Health Council

To 5.1.2e
by email: 5.1.2e

Date: October 1, 2026
Phone: 06 5.1.2e
Your reference: -
Email: 5.1.2e @gr.nl
Our reference: 4491892/4535946 ST/mz Woo
Attachments: Miscellaneous

Subject: Decision on Woo Request Regarding Advice *on Transgender Care for Youth* (Part II)

Dear 5.1.2e ,

I am writing to inform you of the follow-up to your Woo request. In your letter dated July 23, 2026, you requested that the Health Council, pursuant to the Open Government Act (hereinafter: Woo), provide information regarding the advisory report *on Transgender Care for Young People*, No. 2026/12, which was published on June 30, 2026.

You are requesting (copies of) "documents recording consultations or communications written from the time the Herzberger motion (Parliamentary Document 31016, No. 370) was submitted until the time this Woo request was submitted." We conclude that this pertains to information from the period February 15, 2024 (date of the Herzberger motion) through July 23, 2026.
Furthermore, you indicate that your request should be interpreted in the broadest sense of the Woo, "i.e., physical and electronic documents, emails, app communications, audio and video recordings, and any other form of document that falls under the definition of the Woo." You specify this in your request with 9 points.

On September 3, 2026, you received an initial partial decision. That decision also noted that several documents and emails from third parties had been identified. These third parties were given until September 24, 2026, to submit their comments. Now that this deadline has passed, you are hereby receiving the second and final decision.

Decision
With this partial decision, I conclude that information has once again been found that can be (partially) made public. I explain my decision below.

Legal Framework
The right to disclosure serves the public interest in sound and democratic governance. Every citizen is equally entitled to this right. The specific interests of the requester are not taken into account.
Disclosure within the meaning of the Woo means disclosure to everyone. The assessment is therefore made in that light. This assessment is based on Articles 5.1 and 5.2 of the Woo, which specify the cases in which disclosure may or must be refused. For the relevant provisions of the Woo, please refer to Appendix A.

Inventory of Requested Information
The inventory determines which documents are covered by your request.
- Documents: For this inventory, I reviewed the committee's (digital) folder. Folders consulted: Advice, Correspondence, Committee Composition, Meetings, Memo.
- Email messages: I included the email inboxes of the academic secretaries responsible for the Transgender Care for Youth Committee in the inventory.

Visiting Address
Bezuidenhoutseweg 30
2594 AV The Hague
e. info@gr.nl
Tel. 070 340 75 20
www.gezondheidsraad.nl

- WhatsApp: No substantive WhatsApp communication was found with committee members or third parties.

Based on your request, several emails and documents were found. These are included in the inventory list; see Appendix B.

Opinions
On September 7 and 9, 2026, the Health Council sent requests for comments to all third-party stakeholders. In response to the comments received, several emails and documents are being made public, provided that (in)directly identifiable personal data is redacted to prevent an infringement of privacy (in accordance with Article 5.1, paragraph 2e of the Woo). The relevant documents sent to third parties for comment have been added to the inventory list (see Appendix B) and are highlighted in yellow for easy identification. Some of the documents found were already in the public domain. For their locations, please also refer to Appendix B.

Explanation of the Submitted Information
Documents prepared for (committee) meetings and detailed reports thereof are not made public. These are documents intended for internal deliberation, containing the personal policy views of committee members, scientific staff, and other civil servants. It follows from Articles 5.1.2i and 5.2 of the Woo that I am not required to make these public. If the Health Council is to be able to issue sound and independent advice, the unimpeded contribution of scientific secretaries and committee members to the internal deliberations on the preparation of the (draft) advice must be guaranteed. They must be able to communicate openly with one another and with the Council's executive board regarding scientific considerations. The Health Council does, however, make the summaries of (committee) reports public.
Documents and emails containing factual information but of a purely administrative nature are also not made public. The information contained therein is not relevant for this purpose. After all, such documents, which lack substantive relevance, do not form the basis for the advice.

Method of Disclosure
The documents and email messages to be made public are provided to you simultaneously with this decision. The document numbers correspond to the numbers in Appendix B.

Trusting that this has provided you with sufficient information,

met vriendelijke groet

5.1.2e

dr. S.C. Tromp,
Vice Chair

Objection
If you disagree with this decision, you may submit a written objection within six weeks of the date shown at the top of this letter. Please note: You must do this on time; otherwise, your objection cannot be processed. In your objection, include your name and address, as well as the date of this letter. Explain why you disagree with the decision. Don’t forget to sign and date your appeal. Would you please include a copy of this letter with your appeal?

Please email the objection to: 5.1.2e @gr.nl, preferably with a scanned signature, and include the subject line “appeal.”

If you are unable or unwilling to send an email, you may also mail your objection to: the Chair
of the Health Council
c/o Dr. I.D. de Wolf, General Secretary and Director, P.O. Box
16052
2500 BB The Hague

If you submit the objection by email without a signature, you may be asked at a later date to provide proof that you are authorized to file the objection.

Health Council

[redacted]

Date: October 8, 2026
Phone: 06 528 42 809
Your reference: -
Email: communicatie@gr.nl
Our reference: 4529741/4539882 ST/mz Woo
Attachments: -

Subject: Decision on Woo request regarding written mandate for the Transgender Care for Youth Committee

Dear [redacted]

In your message dated September 12, 2026, you requested, pursuant to the Open Government Act (hereinafter: Woo), "disclosure of the written mandate issued by the chair or vice-chair of the Health Council to the Committee on Transgender Care for Youth, chaired by Prof. O.M. Dekkers, which was established on February 5, 2025."

In summary, your request includes:
1. The written mandate, regardless of its title or form, including the accompanying letter or email and the attachments referred to in the mandate.
2. The agenda of the inaugural meeting of February 5, 2025, and the accompanying documents regarding the mandate and scope, including the work plan and any introductory memorandum, as well as any existing summary or list of decisions, to the extent that they set forth the mandate, scope, or adoption of the work plan.
3. Subsequent written amendments to the mandate or scope, including any recorded approval by the chair or vice-chair, up to and including the adoption of the advisory opinion on June 30, 2026.
4. Existing Woo requests that include these documents in whole or in part, including relevant sections of broader requests concerning this committee, and the associated decisions, inventory lists, and documents already released, to the extent that they relate to the above-mentioned documents.

For items 1 through 3, this covers the period from May 13, 2024, through June 30, 2026, and for item 4, from May 13, 2024, through the date of receipt of your request.

I hereby inform you of the decision.

Decision
With this decision, I determine that information has been found that can be made public (in part). I explain my decision below.

Legal Framework
The right to disclosure serves the public interest in sound and democratic governance. Every citizen is equally entitled to this right. The specific interest of the requester is not taken into account.
Disclosure within the meaning of the Woo means disclosure to everyone. The assessment is therefore made in that light. This assessment is based on Articles 5.1 and 5.2 of the Woo, which specify the cases in which disclosure may or must be refused. For the relevant provisions of the Woo, please refer to Appendix A.

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2594 AV The Hague
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Tel. 070 340 75 20
www.gezondheidsraad.nl

Inventory of Requested Information
This inventory determines which documents are covered by your request.

