An assessment of the New Zealand transgender medicine guideline

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## Abstract

This paper is a case study examination of the 2018 document *Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in Aotearoa, New Zealand* (Oliphant et al., 2018) referred to below as the PATHA Guideline and claimed as the work of the Professional Association for Transgender Health Aotearoa (PATHA).

The PATHA Guideline’s origins and its main elements are described. The standards for creating clinical practice guidelines are examined and the approach taken in New Zealand and by three international clinical practice guideline creation tools are outlined. The PATHA Guideline is then examined against the following criteria.

1. Whether the PATHA Guideline complies with the standards set by the internationally recognised clinical pratice guidelines development tools.
2. Whether the PATHA Guideline follows the recommendations in the World Professional Association of Transgender Health 2012 Standards of Care 7 (WPATH SOC 7)(WPATH, 2012) and the evidence supplied where it differs.
3. Whether the use of two different Māori health frameworks to guide the PATHA Guideline helps or hinders the Guideline’s purpose.
4. Whether the kaupapa Māori framing of transgender identities is appropriate.

The broader context for this review is the recent policy and treatment reversals in gender medicine policies in other jurisdictions, as well as the national level evidence-based reviews, which have often brought about those changes. At the same time the literature of the affirmative gender medicine movement, including some of the professional standards and some of the core reference documents, has come under increasingly critical analysis. Rejection of affirmative approaches and the stance that has been taken by WPATH has led to these being replaced in many countries, by approaches that prioritise psychological support and exploration.

This investigation has shown that:

* WPATH SOC 7 had already been the subject of considerable criticism, including by its own authors who advised how its quality could be improved. This information did not influence the PATHA Guideline writers.
* The PATHA Guideline contains no evidence of having been developed to meet any clinical guideline standard. Despite the claimed status as a local interpretation of the WPATH SOC 7, the PATHA Guideline frequently adopts approaches that go considerably beyond the recommendations found there. Evidence to support these additional recommendations is limited or entirely lacking.
* Using Māori health frameworks has some benefits in a New Zealand setting, and for transgender people, but their use in a clinical guideline also appears to be novel. It presents problems with the organisation of the material into a suitable form for a guideline.
* Claims that transgender identities are an indigenous historical fact in New Zealand are not supported by the cited research.

The evidence points to the likelihood of significant overtreatment of people, including many children and young people, who, had they been assessed under the SOC 7 Guideline, would not have had their gender confusion medicalised. The conclusion section suggests that the lack of an agreed approach for creating clinical guidelines is a form of regulatory failure which the authors of the PATHA Guideline have taken advantage of. A series of suggestions for review are made, including that future guidelines should be developed to meet an international Clinical Practice Guideline methodology.

## History of the Guideline

The PATHA was founded in 2019 after splitting off from the Australasian group AusPATH. It is one of the groups of national transgender health organisations, along with AusPATH, USPATH EPATH (the European organisation) and others, who operate under the umbrella of the World Professional Association of Transgender Health (WPATH). The Guideline was published in 2018 (Oliphant et al., 2018) by the Transgender Health Research Lab at the University of Waikato and has subsequently been placed on the PATHA website and is claimed as a product of PATHA. A previous guideline, which the 2018 PATHA guideline says it replaces, was published in 2011 (Counties Manukau DHB, 2011) shortly before WPATH’s SOC 7.

The PATHA Guideline was added to the transgender health care guidance provided by Te Whatu Ora / Health New Zealand which operates the public health system. Te Whatu Ora, 2023b) (Health New Zealand was formed in 2022, following the amalgamation of New Zealand’s District Health Boards into one national organisation). The PATHA Guideline is accompanied on the website by an article in NZ Doctor magazine (behind a paywall) which doubles as background for a professional development course and counts for 1 point of the Medical Council’s continuing professional development programme. Also listed is a self-guided offering from transgender advocacy and activist organisation Gender Minorities Aotearoa (Gender Minorities Aotearoa, 2021) and paid training in ‘Rainbow Mental Health’ from NZ youth charity Inside Out (InsideOUT, 2021) to support ‘*rainbow, takatāpui and MVPFAFF+*[[1]](#footnote-2) *service users*’.

A recent request by a journalist to the Ministry of Health has revealed that it ‘*has not gone through any formal process to review or endorse the PATHA Guideline’*. The information was provided in response to questions about a review of puberty blocker medication. The Ministry of Health committed to the review following the removal of the advice from the Ministry’s website which had said that they are ‘*safe and reversible’*.(Daalder, 2023)

Since the Guideline was published, multiple national level evidence based reviews have taken place in other jurisdictions.(Speak Up For Women, 2023) A uniform finding is that the evidence for using puberty blocker medication is poor. (Cohn, 2023) There is a significant international debate and contested ideas, including in Holland where the protocol (internationally recognised as The Dutch Protocol), used in an adapted form in New Zealand, originated. The Dutch Protocol starts with early social transition for pre-pubertal children, followed by puberty blockers and proceeds to cross sex hormones and surgery.(Klotz, 2023). The reviews in the UK by NICE (National Institute for Health and Care Excellence, 2020) and Oxford University, (Heneghan, 2019), in Finland, (COHERE, 2020) and Sweden,(Canadian Gender Report, 2020) have all led to the adoption of health models that address gender distress through psychological exploration and without assuming that it equates to a transgender diagnosis. In other countries including France, (SEGM, 2022), Ireland (Coyle, 2021) Australia (Morris, 2021) change is being led by professional medical associations. In Norway (Blaff, 2023) and Denmark (Lane, 2023a) government action is leading change. The American Association of Pediatrics announced recently that it will review its currently affirmative guidance based on an evidence-based review (Lane, 2023c) following an unanswered challenge to the basis for their approach (Cantor, 2018) and a campaign by some members demanding a review. (Nainggolan & Ault, 2022) Other professional associations have had strong and credible challenges made against their gender medicine approaches.(Rivers, 2023) There have also been serious rebuttals to, and the reinterpretation of, significant research in the field of affirmative approaches to transgender medicine.(Rivers, 2023)

