline with a particular point of view, rather than it being a genuine process where recommendations arise from evidence. However the one sided perspective is straining at the seams as around the world national health authorities are developing their own standards and giving up on WPATH.

The previous Guidelines have not met inclusion criteria for any international clinical Standard database and have faced serious negative assessments. It is far from clear that SOC 8 would fare any better. And yet, WPATH Guidelines are given as the rationale to support the unthinkable: to physically harm a distressed and vulnerable population.(MacRichards, 2019)

If adopted into New Zealand's practice we would, amongst other things, abandon minimum treatment ages for children, implement a Eunuch sterilisation programme, base our prisons policy on a medical standard, refuse to treat any people with intersex conditions until adulthood, even where there is an identified and agreed treatment path. It surely cannot be appropriate for the government Ministry of Health to adopt guidelines with so many departures from proper evidence-based medical practice?

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