- Documents: For this inventory, I reviewed the committee's (digital) folder. Folders consulted: Advice, Correspondence, Meetings, Memo.
- Email messages: I included the email inboxes of the academic secretaries responsible for the Transgender Care for Youth Committee in the inventory.
- WhatsApp: I also included WhatsApp communications in the inventory. No substantive contact with committee members was found via that medium.
- Decision on the Woo request dated October 1, 2026, regarding the advisory opinion *on Transgender Care for Youth*: I included this decision in the review because it concerns the same subject matter.

Based on your request, several emails and documents were found. These are included in an inventory list; please see Appendix B.

With regard to the requests made in points 2, 3, and 4 of your Woo request, I would like to refer you to the inventory list (Appendix B) accompanying the decision of October 1, 2026, on the Woo request regarding the advisory opinion *on transgender care for young people*—for example, document numbers 212, 215, and 220. You will receive this decision, along with the documents (partially) made public as a result, at the same time as this decision on your Woo request. The first partial decision on the aforementioned Woo request, with accompanying documents, dated September 3, 2026, was already sent to you on September 17, 2026, along with your acknowledgment of receipt.

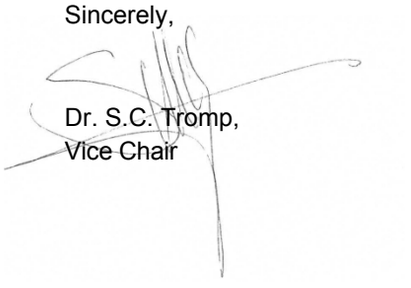
Opinion of a third-party interested party
During the review, an email was found from a third party who was asked on October 1, 2026, to provide comments regarding potential disclosure. In response to the received feedback, this email is being made public, provided that any directly or indirectly identifiable personal data is redacted to prevent an infringement of privacy (in accordance with Article 5.1, paragraph 2e of the Woo). The email in question can also be found in the inventory list (see Appendix B).

Explanation of the Submitted Information
Documents prepared for (committee) meetings and detailed reports on those meetings are not made public. These are documents intended for internal deliberations, containing the personal policy views of committee members, scientific staff, and other civil servants. Articles 5.1.2i and 5.2 of the Woo stipulate that I am not required to make these public. If the Health Council is to be able to issue sound and independent advice, the unimpeded contribution of scientific secretaries and committee members to the internal deliberations on the preparation of the (draft) advice must be guaranteed. They must be able to communicate openly with one another and with the Council's board regarding scientific considerations. The Health Council does, however, make the summaries of (committee) reports public.
Documents and emails containing factual information but of a purely administrative nature are also not made public. The information contained therein is not relevant for this purpose. After all, such documents without substantive relevance do not form the basis for the advice.

Method of Disclosure
The documents and email messages to be made public are provided to you simultaneously with this decision (Appendix C). The document numbers correspond to the numbers in Appendix B.

We trust that this information is sufficient,

Sincerely,



Dr. S.C. Tromp,
Vice Chair

Appeal
If you disagree with this decision, you may submit a written objection within six weeks of the date shown at the top of this letter. Please note: You must do this on time; otherwise, your objection cannot be processed. In your objection, include your name and address, as well as the date of this letter. Explain why you disagree with the decision. Don’t forget to sign and date your appeal. Would you please include a copy of this letter with your appeal?

Please email your objection to:communicatie@gr.nl , preferably with a scanned signature, and include the subject line “objection.”

If you are unable or unwilling to send an email, you may also mail your objection to: the Chair
of the Health Council
c/o Dr. I.D. de Wolf, General Secretary and Director, P.O. Box
16052
2500 BB The Hague

If you submit the objection by email without a signature, you may be asked at a later date to provide proof that you are authorized to file the objection.

Health Council

Exceptions under the Open Government Act

Sections 5.1 and 5.2 of the Open Government Act

(grounds for exemption most relevant to the work of—and collaboration with—the Health Council are printed in italics; see 5.1.2e, 5.1.2i, and 5.2.1)

Article 5.1 Exceptions

Paragraph 1: Information shall not be disclosed pursuant to this Act to the extent that such disclosure:

a. could jeopardize the unity of the Crown;
b. could harm national security;
c. concerns business and manufacturing data that have been disclosed to the government in confidence by natural persons or legal entities;
d. relates to personal data as referred to in Section 3.1 or Section 3.2 of the General Data Protection Regulation Implementation Act, unless the data subject has expressly consented to the disclosure of such personal data or such personal data has apparently been made public by the data subject;
e. numbers used to identify individuals that are prescribed by law or by an order in council as referred to in Article 46 of the General Data Protection Regulation Implementation Act, unless the disclosure clearly does not infringe upon privacy.

Paragraph 2: Information shall also not be disclosed to the extent that the interest in its disclosure is not outweighed by the following interests:

a. the Netherlands' relations with other countries and states and with international organizations;
b. the economic or financial interests of the State, other public-law entities, or administrative bodies; in the case of environmental information, only to the extent that the information relates to acts of a confidential nature;
c. the investigation and prosecution of criminal offenses;
d. inspection, control, and supervision by administrative bodies;
e. the protection of privacy;
f. the protection of business and manufacturing data sensitive to competition other than that referred to in paragraph 1, subparagraph c;
g. the protection of the environment to which this information relates;
h. the security of individuals and businesses and the prevention of sabotage;
i. the proper functioning of the State, other public-law bodies, or administrative bodies—such as the Health Council.

Paragraph 3: If a request for disclosure is denied on one of the grounds listed in paragraph 2, the decision must include an explicit statement of reasons.

Paragraph 4: Disclosure may be temporarily withheld if the interest of the recipient of the information in being the first to receive it clearly so requires. The administrative body shall notify the requester of the time frame within which the disclosure will ultimately take place.

Paragraph 5: In exceptional cases, disclosure of information other than environmental information may also be withheld if disclosure would cause disproportionate harm to an interest other than those mentioned in the first or second paragraph, and the public interest in disclosure does not outweigh this

disadvantage. The administrative body shall not base a decision to withhold disclosure of any information on this ground with respect to the same information on any of the grounds mentioned in the first or second paragraph.

Paragraph 6: Notwithstanding paragraph 1(c), the disclosure of environmental information shall also be withheld to the extent that it would seriously harm the interest referred to in paragraph 1(c) and the public interest in transparency does not outweigh such harm.

Paragraph 7: The first and second paragraphs do not apply to environmental information relating to emissions into the environment.

Article 5.2 Personal Policy Views

Paragraph 1: In the event of a request for information from documents prepared for the purpose of internal deliberation, no information shall be provided regarding personal policy views contained therein. Personal policy views are defined as official advice, visions, positions, and considerations for the purpose of internal deliberation, excluding facts, forecasts, policy alternatives, the consequences of a particular policy alternative, or other elements of a predominantly objective nature.

Paragraph 2: The administrative body may disclose information regarding personal policy views in a form that cannot be traced back to specific individuals, with a view to ensuring sound and democratic governance. If the person who expressed these views or endorsed them has consented to such disclosure, the information may be disclosed in a form that can be traced back to specific individuals.