There is uncertainty about the approach to gender medicine in New Zealand with conflicting directions apparent. The Ministry of Health is also carrying out an evidence brief into the use of puberty blockers drugs (Gower & Wilkins, 2023). Nevertheless in 2022 it won funding intended for the development of an updated Guideline (Verrall, 2022) based on the release of recently published World Professional Association for Transgender Health (WPATH) Standards of Care (SOC 8) which advocates their use.(Coleman et al., 2022) Meanwhile Te Whatu Ora (Health New Zealand) has tendered for organisations to develop ‘*training and workforce development programmes*’(NZ Health Partnerships Limited, 2023) ahead of the creation of a new Guideline, and its advice on criteria for gender surgery has recently reverted from WPATH SOC 8 to the 2012 WPATH SOC 7 guideline. (Te Whatu Ora, 2023a) In contrast to the Ministry of Health, a senior member of PATHA has recently said that puberty blockers are safe and fully reversible (Gower & Wilkins, 2023) even as the PATHA guideline accepts that there are health impacts, including to bone health and sexual functioning. (Oliphant et al., 2018)

## Structure of the PATHA Guideline

The introduction to the Guideline explains that it arises out of WPATH’s Standards of Care version 7 (WPATH SOC 7) from 2012 implying SOC 7 is a source of evidential authority. Despite claims to the contrary, WPATH’s SOC 7 itself falls short of being an evidence based guideline, and it is not represented in any of the international guideline databases (Dahlen et al., 2021). Some of WPATH SOC 7’s own authors have criticised the Guideline’s poor evidence base, and suggested some mitigations, saying that over the years the WPATH Standards of Care has:

evolved substantially, yet it remains largely based on lower-quality evidence (i.e., observational studies) and expert opinion, and with a scope that remains limited primarily to describing best practices for the diagnosis of gender dysphoria and assessing readiness and appropriateness for interventions. SOC v7 lacks any rating of the quality of the available evidence or strength of the recommendations or description of how expert contributors are selected to participate in the process of developing the guidelines.(Deutsch, 2016)

It can be argued that the PATHA Guideline has been built on poor foundations and the PATHA authors did not ameliorate this by using the critique that had been made of WPATH SOC 7to improve their own Guideline. They merely said that it ‘*is not intended to replace the WPATH SOC but to present additional guidance for the provision of gender affirming healthcare in Aotearoa, New Zealand.’* (Oliphant, 2018)

The PATHA Guideline is informed by two Māori health models. The content of the main part of the PATHA Guideline follows that of *Te Whare Tapa Whā: a model of Māori Health* devised by Dr (now Sir) Mason Durie with the content structured according to its four criteria of well-being – mental, physical, family and spiritual health which are conceived as the four walls of a whare (house). (Ministry of Health NZ, n.d.) The model can be applied at an institutional or tribal level and sometimes as a model of personal health. Dr Durie’s *Te Pae Māhutonga* is a second framework, devised for use in public health and health communications, that is based on the Southern Cross and its associated pointer stars.(Community & Public Health, 2020) With two exceptions, discussed below, the way in which this second framework influences the PATHA Guideline is not explained.

The Guideline does not contain a methods section explaining how it was developed. There is no information about how literature was sourced to support the recommendations or how the suggested treatment approaches were derived from the evidence. A detailed outline of the PATHA Guideline is in Appendix 1.

## Medical Guidelines in New Zealand

Medical guidelines are generally understood to have been prepared to meet a clinical practice guideline (CPG) standard. This requires a formalised approach with a systematic literature review guiding the creation of evidence-based recommendations. A structured approach to evaluating the quality of the research is also required. Evidence, rather than expert opinion, is fundamental to clinical guideline development. (Turner, 2023). The CPG of the US National Academy of Science Health Guildines, (National Academies, 2011) and from the World Health Organisation; (World Health Organisation, 2014) for example were used in the creation of WPATH’s 2022 Standards of Care (WPATH SOC 8).(Coleman et al., 2022) The AGREE Collaboration is a charitable Trust founded in 2004 by a group of international guideline developers and researchers to create a tool to assess the quality of guidelines (AGREE, 2017). It has also been used as a guide to guideline creation.

In New Zealand however there appears to be no requirement for clinical guidelines to be created to meet any established standard. The New Zealand Guidelines Group (NZGG) went into receivership in 2012(ANZ Guideline Network, 2020) and has not been replaced. An Australia / New Zealand group exists, (ANZ Guideline Network, 2020) as well as a voluntary ‘best practice’ organisation BPAC. (BPACNZ, n.d.) BPAC’S CPG development approach is adapted from the UK National Institute for Clinical Excellence (NICE). In recognition of New Zealand’s small population, budgetary constraints and indigenous culture, BPAC allows international CPG to be adapted for local use. (BPACNZ, n.d.)

## Assessing PATHA’s Guideline for compliance with Clinical Practice Guideline standards

The criteria for the three CPG development tools listed above were searched for guideline creation steps. A summary of the CPG’s methodology was used to identify the common features. Eight steps were identified as being common to all three of the CPG tools. This analysis is presented in a tabular format as Appendix 2. The discussion below assesses the PATHA guideline against the steps which are:

1. Establishing the nature of the condition and/or the affected population
2. Creating a knowledgable and multidisciplinary panel across skill areas and viewpoints.
3. Considering patient and clinician subgroups and preferences
4. Carrying out a systematic review of the evidence
5. Deploying a structured method of formulating recommendations
6. Describing the procedure for updating the PATHA Guideline
7. Devising a method for recording and addressing conflicts of interest
8. Carrying out an independent pre-publication review

These eight common categories are by no means the whole story. Amongst other useful suggestions that PATHA has not adopted are that AGREE proposes that guidelines:

* considers the health benefits, side effects and risks in formulating the recommendations
* provides advice and/or tools on how the recommendations can be put into practice.
* describes facilitators of and barriers to its application.
* discusses the potential resource implications of applying the recommendations.
* presents monitoring or auditing criteria.(AGREE, 2017)

The lack any of this explanatory material, which would have provide much needed context, also impact the quality of the PATHA guideline. The explosion in numbers seeking treatment alone, provide a solid reason to understand balance of risks and benefits, the ethical issues of treating or not, implementation and scaling, the policy environment, cost and resource implications and understanding the size, nature and the causality of the extremely high rates of increase in the affected population.