Paragraph 3: Without prejudice to paragraphs 1 and 2, information regarding personal policy views may be provided from documents prepared for the purpose of formal administrative decision-making by a minister, a King’s Commissioner, the Provincial Executive, a provincial executive member, the municipal executive, a mayor, or an alderman, information regarding personal policy views shall be provided in a form that cannot be traced back to specific individuals, unless the ability to conduct internal deliberations is disproportionately impaired.

Paragraph 4: Notwithstanding the first paragraph, in the case of environmental information, the interest in protecting personal policy views shall be weighed against the interest in disclosure. Information regarding personal policy views may be provided in a form that cannot be traced back to specific individuals. If the person who expressed these views or endorsed them has consented to this, the information may be provided in a form that does not allow for identification of individuals.

Appendix B Inventory List: Woo Request Based on Written Assignment from the Transgender Care Committee						
No.	**Document**	**Assessment**	**Woo**	**Sender**	**Recipient**	**Comments**
1	20240926 Invitation to the Health Council Advisory Process-1	Partially public	5.1.2e	GR	External	
2	20240926 Invitation to the Health Council Advisory Process-2	Partially public	5.1.2e	GR	External	
3	20240926 Invitation to the Health Council Advisory Process-3	Partially public	5.1.2e	GR	External	
4	20240926 Invitation to the Health Council Advisory Process-4	Partially public	5.1.2e	GR	External	
5	20240926 Invitation to the Health Council Advisory Process-5	Partially public	5.1.2e	GR	External	
6	20240926 Invitation to the Health Council Advisory Process-6	Partially public	5.1.2e	GR	External	
7	20240926 Invitation to the Health Council Advisory Process-7	Partially public	5.1.2e	GR	External	
8	20241001 RE-Invitation to the Health Council’s advisory process—rejection	Partially public	5.1.2e	GR	External	
9	12 x 20241106 Invitation to participate in the Committee on Transgender Care for Youth	Partially public	5.1.2e	GR	Committee	
10	20241203 Invitation to the advisory process -8	Partially public	5.1.2e	GR	External	
11	20250129 Meeting documents for the inaugural meeting on transgender care for youth in the collaboration space	Partially public	5.1.2e	GR	Committee	

Appendix B: Inventory List for the Woo Request Regarding Transgender Care for Youth

No.	Document	Assessment	Woo	Sender	Recipient	Comments
1	20240606 - Internal - Preparation - Letter to Parliament and the article from the NJB	Partially public	5.1.2e	INTERNAL		
2	20240711 RE_ Consultation on the Health Council's advisory opinion on transgender care - Ministry of Health, Welfare, and Sport	Partially public	5.1.2e	VWS	GR	
3	20240712 - Internal - RE_ Committee Member for Legal Affairs	Not public	5.2.1	INTERNAL		
4	20240718 RE_ Contact with the Health Council regarding transgender care - Ministry of Health, Welfare, and Sport	Partially public	5.1.2e	GR	VWS	
5	20240819 RE_ Introduction GR - VWS transgender care	Partially public	5.1.2e	GR	VWS	
6	20240823 RE_ Exploratory meeting with the Health Council	Partially public	5.1.2e	GR	External	
7	20240823 RE_ Exploratory meeting with the Health Council	Partially public	5.1.2e	GR	External	
8	20240823 RE_ Exploratory meeting with the Health Council	Partially public	5.1.2e	GR	External	
9	20240823 RE_ Exploratory meeting with the Health Council	Partially public	5.1.2e	GR	External	
10	20240827 RE_ Exploratory discussion on transgender care	Partially public	5.1.2e	GR	External	
11	20240927 - Internal - Developmental Psychology and Epidemiology	Not public	5.2.1	Secretary	Secretary	
12	20240927 RE_ Exploratory Meeting with the Health Council - Rejection	Partially public	5.1.2e	GR	External	
13	20241003 RE_ Further information	Partially public	5.1.2e	GR	External	
14	20241015 RE_ Meeting on transgender care: VWS-GR	Partially public	5.1.2e	GR	VWS	
15	20241022 RE_ Introduction to the advisory process on transgender care	Partially public	5.1.2e	GR	Committee Member	

16	20241022 RE_ Exploratory Meeting with the Health Council	Partially public	5.1.2e	GR	External	
17	20241031 RE_ Health Council - Feedback on exploratory meeting	Partially public	5.1.2e	GR	External	
18	20241031 RE_ About Cass review	Partially public	5.1.2e	GR	External	
19	20241112 RE_ Exploratory Meeting with the Health Council	Partially public	5.1.2e	GR	External	
20	20241115 - Internal - Child and Adolescent Psychiatrists ESCAP Statement on Transgender Care	Not public	5.2.1	INTERNAL		
21	20241120 Re: Feedback on exploratory meeting with the Health Council	Partially public	5.1.2e	GR	External	
22	20241120 RE_ Exploratory Meeting with the Health Council	Partially public	5.1.2e	GR	External	
23	20241120 RE_ Exploratory Meeting with the Health Council	Partially public	5.1.2e	GR	External	
24	20241122 RE_ Exploratory Meeting with the Health Council	Partially public	5.1.2e	GR	External	
25	20241128 Re: Exploratory Meeting with the Health Council	Partially public	5.1.2e	GR	External	
26	20241206 RE_ Invitation to the Health Council's advisory process	Content not relevant	5.1.2e	GR	External	Email with meeting dates
27	20241217 RE_ Introductory Meeting VWS-GR	Partially public	5.1.2e	GR	VWS	
28	20241224 Re: Feedback on exploratory meeting with the Health Council	Partially public	5.1.2e	GR	External	
29	20250117 RE_ Response from NSC	Partially public	5.1.2e	GR	VWS	
30	20250206 RE_ Advisory Process on Transgender Care	Not public	5.2.1	GR	Committee	
31	20250206 RE_ tgZ Committee, Ministry of Health, Welfare and Sport-GR	Partially public	5.1.2e	VWS	GR	
32	20250206 RE_ Website	Content not relevant				Update of affiliation on website

33	20250210 RE_ GR transgender care - schedule consultation on written input	Content not relevant				Indicate availability for consultation date
34	13x Re_ Written round regarding consultation - Transgender Care Committee for Youth, February 13–2 through February 27, 2025	Not public	5.2.1	GR	Committee	
35	20250220 RE_ Meeting dates for the Committee on Transgender Care for Youth set	Not public	5.2.1	Committee Member	GR	
36	20250227 Consultation Approach	Not public	5.2.1	GR	Committee	
37	20250305 RE_ tgZ Committee - Ministry of Health, Welfare and Sport	Not public	5.2.1	VWS	GR	
38	20250312 RE_ Additional questions regarding the consultation with the Committee on Transgender Care for Youth	Not public	5.2.1	GR	Committee	
39	20250313 Specific questions for consultation	Not public	5.2.1	GR	Committee	
40	20250318 Consultation with the Health Council	Content not relevant		GR	External	Invitation email; no substantive information regarding the advisory opinion
41	20250320 FW_ Invitation to consultation on transgender care for youth - April 11	Content not relevant		GR	External	Invitation email; no substantive information regarding the advisory opinion
42	20250320 Review Invitation letter to parents and young people	Partially public	5.1.2e	GR	External	
43	20250324 Re: Invitation letter to parents and young people	Partially public	5.1.2e	GR	External	
44	20250325 Consultation with the Health Council	Content not relevant		GR	External	Invitation email; no substantive information regarding the advisory opinion
45	20250401 RE_ Consultation Update 11_4	Not public	5.2.1	GR	Committee	
46	20250407 Submission to the Health Council with appendix: input for consultation	Content not relevant		Transvisie	GR	Forwarded email with no content; attachment not public
47	20250409 FW_ Meeting Agenda: Consultation on Transgender Care for Youth - April 11, 2025 - Parent 1; with PowerPoint attachments (timeline of diagnosis and treatment	Content not relevant		parent	GR	Forwarded email with no content; attachment not public
48	20250409 FW_ Meeting Agenda: Consultation on Transgender Care for Youth - April 11, 2025; with attachments	Content not relevant		Front	GR	Forwarded email with no content; awaiting attachment of opinion
49	20250409 Fwd_ FW_ April 8 at 8:00 p.m. Online preparatory meeting for the session with the Health Council - parent 2: with attachment	Content not relevant		parent	GR	Forwarded email with no content; attachment not public

50	20250410 FW_ Presentation for the April 11, 2025, consultation—Transgender care for young people	Content not relevant		Transgender Network	GR	Forwarded email with no content; awaiting attachment with opinion on the consultation response
51	20250410 FW_ Presentation for the April 11, 2025, consultation—Transgender care for young people	Content not relevant				Procedural question
52	2x 20250422 Invitation to speak at the Health Council Committee meeting – May 16, 2025	Content not relevant				Forwarded email with no content; awaiting attachment with opinion on the consultation response
53	20250501 RE_ Follow-up to the advisory process on transgender care for young people	Partially public	5.1.2e	External	GR	
54	20250508 RE_ Documents relevant to our recommendation	Not public	5.2.1	Committee Member	GR	
55	20250514 RE_ Preliminary discussion for the fourth meeting on transgender care	Content not relevant		Committee Member	GR	Not substantive. Email attachments: https://www.njb.nl/blogs/transgenderzorg-aan-kinderen-juridische-
56	20250516 AW_ Invitation to speak at Committee meeting of Health Council – May 16, 2025	Content not relevant				
57	20250520 RE_ Memo on legal aspects of transgender care for young people	Not public	5.2.1	Ministry of Health, Welfare, and Sport	GR	
58	20250606 RE_ Update on transgender care: Ministry of Health, Welfare and Sport (VWS) - GR	Partially public	5.1.2e	Ministry of Health, Welfare, and Sport	GR	
59	20250625 RE_ Meeting documents for the committee meeting on transgender care for youth in the collaboration space on June 26, 2025	Not public	5.2.1	Committee Member	GR	
60	20250729 RE_ Consultation	Content not relevant				Not substantive. Agenda coordination
61	20251010 GR Committee on Transgender Care for Youth meeting today	Not public	5.2.1	Committee Member	GR	
62	7x 20251024 Report on the consultation with the Health Council's Committee on Transgender Care for Youth – Parent 1	Content not relevant				Accompanying email for the consultation report. The report is available on the website https://www.gezondheidsraad.nl/
63	20251104 RE_ IC forms for transgender care for youth	Not public	5.2.1	Committee Member	GR	
64	20250324 Appendix 1 - Invitation Letter for Health Council Consultation (5x)	Partially public	5.1.2e	GR	External	Letters with the same content sent to 5 recipients
65	20251125 RE_ Update on Health Council advice to the Ministry of Health, Welfare and Sport (VWS)-GR	Partially public	5.1.2e	Ministry of Health, Welfare, and Sport	GR	
66	20251212 Input regarding agenda items 4 and 5	Not public	5.2.1	Committee Member	GR	

67	20251212 Input: Meeting Documents for the Committee Meeting on Transgender Care for Youth in the Collaboration Space - December 12, 2025	Not public	5.2.1	Committee Member	GR	
68	20251212 Re: References for the Swedish healthcare model	Not public	5.2.1	Committee Member	GR	
69	20251212 Re: Written input on meeting documents	Not public	5.2.1	Committee Member	GR	
70	20251215 transgender and WKKGZ - Debets	Not public	5.2.1	Committee Member	GR	
71	20251217 RE_ Letter requesting postponement of publication	Partially public	5.1.2e	VWS	GR	
72	20251218 Draft Chapter 2 - Start-up Phase	Not public	5.2.1	Committee Member	GR	
73	20251218 Re: Written input on meeting documents	Not public	5.2.1	Committee Member	GR	
74	20251218 Invitation to the LNOT Committee meeting and other relevant documents - 101	Partially public	5.1.2e	GR	Committee	
75	20251219 RE_ Letter requesting postponement of publication - VWS	Partially public	5.1.2e	VWS	GR	
76	20251219 RE_ Draft Chapter 2 - Start-up Phase	Not public	5.2.1	Committee Member	GR	
77	20251223 RE_ Outline for Draft Chapter 2 - Start-up Phase	Not public	5.2.1	Committee Member	GR	
78	20260106 RE_ Methodological Considerations Regarding the Advisory Opinion on Transgender Care for Youth	Not public	5.2.1	Committee Member	GR	
79	3x 20260108 Re: Draft text for preliminary phase	Not public	5.2.1	Committee Member	GR	
80	20260113 RE_ Literature on transgender care for youth—section on outcomes of not providing treatment	Not public	5.2.1	Committee Member	GR	
81	20260113 RE_ Parliamentary questions from the SGP and ChristenUnie regarding the GR investigation	Partially public	5.1.2e	VWS	GR	
82	20260121 RE_ Draft text for preliminary phase	Not public	5.2.1	Committee Member	GR	
83	2x 20260121 RE_ Written input on meeting documents	Not public	5.2.1	Committee Member	GR	

84	20260128 Additions to meeting documents	Not public	5.2.1	Committee Member	GR	
85	20260128 FW_ Meeting documents for the committee meeting on transgender care for youth in the collaboration space - January 23, 2026 - Thesis: Risk Mitigation Off	Not public	5.2.1	Committee Member	GR	
86	20260128 FW_ Meeting documents for the committee meeting on transgender care for youth in the collaboration space - January 23, 2026	Not public	5.2.1	Committee Member	GR	
87	20260129 Follow-up to Meeting 8	Not public	5.2.1	Committee Member	GR	
88	20260209 RE_ Total Population Figures	Not public	5.2.1	Committee Member	GR	
89	20260220 RE_ Health Council _ Consultation on the Advisory Opinion on Transgender Care for Youth	Partially public	5.1.2e	GR	Expert consulted	
90	20260313 Comments on the new version of the draft recommendation	Not public	5.1.2e	Committee Member	GR	
91	20260313 Language-related issues in the Third Draft Recommendation	Not public	5.1.2e	Committee Member	GR	
92	20260314 third draft opinion comments	Not public	5.1.2e	Committee Member	GR	
93	20260316 The desired changes to the draft recommendation	Not public	5.1.2e	Committee Member	GR	
94	20260317 Feedback on documents from March 13	Not public	5.1.2e	Committee Member	GR	
95	20260319 H2 viewed	Not public	5.1.2e	Committee Member	GR	
96	20260423 RE_ Preliminary Consultation Meeting on Transgender Care	Not public	5.1.2e	Committee Member	GR	
97	20260424 My comments on the preliminary opinion	Not public	5.1.2e	Committee Member	GR	
98	20260429 Re: Transgender Care - References on the Effect of Stress on Cognitive Development	Not public	5.2.1	Committee Member	GR	
99	20260519 Re: Preliminary review comments from the deliberation group	Not public	5.2.1	Internal		
100	20260521 RE_ Deliberation Group Briefing on Transgender Care for Youth	Partially public	5.1.2e	GR	VWS	