The following section assesses the Guideline against the eight steps. Then the Guideline is compared with WPATH SOC 7

#### Establishing the nature of the condition or the affected population

The basis of a medical guideline requires that the client population and/or the medical condition can be closely defined. For example the WHO Guidelines for the management of diabetes / people with diabetes states ‘*Diabetes mellitus, commonly known as diabetes, is a group of metabolic disorders characterized by the presence of hyperglycaemia in the absence of treatment’* (World Health Organisation & International Diabetes Federation, 2020)*.*

There are a number of problems in identifying a precise population in the PATHA guideline.

* Research is cited that shows that the number of people seeking gender medicine interventions in New Zealand has increased rapidly, (Delahunt et al., 2018) but the PATHA Guideline does not mention that the age of referral has changed to be increasingly composed of post-pubertal, rather than very young children (and a smaller number of older people), nor that the sex of those presenting had changed from mostly male to mostly female as the New Zealand research also shows.(Delahunt, 2018) These findings were emerging as early as 2015 in other jurisdictions, and the researchers were calling into question whether the same treatment regime was relevant (or advisable) for this new cohort (Kaltiala-Heino et al., 2015) but the PATHA guideline does not mention these significant changes.
* The definition of trans / transgender in the terminology section is incomplete as it does not mention dysphoria as a likely defining factor, required for treatment, even though this is mentioned elsewhere.
* The PATHA Guideline is self-contradictory. In the mental health section it says that being transgender ‘*is often but not always accompanied by gender dysphoria, a person’s discomfort or distress with their body or gender roles associated with their sex assigned at birth*’ and advises treatment is available irrespective of whether there is dysphoria. However, the sections on getting gender affirming treatment with cross sex hormones and surgery say that these can only be provided where there is gender dysphoria.
* The Guideline says that the treatments are *‘medically necessary’* but a list of surgical interventions says that each may or may not be necessary. The Guideline says that this is because ‘*each trans person will undertake a unique journey to affirm their gender’*.
* The PATHA Guideline says, ‘*being transgender can be one way of being gender diverse, but not all gender diverse people identify as being transgender and vice versa*.’ The PATHA Guideline also advises that ‘*supporting trans and gender diverse children requires a developmentally appropriate and gender affirming approach which involves assisting children to create an environment where their gender can be affirmed*’. What are gender non-conforming children being affirmed as, if by the earlier definition, some will not be transgender? And what treatment is appropriate when the standard says, by implication, that not all transgender people are ‘*gender diverse’*?
* A conflation of being gender diverse with being transgender is common in transgender literature and in a paper referenced by the PATHA Guideline, (Ehrensaft, 2017) psychologist Dr Diane Ehrensaft describes, as transgender, a gender non-conforming lesbian who finds out about being transgender on social media and who is then encouraged by her partner to consider herself as male. The referencing of this research raises red flags, about whether PATHA also regards as transgender, people influenced by social media and social pressure when homophobia has not been ruled out.

In contrast SOC 7 is much clearer, and takes a conservative stance, stating that ‘*only some gender nonconforming people experience gender dysphoria at some point in their lives’* .

#### Creating a knowledgeable and multidisciplinary panel across skill areas and viewpoints

Most, possibly all, of authors appear to have become members of PATHA, and several are members of WPATH. A number work in youth or gender clinics but others have no clinical background. Some are themselves transgender. It is not clear whether authors are working on the guideline in a personal capacity, as part of a self-selected interest group, or on behalf of their professional organisations or their employers. It is not clear that any represents the interests or viewpoints of Tangata Whenua or has tribal affiliations. It appears that none are surgeons, endocrinologists or psychiatrists. These latter are presumably the kinds of people who would provide diversity across skill areas, and who should be staffing the multi-disciplinary teams that the PATHA Guideline’s recommendation on this point argues for, and who should therefore be stakeholders in the Guideline’s development (Leibowitz & de Vries, 2016).

#### Consider patient and clinician subgroups and preferences

There is no evidence that the professional clinical groups beyond the listed authors were involved in writing the PATHA Guideline. The introduction to the PATHA Guideline gives acknowledgment to many clinicians and transgender people, and an organisation, Gender Minorities Aotearoa, without whom the PATHA Guideline ‘*would not have been possible*’ but specific roles are not recorded.

Clinician Subgroups.

The PATHA Guideline was endorsed at publication by three organisations: AusPATH; the New Zealand Sexual Health Society and the New Zealand Society of Endocrinology and so presumably principals from those organisations felt able to promote its endorsement within their own organisations through some unspecified process. There is no evidence that clinician subgroups from specific professional areas such as psychiatry, paediatric or endocrinology services were invited to participate in the development of the Guideline.

Patient subgroups

On the other hand the involvement of the transgender community has gone well beyond the approach taken by WPATH and this is discussed in more detail in the section below which compares the PATHA Guideline recommendations to those of WPATH SOC 7.

#### Carry out a systematic review of the evidence

The Clinical Guideline Deveopment advice says that the evidence review should be used as follows:

* The strengths and limitations of the body of evidence should be clearly described.
* There should be a quality assessment of the primary studies

The PATHA Guideline provides no indication of a systematic evidence review having taken place, or of the evidence being analysed for quality. No process for selecting resources is outlined and a surprisingly modest 52 references are listed, of which only half are from peer-reviewed literature and a further quarter relate to the creation of the PATHA Guideline within a Māori framework.

Thus the clinical recommendations are only sparingly referenced. Of the papers that make the case for affirmation, two are from the foundational ‘Dutch protocol’(de Vries et al., 2011; De Vries et al., 2014). While they have been influential the approach has subsequently been analysed more fully and was found to be largely experimental and the associated research misleading.(Abbruzzese et al., 2023; Biggs, 2022; Levine et al., 2022). Moreover the young people they reported on do not appear to be flourishing compared with their peers (Cohn, 2023).

Dr Diane Ehrensaft, cited in the Guideline and mentioned above, is a psychologist and early advocate of affirmative approaches, who claims that how babies interact with hair adornments (girls) and onesies (boys) can indicate cross sex identification. (4thwavenow, 2016; Ehrensaft, 2019) Also in contrast to the available evidence, she claims that it is possible to determine which children will remain cross-sex identified.(Ehrensaft, 2016) Whilst the PATHA Guideline does not make these claims it is concerning that the Guideline cites ‘experts’ who use what appears to be unevidenced thinking in support of treatment.

#### Deploy a structured method of formulating recommendations

The CPG tools suggest that there should be a synthesis of the body of evidence, and a quality assessment for each clinical recommendation. But there is no evidence that any such process has taken place.

There is nothing to demonstrate that the recommendations have arisen as the result of a formal process of weighing and assessing the available evidence, such as the use of GRADE (Grading of Recommendations, Assessment, Development, and Evaluations) (Siemieniuk & Guyatt, 2016), or any similar approach as advised by all of the CPG advice. GRADE is a technique that can be used with any of the medical guideline development approaches. It is a transparent and systematic framework for developing and presenting summaries of evidence that guide the development of clinical practice.

The PATHA Guideline contains 5 sets of recommendations, many sets of practice points and includes treatment advice in the general narrative but, since it appears that they are not the result of a transparent and systematic approach, what do they represent? Often the reason for recommendations is not explained in the prior narrative. While there may be stronger evidence in WPATH SOC 7, there is no cross-referencing to it.

#### Describe the procedure for updating the PATHA Guideline

There is no reference to a process for updating the PATHA Guideline.

#### Carry out a pre-publication independent review

There is no evidence in the document that there was an independent review of the PATHA guideline prior to publication.

#### Devise a method for recording and addressing conflicts of interest

There is no evidence that conflicts of interest were collected, assessed, or managed. Neither is it clear how the Guideline was funded and what influence such funding has had on the content of the guideline.The authors are apparently all members of PATHA. The majority are in career roles where they implement the very gender medicine that the guideline advises and they would appear to have a vested interest in the growth of affirmative gender medicine in the hospital system, youth and student health services, in primary care and in the private sector medicine sectors that employs most of them. The opportunities for groupthink or self-interest should be obvious and should surely have been managed transparently.

## Differences between PATHA and SOC 7

The following elements of the PATHA Guideline differ markedly from WPATH SOC 7 and yet, in almost all cases, little new evidence is presented to explain the changes. The research process for this section involved identifying recommendations or advice in the Guideline that appeared extreme, surprising or contrary to usual medical practice and which would be material in influencing treatment outcomes. Then the WPATH SOC 7 was searched for the corresponding information. In each case selected the SOC 7 advice differed. Some of the elements that were identified are supported by some evidence but as it appears there was no literature review, the referenced articles have been selected to support the treatment stance rather than being a balanced view of the evidence for it. The recommendations on mental health, puberty suppression, gender affirming care as well as neuro-diversity are in this category. Other elements, such as the advice on social transition, including the use of potentially damaging binders, and the approach to informed consent did not have any citations in support. Each difference identified between WPATH and PATHA either lowers the bar to treatment, and/or sees as eligible for treatment, people who would not have been treated using WPATH SOC 7. The section below provides specific detail on how this has occurred. In many cases the narrative descriptions below are supported by footnotes which link to extracts from WPATH’s SOC 7 and the PATHA Guideline to enable a comparison to be made.

#### Affirmation

The approach to ‘affirmative’ treatment raised a red flag and the issue is addressed more fully below with the information on diagnosis. It is mentioned throughout both documents rather than as a discrete topic. Essentially WPATH affirms within the context of a diagnosis; with a recognition that other outcomes are possible, that many resolve their gender confusion and aware that full information about gender medicine will dissuade some patients from proceeding. The PATHA Guideline does not acknowledge any such limitations.

#### Mental Health

WPATH requires mental health conditions to be reasonably well controlled. In contrast the PATHA Guideline says that mental health issues and even an inability to verbalise opposite sex identification are not barriers to combining mental health and gender transition treatment.[[2]](#footnote-3)

#### Causes of associated mental health conditions

The PATHA section on Minority Stress suggests that stigma and oppression are the sole cause of the mental health problems faced by transgender people. (This is contradicted elsewhere in the PATHA Guideline which finds that body dysphoria and mental health issues with other causes and the stress of transition may be in play). PATHA also argues that WPATH SOC 7 advises mental health treatment can continue alongside gender affirmation. However the wording of the WPATH SOC 7 makes clear that mental health problems may arise from other causes than stigma, and that failing to treat them can have important negative consequences. With the benefit of hindsight more recent research shows just how significant adverse life events are in the genesis of gender confusion. (Cass, 2022; Kozlowska et al., 2021)[[3]](#footnote-4)

#### Ethical issues about proceeding to treatment

WPATH SOC 7 acknowledges that neither the decision to treat, nor not to treat, is neutral. The PATHA approach is significantly more activist with PATHA only noting the potential harms of failing to treat.[[4]](#footnote-5)

#### Desistance because dysphoria resolves

Evidence from WPATH and from the Manukau 2012 Guideline says that there is significant desistance or resolution at puberty from opposite sex identification (Counties Manukau DHB, 2011). PATHA minimises this significant evidence.[[5]](#footnote-6)

#### Social transition

WPATH acknowledges that social transition is controversial, and that parents must ‘*explicitly let the child know that there is a way back*’ from acting as if the other sex. This concern is not reflected by PATHA Guideline section on social transition includes of children and young people despite the entirely anticipatable likelihood that such an approach would solidify the transgender identity of children and young people who would otherwise have desisted. Evidence from after 2018 has shown clearly that social transition correlates with the persistence of a transgender identity.(Stats for Gender, 2022)