101	20260604 Responses to Parliamentary Questions from the SGP	Partially public	5.1.2e	VWS	GR	
102	20260611 RE_ Answers to Parliamentary Questions DRAFT	Partially public	5.1.2e	GR	VWS	
103	20260612 RE_ Choice of words regarding fertility in GR advisory report on transgender care	Not public	5.2.1	Committee Member	GR	
104	20260623 RE_ What is the status of the recommendation?	Partially public	5.1.2e	Committee Member	GR	
105	14 invitation letters to committee members dated November 6, 2024	Partially public	5.1.2e	GR	Committee	
106	4 draft letters regarding the postponement of the publication of the advisory report on transgender care for young people dated November 26 and 27, 2025	Not public	5.1.2i; 5.1.2e	GR	VWS	Letter is public https://www.gezondheidsraad.nl/documents/2025/12/15/letter-to-vws-regarding-expected-
107	20250213 Proposal for Consultation on Transgender Care for Youth_	Not public	5.2.1	INTERNAL		
108	9x 20250221 Re: Written Round Regarding Consultation—Committee on Transgender Care for Youth	Not public	5.2.1	Committee	GR	
109	3x RE_ Meeting documents for the committee meeting on transgender care for youth in the collaboration space on June 26, 2025, from June 24 and June 26, 2025	Not public	5.2.1	Committee	GR	
110	20251209 H2adviceforDanique	Not public	5.2.1	Committee Member	GR	
111	20251212 Ethical Reflection_V1 and V22	Not public	5.2.1	Committee Member	GR	
112	Email 20251212 Feedback on line of reasoning	Not public	5.2.1	Committee Member	GR	
113	20251212 Response regarding agenda items 4 and 5	Not public	5.2.1	Committee Member	GR	
114	Email 20251212 Transgender and the WKKGZ	Not public	5.2.1	VWS	GR	
115	20251212 RadboudUMC Referral Policy 20251028	Already public	N/A	Committee Member	GR	Public Information https://www.radboudumc.nl/nieuws/2024/revised-referral-policy-for-transgender-care-for-children-
116	20251212-101-07.2 Outline of reasoning and text plan for transgender care for young people	Not public	5.2.1	Committee Member	GR	
117	3x 20251212-101-07.3 Initial draft opinion on transgender care for young people	Not public	5.2.1	Committee Member	GR	

118	Email 20251215 transgender and WKKGZ	Not public	5.2.1	Ministry of Health, Welfare and Sport	GR	
119	Email 20251216 Follow-up to previous meeting	Not public	5.2.1	Committee Member	GR	
120	20251212 Ethical Reflection	Not public	5.2.1	Committee Member	GR	
121	Email 20260111 Re: GR Committee on Transgender Care for Youth	Not public	5.2.1	Committee Member	GR	
122	Email 20251212 Re: Written Input on Meeting Documents	Not public	5.2.1	Committee Member	GR	
123	Re: Meeting documents for the committee meeting on transgender care for youth in the collaboration space—December 12, 2025	Not public	5.2.1	Committee Member	GR	
124	20260128-101-08.2 Second Draft Opinion on Transgender Care for Youth	Not public	5.1.2i; 5.2.1	Committee Member	GR	
125	20260128-101-08.3 Discussion Paper on Ethical Reflection	Not public	5.1.2i; 5.2.1	Committee Member	GR	
126	Email 20260129 Follow-up to Meeting 8	Not public	5.2.1	Committee Member	GR	
127	Email 20260127 Transgender Care	Not public	5.2.1	Vice Chair of the GR	GR	
128	5x 20260313-101-09.2 Third draft advisory opinion on transgender care for young people	Not public	5.1.2i; 5.2.1	Committee Member	GR	
129	20260313 Comments on the Third Draft Opinion	Not public	5.2.1	Committee Member	GR	
130	Email 20260313 Language-related issues in the Third Draft Recommendation	Not public	5.2.1	Committee Member	GR	
131	6x 20260424-101-10.2 Draft Recommendation on Transgender Care for Youth	Not public	5.1.2i; 5.2.1	Committee Member	GR	
132	3x 20260424-101-10.3 Background Document: Physical and Mental Outcomes	Not public	5.1.2i; 5.2.1	Committee Member	GR	
133	2x 20260424-101-10.4 Background Document: Quitting, Regret, and Detransition	Not public	5.1.2i; 5.2.1	Committee Member	GR	
134	20260424-101-10.5 Background Document: Legal Framework	Not public	5.1.2i; 5.2.1	Committee Member	GR	

135	20260424-101-10.6 Report on the Consultation Regarding Transgender Care for Youth	Not public	5.2.1	Committee Member	GR	
136	20260424 Preliminary opinion TGZ confidential	Not public	5.1.2i; 5.2.1	Committee Member	GR	
137	Email 20260428 Re: Meeting documents for the committee meeting on transgender care for youth in the collaboration space—April 24, 2026	Not public	5.1.2i; 5.2.1	Committee Member	GR	
138	2x 20260506 Background Document: Legal Framework	Not public	5.1.2i; 5.2.1	Committee Member	GR	
139	5x 20260506 Draft Recommendation on Transgender Care for Youth Claahsen 20260505	Not public	5.1.2i; 5.2.1	Committee Member	GR	
140	Email 20260512 RE_ Written Round on Transgender Care for Youth	Not public	5.1.2i; 5.2.1	Committee Member	GR	
141	20260119 Draft Responses to Parliamentary Questions from the SGP and CU	Not public	5.2.1	GR	Ministry of Health, Welfare, and Sport	
142	20260122 Draft responses to parliamentary questions from the SGP and CU	None (concerns a document from VWS)		GR	Ministry of Health, Welfare, and Sport	VWS is formulating a substantive assessment. Disclosure is contingent upon VWS's decision-making.
143	20260126 Parliamentary Question: Response regarding the Health Council's draft	None (concerns a document from VWS)		Ministry of Health, Welfare, and Sport	GR	VWS is formulating a substantive assessment. Disclosure is contingent upon VWS's decision-making.
144	20260309-CZ-1093277 Letter to Parliament from VWS regarding parliamentary questions from the SGP and CU	None (concerns a document from VWS)		Ministry of Health, Welfare, and Sport	House of Representatives	VWS forms the substantive assessment. Disclosure depends on VWS's decision-making. The final document is public.
145	20260610 Answers to Parliamentary Questions (DRAFT)	None (concerns a document from VWS)		Ministry of Health, Welfare, and Sport	GR	VWS forms a substantive assessment. Disclosure depends on VWS decision-making. https://www.tweedekamer.nl/kamerstukken/kamervragen/detail?id=2026Z11665&did=2026D31920
146	20260630-Cover Letter-Transgender Care for Youth-101-GR-VWS_def	Already public	N/A	GR	Ministry of Health, Welfare, and Sport	https://www.gezondheidsraad.nl/documents/2026/06/30/cover-letter-to-vws-accompanying-advice-on-transgender-care-for-youth
147	20251029 GR response to email RE_ Urgent concerns regarding the independence of the temporary committee on transgender care for young people - e-	Partially public	5.1.2e	GR	Citizen	
148	20251029 GR Response to Email from the Transgender Care for Youth Committee_signed	Partially public	5.1.2e	GR	Citizen	
149	20251110 Re: Urgent concerns regarding the independence of the Transgender Youth Care Committee	Partially public	5.1.2e	Citizen	GR	
150	20251119 Memorandum from the BO regarding correspondence	Not public	5.2.1	INTERNAL		
151	20251126 GR's Response to the Letter of November 10—Final	Partially public	5.1.2e	GR	Citizen	

152	20250619 RE_ GR Advisory Opinion_ZiNL_VWS	Partially public	5.1.2e	VWS, ZiNL	GR	
153	20260422 GR's response to email RE_ Addendum to my case regarding gender-affirming care—email correspondence from April 8 through April 22, 2026	Partially public	5.1.2e	GR	Citizen	Email exchange in response to a public inquiry from Landman
154	20260422 GR's response to the email of April 8	Partially public	5.1.2e	GR	Citizen	Email exchange in response to a public inquiry from Landman
155	20260622 Re: Addendum to my case regarding gender-specific healthcare	Partially public	5.1.2e	Citizen	GR	
156	20240919 Draft introductory memo (3 copies with the same date)	Not public	5.1.2i; 5.2.1	Secretaries	Board	
157	20240919 Environmental Analysis of Transgender Care	Not public	5.2.1	Secretaries	Board	
158	20241022 and 20241119 Notes on committee composition and expert consultation on transgender care	Not public	5.1.2i; 5.2.1	Secretaries	Board	
159	20241203 Memo on BO Committee Composition for Transgender Care	Not public	5.1.2i; 5.2.1	Secretaries	Board	
160	5x Draft discussion document for expert consultation, period June 1–2025 1, 2025	Not public	5.1.2i; 5.2.1			
161	20250306 draft emails	Not public	5.2.1			
162	20250411 - List of Participants in the Consultation on Transgender Care for Youth	Not public	5.1.2e; 5.2.1			The final list of participants is included in the report https://www.gezondheidsraad.nl/documents/2026/06/30/report-
163	Draft agenda for consultation on transgender care for youth—version after revision round, saved on March 10, 2025	Not public	5.2.1			
164	Draft invitation to consultation, Parts 1–2: Transgender Care for Youth, saved on February 7, 2025	Not public	5.2.1			
165	Draft invitation to stakeholder consultation on transgender care for youth, saved on February 27, 2025	Not public	5.2.1			
166	International Experts, saved on February 27, 2025	Not public	5.2.1			
167	Draft legal memo on transgender care, period March 10 through May 9, 2025	Not public	5.2.1			
168	20250904 and 20250918 Draft legal chapter on transgender care	Not public	5.2.1			

169	20250610 Discussion document on legal capacity	Not public	5.2.1			
170	20240829 Discussion Guide for Exploratory Conversations	Not public	5.2.1			
171	20250225 Discussion Guide for the Consultation Process	Not public	5.2.1			
172	20250926 and 20250930 Discussion Document: Discontinuation of Treatment + Conceptualization	Not public	5.2.1			
173	20241217 - Report of the Executive Board, December 17, 2024_discussion by Committee 101	Partially public	5.1.2e	Internal		
174	20240718 Overview of Gender Team Staff in the Netherlands	Not public	5.1.2e	Secretary	Transgender Care Committee	Document contains only names and email addresses
175	2X 20240820 Emails from experts during the exploratory phase_final	Not public	5.2.1	Secretary	Transgender Care Committee	
176	20240924 Draft emails to committee members	Not public	5.2.1	Secretary	Transgender Care Committee	
177	20240924 Transgender Care_Approaching Prospective Members	Not public	5.1.2e; 5.2.1	Secretary	Transgender Care Committee	Document contains only names and addresses
178	20241022 Overview of committee membership	Not public	5.1.2i; 5.1.2e	Secretary	Transgender Care Committee	Document contains specific personal information. The committee's membership is listed at the end of the advisory report
179	3X 20250123_Composition of the Transgender Care Committee for Youth	Not public	5.1.2i5.2.1	Secretary	Transgender Care Committee	
180	2X 20250310_Composition of the Transgender Care Committee for Youth_update	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
181	Transgender Care Advisory Report_Potential Committee Members saved on July 15, 2024	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
182	20250926 Outline of the first draft recommendation	Not public	5.1.2i	Secretary	Transgender Care Committee	
183	4X 20251204 Draft Chapter 2	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
184	2X 20251205 First Draft Recommendation on Transgender Care for Youth	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
185	3X 20260121 Second Draft Recommendation on Transgender Care for Youth	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	

186	20260120 Draft Chapter 2 with Start-up Phase	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
187	20260128 Second Draft Recommendation on Transgender Care for Youth—with open comments	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
188	2X 20260305 Third Draft Recommendation on Transgender Care for Youth	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
189	3X 20260227 Chapters 1 and 2	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
190	20260605 Draft Recommendation on Transgender Care for Youth_Colophon	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
191	AD1-Physical-and-Mental-Outcomes dated June 30, 2026	Already public		Secretary	Transgender Care Committee	https://www.gezondheidsraad.nl/documents/2026/06/30/physical-and-mental-outcomes
192	AD2-Stopping-Regret-and-Detransition dated 06/30/ 2026	Already public		Secretary	Transgender Care Committee	https://www.gezondheidsraad.nl/documents/2026/06/30/stopping-regret-and-detransition
193	AD3-Legal-Framework-for-Transgender-Care-for-Youth dated June 30, 2026	Already public		Secretary	Transgender Care Committee	https://www.gezondheidsraad.nl/documents/2026/06/30/legal-framework-for-transgender-care-for-youth
194	Transgender Care for Adolescents Summary dated June 30, 2026	Already public		Health Council	Health Council	https://www.healthcouncil.nl/documents/2026/06/30/transgender-care-for-adolescents
195	Transgender Care for Adolescents Advisory Opinion dated June 30, 2026	Already public		Health Council	Health Council	https://www.gezondheidsraad.nl/documents/2026/06/30/advice-on-transgender-care-for-youth
196	Transgender Care for Youth— Summary dated June 30, 2026	Already public		Health Council	Health Council	https://www.gezondheidsraad.nl/documents/2026/06/30/summary-of-advice-on-transgender-care-for-youth
197	20240513_Request-for-Advice-GR-transgender-care_VWS_20240521_Finalized	Already public		VWS - Minister of Medical Care	Chair of the Health Council	https://www.gezondheidsraad.nl/documents/2024/05/13/request-for-advice-vws-on-transgender-care
198	3X 20260622_Briefing for the Minister of Health, Welfare, and Sport on Transgender Care for Youth	Partially public	5.1.2e	Health Council	VWS - Minister of Medical Care	
199	Memorandum on preparation for consultation (1)2 dated June 1, 2026	Not public	5.2.1	Ministry of Health, Welfare and Sport	Health Council	
200	Memorandum on preparation for consultation (1)2 Draft responses saved on June 18, 2026	Not public	5.2.1	Health Council	Ministry of Health, Welfare and Sport	
201	Presentation from the press briefing on transgender care for young people dated June 30, 2026	Partially public	5.1.2e	Health Council	Press	
202	20250212 Introductory Letter on Transgender Care for Youth	Not public	5.1.2i; 5.2.1	Chair of the Health Council	VWS - Minister of Medical Care	The final document is public: https://www.gezondheidsraad.nl/documents/2025/02/07/startbrie