The PATHA Guideline also suggests that schools are a safe place for children to transition. In retrospect such suggestions have set the scene for the highly controversial policy in schools that children are transitioned while families are left unaware.(Resist Gender Education, 2023) No evidence at all is cited for this change. Why, when social transition is suggested to happen at school, was input from the wider family disregarded by the PATHA Guideline, especially since Te Whare Tapa Whā advice suggests it as a necessary foundation to health and WPATH requires parental support prior to treatment? Is it appropriate that the Guideline has effectively encouraged secret school social transition where teachers are expected to endorse a feeling that may have many causative factors? [[6]](#footnote-7)

#### Diagnosis

WPATH recognises that a diagnostic and psychiatric assessment may result in either of the following: a gender dysphoria diagnosis that facilitates access to healthcare; the presence of psychosis or delusions; no diagnosis or the identification of other causal factors for gender confusion. Informed consent is discussed within the context of assessment and information about the limitations of treatment. Explaining the limitations of treatment is a diagnostic tool. PATHA on the other hand eschews diagnosis in favour of affirming the perspective but provides no evidence for why the approach is proposed. The views of the patient that they are transgender is paramount and the term diagnosis is not even used in relation to assessment of suitability for medical intervention. Explanations that there are technical limits to treatment are not included in the Guideline. Instead medication and surgery are described as elements of a patient driven gender ‘journey’. Moreover it presents informed consent as simply an aspect of self-determination, even in under 16s. However, the process of informed consent described in the PATHA Guideline is controlled by legislation. Special conditions are required prior to the prescribing of unapproved medicines under the Medical Council’s prescribing advice. These include puberty blockers and cross sex hormones (Medsafe, 2020) although this legal aspect is not mentioned by the Guideline. There are rulings by the Health & Disability Commissioner that relate specifically to the requirements for clinicians when prescribing unapproved medicines that are also not mentioned.[[7]](#footnote-8) (Health and Disability Commission, 2012) Neither is any evidence presented for the medical benefits of providing affirmation rather than diagnosis and there is nothing to explain why such an approach does not create a risk of overtreatment. There is also no discussion about how clinicians meet the Medical Council’s prescribing guidance that requires that they only prescribe medicines or treatment when they have adequately assessed the patient’s condition. Such a process would seem to go beyond mere affirmation of a gender journey and require an assessment of the causes of dysphoria or the belief of the patient that they are transgender.(New Zealand Medical Council, 2020)

#### Puberty suppression

WPATH has a list of four minimum criteria before introducing puberty suppression but PATHA’s advice has none. PATHA also goes beyond WPATH in advising that their use continues until other treatment is commenced and advising their use can commence in ‘late puberty’ and that lack of parental support ‘should not preclude them from receiving support and care’ whereas WPATH SOC 7 requires both parental consent and ongoing support. The PATHA Guideline on these points relies heavily on the AusPATH guideline whose own recommendations ‘*are based primarily on clinician consensus, along with previously published standards of care, treatment guidelines and position statements, and data from a limited number of non-randomised clinical studies and observational studies’* (Telfer et al., 2018)*.* Clinical consensus, absent evidence, is the lowest form of medical evidence. (Turner, 2023)The other main evidence for puberty suppression was a systematic review from the Endocrine Society which acknowledged that the evidence base used was weak even as it recommended an affirmative approach and blockers (Endocrine Society & Hembree, 2017; Lane, 2023b).[[8]](#footnote-9)

#### Blockers potential to impact on male genitals

WPATH recognises that early pubertal suppression will impact later surgical options for boys, because the penis and testes remain at the size of a child’s, but PATHA does not spell out the implications. These are the less desirable surgical options available for surgery to imitate female genitals and impacts on sexual function. These are unsatisfactory impacts that were easy to anticipate and in the last year both lack of tissue and lack of sexual response from puberty blockade have been addressed as problems by WPATH president Marci Bowers (Shrier, 2021). [[9]](#footnote-10)

#### Involvement of the transgender community in clinical guideline development

The involvement of transgender people in the development of the WPATH SOC 7 was achieved through a formal process of consultation. In contrast the PATHA Guideline process ensured that ‘*Transgender people have been involved in the steering of the project, including development of services and these guidelines. The importance of trans community leadership in the development of trans healthcare services is paramount’*. This level of community leadership is introduced as part of the Māori context for the Guideline and *Te Pae Māhutonga* which is described in more detail below. Thisis surely a risk especially in the absence of so many of the other steps for the development of clinical practice guidelines. There is strong evidence from the USA and UK that activist pressure from transgender advocates has impacted the practice of transgender medicine and research. (Bazelon, 2022; Dixon, 2023; Kay, 2019; Shrier, 2021). Adult transgender people who recall their childhood distress should not be guiding treatment policy for those children who have dysphoria or are gender questioning when most of the children will have resolved their feelings about their gender by the end of puberty. It appears highly likely that it is this very close involvement of transgender people and their allies at the heart of the PATHA Guideline that accounts for at least some of the recommendations, having such a remarkably different focus than those in WPATH SOC 7.[[10]](#footnote-11)

## Assessment of the use of Māori Health frameworks

There is no reason that Māori health frameworks could not be used in the development of evidence-based care. The use of such frameworks would offer some opportunities that medical models sometimes lack. These would include the ability to address issues of human meaning – represented by the theme of the spiritual in *Nga Whare Tapa Whā* – and a holistic understanding of the person (the patient) in their context of family, and community. It is surely important though that using these frameworks would not occlude the need for robust evidence and precision in meaning.

Presenting the guide in the format of Dr Durie’s schema does present some challenges. It is not a model intended for the creation of evidence-based guidelines. It makes for an idiosyncratic structure that is not well sign-posted. It allows internal contradictions to remain invisible and thus unaddressed. For example the mental health information in the PATHA guideline is contained under multiple headings with parts of the full picture revealed piecemeal. In another example the information that ‘*some previously gender-expansive children may shift along the gender spectrum to find their gender identity more aligned with the sex assigned at birth*’ (in the young people section of the family section) is separated from both information about social transition (in the section on spiritual health) and from the section on puberty blockers (in the section on physical health). This prevents the iatrogenic impacts of social transition and puberty blockers from being seen clearly. As mentioned above, without treatment many would have resolved their gender confusion. Recent commentary from WPATH’s principal clinicians and a recent British Medical Journal editorial attest to this iatrogenic effect of overmedicalisation by puberty blockers. (Abbasi, 2023; Shrier, 2021).

Another problem is whether the chosen models have been applied correctly. The use of elements of *Te Pae Māhutonga,* intended as a health communications and public health tool, appear to be opportunistic. The feature associated with giving priority to the demands of community leadership has been described above. Another element associated with a pointer star of the Southern Cross *‘which has the themes of autonomy or Te Mana Whakahaere’* whichthe PATHA Guideline says means ‘*the principle of trans people’s autonomy of their own bodies, represented by healthcare provision based on informed consent.’* It is far from clear though, the model was ever intended to be used to justify the demands that individuals should be able to make of the health system for individualised treatment or that it suggested that health care should be self-determined and not the subject of clinical diagnosis.

There is no reason why the CPG material, if it did exist, could not have been incorporated into the Guideline irrespective of the guiding framework. That is has not been, adds additional doubt that an evidence based approach was ever attempted. It would be unfortunate if using a kaupapa (method or philosophy) Māori framework has provided cover for inadequately researched and evidenced medical recommendations.

## Are gender identities indigenous to New Zealand?

By setting the PATHA Guideline in the context of Te Ao Māori (the Māori world) it appears to have been important to support the idea of transgenderism as indigenous. Such proof would therefore be used to demonstrate that it is a longstanding and an unassailable element of NZ Māori culture and perhaps even has standing as a Treaty of Waitangi issue. In the PATHA Guideline section on pre-colonial Māori society the text purports to demonstrate that ‘*It is increasingly apparent that, in Aotearoa pre-colonial Māori society, people of diverse genders and sexualities were both accepted and valued within whānau’* even as the cited references provide contrasting information. The PhD of Elizabeth Kerekere states categorically that *‘there is not yet evidence that Māori had diverse gender identities or that takatāpui played specific roles in pre-colonial times’* (Kerekere, 2017). Neither are PATHA’s claims about ‘diverse genders’ substantiated in the other research cited. A close examination of the other resources cited in the PATHA Guideline, in support of the idea of indigenous gender identities, provides no evidence of them.(Salmond, 2017; Te Awekotuku, 1996)

While it appears there are no New Zealand data on indigeneity and gender transition, there are strong values in Te Ao Māori related to holistic approaches. The main groups who seek transgender care do not appear to be predominantly Māori. If New Zealand is following the overseas experience it appears likely that the predominantly young people seeking gender medicine are overwhelmingly likely to be predominantly European and middle class.(Littman, 2018; Manjra et al., 2022) Anecdotal evidence from New Zealand teachers and clinicians accords with this assessment. From the commentary that is available it seems that gender transition is antithetical to the views of many Māori.(Landy, 2023; Mana Wāhine Kōrero, 2023) The creation of multiple neologisms for transgender and non-binary people as well as the repurposing of takatāpui, the only Māori language term that may be used to self-describe gay and lesbian relationships, to also describe the transgender community is indicative of the recent emergence of transgenderism in te Ao Māori. Sterilising the young, binding breasts, undermining fertility have no historical precedents in Māori mythology, songs or literature.(Landy, 2023) Is the approach that has been taken, of binding Māori society to transgender identities to provide historical legitimacy, simply a new form of colonialism? Beyond New Zealand’s indigenous voices there are other writers who argue that it is.(Beatrice, 2020; Pember, 2016)

## Discussion and findings

The real world impacts of the PATHA Guideline are in the creation of medical pathways. These affirmative pathways have fast-tracked hundreds and possibly thousands of young people and children into social transition and medicalisation that has had irreversible effects on them. By way of an example the ‘welcome letter’ for those accessing youth gender services at Auckland’s Centre for Youth Health begins with affirming each child’s gender goals with discussions of puberty blockers, cross sex hormones and fertility preservation (for boys) in the first 90 minute appointment.(Centre for Youth Health & Healthpoint, n.d.) By doing this the implementation of the PATHA health guideline appears to take the view that lifelong medication is preferable to an unmedicated life. But why is it not best to have a child happy in the body they were born with and having fewer invasive and life altering procedures? In summary whereas WPATH SOC 7 diagnoses and treats gender dysphoria the PATHA Guideline affirms transgender identities.

The Guideline falls well below customary standards of medical rigor, especially for such an influential document in a novel, experimental and rapidly growing area of medicine. The WPATH SOC 7 is no panacea and itself falls short of being an evidence based Guideline. The authors could have taken advantage of the work critiquing SOC 7 (Deutsch, 2016) to enhance the quality of the PATHA Guideline but that did not happen. Instead on each occasion where the PATHA Guideline differs from WPATH it effectively amplifies the faults. These treatment approaches, especially when they differ substantially from WPATH’s SOC 7, are especially concerning. Each makes medicalisation more likely or fails to provide patients with important information. It appears the changes have been advocated for by activist transgender groups and individuals, and the recommendations are supported, if at all, by cherry-picked evidence.

To summarise the findings: The authors did not take the available route of creating a guideline for New Zealand conditions by adapting the best available evidence as the BPAC would have advised. It appears that the PATHA Guideline lacks the systematic and transparent methodology expected of an evidence based clinical practice guideline in almost every respect. The population needing treatment and/or the symptoms that define the transgender condition (and thus the treatments on offer) suffer from definitional problems. It appears there are skill gaps in the team of authors and whether their participation is as individuals, or as institutional representatives is unclear. There is no evidence of a systematic literature review, nor a process for formulating clinical recommendations that arise from an evidence base. There is nothing to demonstrate that there was either an independent pre-publication review, a process for managing conflicts of interest or a plan for reviewing the PATHA Guideline.

The affected population of transgender people who were involved in the scoping and preference setting appear to have been central to the philosophical approach taken by the Guideline. Rather than a formal engagement process PATHA went well beyond the WPATH SOC 7 approach to gathering opinion by including activist groups and individuals at the centre of the process. When the Guideline makes recommendations that go beyond WPATH’s advice, but are presented without evidence, it is valid to be concerned that the guideline writers have struck the wrong balance.