203	20260310 RE_ Health Council _ Consultation on Advisory Opinion on Transgender Care for Youth	Partially public	5.1.2e	GR	Consulted expert	
204	260521 agreement regarding exclusive story	Partially public	5.1.2e	Journalist	GR	
205	260522 Proposal for a communication to be discussed in the publication consultation; with attachment: Proposal for a communication on transgender care	Not public	5.2.1	Communication	Internal GR	
206	June 26, 2018: Press release and advisory note sent to NRC under embargo regarding an interview; with attachments: embargoed copies of the press release and advisory note	Email not relevant	5.1.2e	GR	Journalist	Forwarded email; advisory note and press release made public
207	260622 Email Q&A on transgender care for internal use by the spokesperson's office, with Q&A attachment	Email not relevant		Communication	Internal GR	Forwarded email; document public (see 348)
208	260623 invitation to the media for a press briefing	Partially public	5.1.2e	GR	Press	
209	June 26, 209 press release under embargo sent to spokespeople for gender clinics; with press release attachment	Email not relevant		GR	Gender Clinics	Email sent to gender clinics; press release made public
210	June 26, 2026: Press release under embargo sent to VWS spokespersons; with press release attachment	Email not relevant		GR	VWS	Forwarded email; press release public
211	June 30, 2026: Press release sent to media under embargo	Email not relevant		GR	Press	Forwarded email; press release public
212	Approved minutes of the 1st meeting, saved on March 21, 2025	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	
213	Health Council Presentation_20250205_version2, document date 5-2-2025	Not public	5.2.1	Consulted expert	GR	
214	20250205-101-01.1 Agenda for the 1st meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
215	20250205-101-01.3 Initial Memorandum on Transgender Care for Youth	Not public	5.1.2i; 5.2.1	Secretary	Transgender Care Committee	
216	2x 20250205-101-01.4 Proposal Expert Consultation	Not public	5.2.1	Secretary	Transgender Care Committee	
217	20250205-101-01.2 Request for Advice on Transgender Care	Already public		Secretary	Transgender Care Committee	
218	20250213 Proposal for Consultation on Transgender Care for Youth (Final Draft)	Not public	5.2.1	Secretary	Transgender Care Committee	
219	Written input for the consultation on transgender care, saved on February 26, 2025	Not public	5.2.1	Secretary	Transgender Care Committee	

220	Approved minutes of the 2nd meeting, saved on June 23, 2025	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	
221	20250307-101-02.1 Agenda for the 2nd meeting	Not public	5.1.2nd	Secretary	Transgender Care Committee	
222	20250307-101-02.2 Draft Report of the 1st Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
223	20250307-101-02.3 Outline of Recommendations on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
224	Speakers on behalf of organizations—consultation April 11, 2025	Not public	5.1.2nd	Secretary	Transgender Care Committee	
225	20260416 Report on the Consultation on Transgender Care for Youth	Not public (final report is public)	5.2.1	Secretary	Transgender Care Committee	https://www.gezondheidsraad.nl/documents/2026/06/30/report-on-consultation-transgender-care-committee-for-youth-
226	3x 20251114 Report on the Consultation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
227	Response to the Health Council Committee, saved on February 2, 2026	Not public	5.2.1	Voorzij Foundation	Transgender Care Committee	
228	20251114 Report on the Consultation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
229	20251024 Submit accompanying emails with the consultation report to invitees	Not public	5.2.1	Secretary	Transgender Care Committee	
230	Report on the Consultation on Transgender Care for Youth_Session 3, saved on 10/24/2026	Not public	5.2.1	Secretary	Transgender Care Committee	
231	Report on the Consultation on Transgender Care for Youth—Session 2, saved on 10/24/2026	Not public	5.2.1	Secretary	Transgender Care Committee	
232	Report on the Consultation on Transgender Care for Youth—Session 1, saved on 10/24/2026	Not public	5.2.1	Secretary	Transgender Care Committee	
233	Recommendations, document date 04/11/2025	Partially public	5.1.2nd	Consultation Participant	Health Council of the Netherlands—Transgender Care Committee	
234	Health Council Gender Care—written contribution, saved on April 3, 2025	Not public	5.1.2nd	Consultation Participant	Transgender Care Committee	
235	Written submission, saved on April 9, 2025	Not public	5.1.2nd	Consultation Participant	Transgender Care Committee	
236	Written submission, saved on April 9, 2025	Not public	5.1.2nd	Consultation Participant	Transgender Care Committee	

237	Written submission, April 11, 2025	Partially public	5.1.2e	Consultation Participant	Transgender Care Committee	
238	Written submission for Session 2 of the Health Council, April 11, 2025	Not public	5.1.2e	Consultation participant		
239	For the Health Council of the Netherlands—April 11, 2025	Not public	5.2.1	Consultation Participant	Transgender Care Committee	
240	PowerPoint	Not public	5.1.2e	Consultation Participant	Transgender Care Committee	
241	PP Presentation by the Health Council, April 25	Partially public	5.1.2e	Consultation Participant	Transgender Care Committee	
242	20250411-101-03.1 Action Plan - Consultation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
243	20250411-101-03.2 Background Information	Not public	5.2.1	Consultation participant	Transgender Care Committee	
244	20250411-101-03.3 List of invitees	Not public	5.1.2e	Secretary	Transgender Care Committee	This document contains only names and email addresses. The report on the consultation, including a list of speakers, can be found at the
245	20250411-101-03.4 Agenda for the consultation on transgender care for youth_committee	Not public	5.2.1	Secretary	Transgender Care Committee	
246	Agenda for Consultation on Transgender Care for Youth_Sessions 2-3, saved on April 4, 2025	Not public	5.2.1	Secretary	Transgender Care Committee	
247	Agenda for Consultation on Transgender Care for Youth_Session 1, saved on April 4, 2025	Not public	5.2.1	Secretary	Transgender Care Committee	
248	Appendix 1 - Invitation letter for consultation with the Health Council, document date March 24, 2025	Partially public	5.1.2e	Secretary	Consultation Participant	Letter to all invitees to the consultation
249	20250318 email to experts by experience—draft	Not public	5.2.1	internal		
250	20250516-Presentation	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
251	20250516-Presentation	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
252	20250516-Presentation Health Council Committee-Confidential	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
253	20250516-Written contribution	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	