#### Questions that arise

The creation of this guideline and the lack of any critical assessment of its approach over 5 years, especially by the Ministry of Health, appears to be a kind of regulatory failure. Should the Ministry mandate that, in future, clinical guidelines are created to an agreed standard and require an external assessment? What are the arrangements that usually apply to implementing new medical approaches and is the PATHA Guideline an outlier? Surely it cannot be that any interest group can embed their thinking in a medical guideline deciding that good practice equates to the approach that benefits their careers or advances their personal treatment journeys? Should a guideline propose massive steps beyond international norms without good reason? Based on the Health and Disability case cited above (Health and Disability Commission. 2012) does the Guideline provide the evidence that the medicine does, as the judgement required, allow the practitioner to meet the ‘*obligation to satisfy themselves that the medicine is safe and efficacious’* as the Health and Disability Commission requires?  Should Waikato University also review the Guideline against their standards for academic adequacy? Surely it should not be using the evidence of the adults whose childhood memories of their own gender discomfort account for only a small proportion of the overall population of people with the same discomfort to set the criteria for who is transgender. By downplaying the evidence that most gender questioning children resolve their confusion, present in the WPATH SOC 7, and in the previous New Zealand guideline, there is great cause for concern as children and young people, who would not otherwise have been lifelong patients are now permanently medicated.

The Ministry of Health has previously advised that PATHA will write the new standard following the release of WPATH SOC 8 and the work has received budget funding. Based on the current approach what checks on process and quality should the Ministry insist upon to ensure that this work is satisfactory? Should the New Zealand Sexual Health Society and the New Zealand Society of Endocrinology review the basis for their endorsement of it? Should the Medical Council review their guidance and professional training and should Health New Zealand’s health pathways that depend on the Guideline be reviewed?

The PATHA Guideline recommendation states that ‘*all health services provide equitable and accessible gender affirming healthcare services that align with international standards, evidence-based literature and community feedback*.’ But the evidence that this applies to the development of their own standard is missing. Even with the proviso that WPATH’s SOC 7 is not strictly an evidence based guideline either, there is no reason why local guidelines should not provide a locally appropriate version of an international guideline as the BPAC process describes.(BPACNZ, n.d.)

Finally, based on these findings, the authors’ suggestion that their work should ‘*support the development of health services providing gender affirming healthcare around the country and provide guidance to District Health Boards (DHBs)*’ should surely have been called into question in the 5 years since its publication.

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## Appendix I The structure of the PATHA Guideline

The Introduction

* Discusses the increase in numbers but offers no explanation for them.
* Explains that the older Guideline required updating to be in step with: a) current practice b) new international guidelines c) a care landscape that is evolving rapidly.
* Explains the obligations and commitments that exist under the Treaty of Waitangi
* Describes the importance of patient autonomy Te mana whakahaere: autonomy and community leadership -elements of a public health communication model.
* Explains Dr Mason Durie’s Te Whare Tapa Whā.
* Makes recommendations for the provision of gender affirming healthcare.

Subsequent chapters cover issues related to gender medicine are ordered according to Nga Whare Tapa Whā and each contains practice points directed to medical practitioners and recommendations directed to District Health Boards as well as other guidance in the text.

Taha Wairua | spiritual health has the following sections.

* Pre-colonial Māori society
* Aotearoa today and minority stress
* Trans positive health services: flexible and responsive
* Social Transition
* Practice Points
* Recommendations for trans positive health services

Taha Whānau | family health has the following sections.

* Whānau and young people and practice points
* Gender diverse children
* Young people and practice points
* Schools and practice points for school health teams
* Partners and friends: young people and adults
* Whānau and self-determination and practice points
* Recommendations for services that are supportive of whānau

Taha Hinengaro | mental health has the following sections.

* The role of mental health professionals and practice points
* Neurodiversity and gender diversity and practice points
* Recommendations for supporting positive mental health

Taha Tinana | physical health contains the following sections

* Transition goals
* Informed consent
* General healthcare
* Healthcare for young people (and practice points related to young people)
* Fertility preservation and contraception
* Puberty suppression using GnRH agonists (with medicine and dose)
* Gender affirming hormone treatment
* Feminising hormonal therapy
* Masculinising hormonal therapy
* Gender affirming surgical treatment
* Laser hair removal
* Voice and communication training
* Recommendations for provision of gender affirming healthcare

The other elements are:

* Terminology used 2 pages
* References 2 pages
* Appendix A. Tanner stages 2 pages
* Appendix B. Fertility information 3 pages
* Consent forms for puberty blockers and feminising and masculinsing hormone therapy

## Appendix II Criteria for assessing the PATHA Guideline

|  | AGREE II | National Academies | WHO |
| --- | --- | --- | --- |
| 1 | The overall objective(s) of the guideline is (are) specifically described. | Establish Evidence foundations | Disease burden and distribution across subgroups  Background on the intervention or topic  History of this guideline |
| 2 | The guideline development group includes individuals from all the relevant professional groups. | Developed by a knowledgeable, multidisciplinary panel of experts and representatives from key affected groups. | Steering group  Guideline development group  Guideline methodologist(s) |
| 3 | The views and preferences of the target population (patients, public, etc.) have been sought. | Consider important patient subgroups and patient preferences, as appropriate. | Stakeholders, including service users.  External partners |
| 4 | Systematic methods were used to search for evidence. | Based on a systematic review of the existing evidence. | Need for new systematic review.  Study inclusion and exclusion criteria  Evidence identification and retrieval  Systematic review methods |
| 5 | The methods for formulating the recommendations are clearly described. | Provide a clear explanation of the logical relationships between alternative care options and health outcomes, and provide ratings of both the quality of evidence and the strength of the recommendations. | Use of the GRADE framework  Factors to consider, e.g. values and preferences; resource use; equity, human rights, and gender.  Tools for formulating recommendations |
| 6 | The guideline has been externally reviewed by experts prior to its publication. | External review of the CPG, including specified mechanisms for ensuring public stakeholder comment | Systematic review team  External review group |
| 7 | A procedure for updating the guideline is provided. | Reconsidered and revised as appropriate when important new evidence warrants modifications of recommendations. | Plans for when and how to update.  Strategies for identifying new information |
| 8 | Competing interests of members of the guideline development group have been recorded and addressed. | Based on an explicit and transparent process that minimizes conflicts of interest; | Collecting disclosures of interest  Assessing disclosures of interest  Managing conflicts of interest |

## Author details

Jan Rivers is a Wellington former public servant, who has worked in information management, libraries and research. She is the co-author of [Sex, Gender and Women’s Rights](https://ojs.victoria.ac.nz/pq/article/view/7316) an examination of the policy capture by ideas from gender ideology in the New Zealand Public Sector. She can be contacted at [jan@publicgood.org.nz](mailto:jan@publicgood.org.nz).

1. MVPFAFF is an acronym that represents gender diverse Pasifika people. [↑](#footnote-ref-2)
2. ##### Mental Health

   WPATH

   To access gender affirming hormones and surgery SOC 7 says: *If significant medical or mental concerns are present, they must be reasonably well-controlled.* Untreated mental health conditions can complicate treatment.

   PATHA

   *Include mental health issues as part of a holistic psychosocial assessment, for example discussion of anxiety, depression, risk of self-harm, while being clear that having mental health issues is not a barrier to accessing gender affirming services.*

   *Although some neurodiverse people may have difficulty in articulating their gender identity, this should not create an unnecessary barrier to access any relevant gender affirming services. Some people may express their gender identity non-verbally*. [↑](#footnote-ref-3)
3. *Cause of associated mental health conditions*

   WPATH

   *Clients presenting with gender dysphoria may struggle with a range of mental health concerns*

   *whether* ***related or unrelated*** *to what is often a long history of gender dysphoria and/or chronic minority stress.*(Emphasis added)

   *Mental health professionals should screen for these and other mental health concerns and incorporate the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria.*

   *PATHA*

   *It is becoming increasingly accepted that it is the additive effects of minority stress that results in mental health difficulties.*

   *The WPATH standards emphasise that the having medical or mental health concerns does not mean gender affirming care cannot be commenced, rather that these need to be responded to alongside gender affirming care.* [↑](#footnote-ref-4)
4. #### Ethical issues about proceeding to treatment

   WPATH

   *Neither puberty suppression nor allowing puberty to occur is a neutral act.*

   PATHA

   *Withholding gender affirming treatment is not considered a neutral option, as this may cause or exacerbate any gender dysphoria or mental health problems.*

   *Acknowledge that withholding gender affirming healthcare is not considered a neutral option.* [↑](#footnote-ref-5)
5. *Desistance because dysphoria resolves*

   WPATH SOC 7

   ***In most children****, gender dysphoria will disappear before or early in puberty.* (Emphasis added)

   *An important difference between gender dysphoric children and adolescents is in the proportion for   
   whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably   
   continue into adulthood. Rather, in follow-up studies of prepubertal children (mainly boys) who   
   were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood   
   for only 6-23% of children. Boys in these studies were more likely to identify as gay in adulthood than as transgender Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood.*

   PATHA

   [At adolescence] ***some previously gender-expansive children******may shift along the gender spectrum*** *to find their gender identity more aligned with the sex assigned at birth.* (Emphasis added) [↑](#footnote-ref-6)
6. Social Transition

   WPATH says *'This is a controversial issue, and divergent views are held by health professionals. Transgender people should be supported through these steps of social transition to allow them to have positive experiences in the world as a truer representation of themselves.   
   The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.*

   PATHA  
   *Transgender people should be supported through these steps of social transition to allow them to have positive experiences in the world as a truer representation of themselves. Social transition can also start out part-time in known safe environments, such as home or school*. [↑](#footnote-ref-7)
7. The judgement states 54. “*In using or prescribing an unapproved medicine, a practitioner is required to comply with the Medicines Act 1981. In addition, when prescribing an unapproved medicine to a patient, the practitioner has an obligation to satisfy themselves that the medicine is safe and efficacious. This legal obligation arises from Right 4(1) of the Code. Right 4(1) requires that services are provided with reasonable care and skill…. and also relevant professional standards as set by the Medical Council of New Zealand* (MCNZ).  
   56. …. *appropriate steps for a practitioner to take before prescribing an unapproved medication would be to carefully review independent clinical evidence, peer-reviewed journals, and to engage in discussions with more experienced colleagues*. [↑](#footnote-ref-8)
8. Puberty Suppression

   WPATH

   *In order for adolescents to receive puberty suppressing hormones, the following minimum criteria   
   must be met:  
   1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity   
   or gender dysphoria (whether suppressed or expressed);  
   2. Gender dysphoria emerged or worsened with the onset of puberty;   
   3. Any co-existing psychological, medical, or social problems that could interfere with treatment   
   (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent’s situation and functioning are stable enough to start treatment;   
   4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process*

   PATHA

   *Be aware of the positive impact of puberty blockers (GnRH agonists) on future well-being. Be mindful of the need to refer promptly and be aware of referral pathways.* [↑](#footnote-ref-9)
9. Blockers potential to impact on male genitals

   *WPATH*

   *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).*

   PATHA

   *For trans women and transfeminine people, puberty suppression at Tanner stage 2-3 may limit the availability of penile and scrotal skin used to create a neovagina and labia. This needs to be balanced with the desire to avoid voice deepening and other secondary sexual characteristics which will progress if continuing past Tanner stage 2-3.* [↑](#footnote-ref-10)
10. #### Involvement of the transgender community in clinical guideline development

    WPATH

    The Standards of Care revision process had donor funds which supported amongst other things a

    *‘Process of soliciting international input on proposed changes from gender identity professionals*

    *and the transgender community.’*

    PATHA

    *‘Transgender people have been involved in the steering of the project, including development of services and these guidelines. The importance of trans community leadership in the development of trans healthcare services is paramount.’* [↑](#footnote-ref-11)