254	20250516-Written contribution-Gender dysphoria in youth in Sweden	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
255	20250516-Written contribution-Position paper Dutch Protocol	Partially public	5.1.2e	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
256	20250516-Written Contribution-njb25_transgender-care-for-children	Already public		Consulted expert	Health Council of the Netherlands—Transgender Care Committee	https://www.njb.nl/blogs/transgen-of-transgender-care-for-children-legal-concerns-regarding-the-Dutch-protocol-2018/
257	20250516-Written Contribution_Puberty Blockers and the Medicines Act	Already public		Consulted expert	Health Council of the Netherlands—Transgender Care Committee	https://www.boomportaal.nl/tijdschrift/TvGR/TvGR_0165-0874_2024_048_006_003
258	20250516-Written contribution-Prof	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
259	20250516-Written contribution-Prof	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
260	Polish guideline 104289-466294-1	Already public		Department of Pediatrics and Pediatric Endocrinology	Health Council of the Netherlands—Transgender Care Committee	https://pubmed.ncbi.nlm.nih.gov/40071796/
261	Situation in Sweden, document date May 16, 2025	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
262	Smids 2025 International Criticism of the Dutch Protocol, saved on June 3, 2025	Already public		Consulted expert	Health Council of the Netherlands—Transgender Care Committee	https://www.ntvg.nl/artikelen/international-criticism-of-the-dutch-protocol
263	20250506 Accompanying email with invitation to experts	Not relevant	5.1.2e	Secretary	Consulted expert	Email sending the invitation letter
264	20250509 Final email to foreign experts_final	Not relevant	5.1.2e	Project collaborator	Consulted expert	Email sending the invitation letter
265	Attachment 1 - Invitation, document dated April 23, 2025	Not public	5.2.1	Secretary	Consulted expert	Draft document
266	Attachment 1, document dated April 23, 2025	Not public	5.1.2e	Secretary	Consulted expert	Subject: Draft. Content identical to Doc. No. 270
267	Attachment 1, document dated April 23, 2025	Not public	5.1.2e	Secretary	Consulted expert	Subject: Draft. Content identical to Doc. No. 270
268	Attachment 1, document dated April 23, 2025	Not public	5.1.2e	Secretary	Consulted expert	Subject: Draft. Content identical to Doc. No. 270
269	Attachment 1 - Invitation to Professor, document dated April 23, 2025	Not public	5.1.2e	Secretary	Consulted expert	Subject: Draft. Content identical to Doc. No. 270
270	2x Attachment 1 - Invitation to Prof., document dated May 6, 2025	Partially public	5.1.2e	Secretary	Consulted expert	

271	Attachment 1 - Invitation to Prof., document dated April 23, 2025	Not public	5.1.2e	Secretary	Consulted expert	Subject: Draft. Content identical to Doc. No. 270
272	Attachment 2 - List of invited speakers, saved on May 6, 2025	Not public	5.1.2e	Secretary	Transgender Care Committee	
273	Speakers at the 4th meeting, document date May 16, 2025	Not public	5.1.2e	Secretary	Transgender Care Committee	
274	5x Approved minutes of the 4th meeting, saved on 10/17/2025	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	
275	3x 20250516-101-04.1 Agenda for the 4th meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
276	2x 20250516-101-04.2 Draft Report of the 2nd Meeting_Meeting Notes	Not public	5.2.1	Secretary	Transgender Care Committee	
277	2x 20250516-101-04.3 Action Plan - Consultation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
278	2x 20250516-101-04.4 Discussion Paper: Legal Aspects of Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
279	June 25, 2026 Cass Review—Final Report and Recommendations	Not public	5.1.2e; 5.2.1	Consulted expert	Health Council of the Netherlands—Transgender Care Committee	
280	The Cass Review: Distinguishing Fact from Fiction, saved on June 27, 2025	Already public		The American Journal of Bioethics	Health Council of the Netherlands—Transgender Care Committee	https://doi.org/10.1080/15265161.2025.2504397
281	Final report of the 5th meeting, filed on October 17, 2025	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	Summary
282	5x 20251010-101-06.x Draft Report of the 5th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
283	2x 20250626-101-05.1 Agenda for the 5th meeting	Not public	5.1.2e	Secretary	Transgender Care Committee	
284	4x 20250626-101-05.2 Discussion Paper on Discontinuing Treatment	Not public	5.2.1	Secretary	Transgender Care Committee	
285	Approved minutes of the 6th meeting, saved on December 5, 2025	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	
286	3x 20251212-101-07.x Draft Report of the 6th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
287	2x 20251010-101-06.1 Agenda for the 6th meeting	Not public	5.2.1	Secretary	Transgender Care Committee	

288	4x 20251010-101-06.2 Discussion Paper on Discontinuing Treatment	Not public	5.2.1	Secretary	Transgender Care Committee	
289	3x 20251010-101-06.3 Discussion Paper on Mental and Physical Outcomes of Puberty Blockers	Not public	5.2.1	Secretary	Transgender Care Committee	
290	2x 20251010-101-06.4 Summary of Consultation for the 3rd Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
291	2x 20251010-101-06.5 Detailed Report on the Consultation at the 3rd Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
292	2x 20251010-101-06.6 Draft Report of the 4th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
293	2x 20251010-101-06.7 Draft Report of the 5th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
294	Amendment to document GR 20251010	Not public	5.2.1	Transgender Care Committee Member	Transgender Care Committee	
295	Keynote_download_final, saved on 10/08/2025	Already public		Expert consulted	Transgender Care Committee	https://epath.eu/wp-content/uploads/2025/10/Georg_Romer_Public.pdf
296	20260128-101-08.5 Draft Report of the 7th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
297	Approved minutes of the 7th meeting, saved on January 22, 2026	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	
298	2x 20251212-101-07.1 Agenda for the 7th meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
299	2x 20251212-101-07.2 Outline of the line of reasoning and text plan for transgender care for young people	Not public	5.2.1	Secretary	Transgender Care Committee	
300	3x 20251212-101-07.3 Initial draft advisory opinion on transgender care for young people	Not public	5.2.1	Secretary	Transgender Care Committee	
301	2x 20251212-101-07.5 Draft Report of the 6th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
302	3x 20260128-101-08.1 Agenda for the 8th meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
303	2x 20260128-101-08.2 Second Draft Advisory Opinion on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
304	3x 20260128-101-08.3 Discussion Paper on Ethical Reflection	Not public	5.2.1	Secretary	Transgender Care Committee	

305	3x 20260128-101-08.4 Background Document: Physical and Mental Health Outcomes	Not public	5.2.1	Secretary	Transgender Care Committee	
306	2x 20260128-101-08.5 Draft Report of the 7th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
307	Approved minutes of the 8th meeting, filed on March 6, 2026	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	
308	2x 20260313-101-09.1 Agenda for the 9th meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
309	3x 20260313-101-09.2 Third Draft Advisory Opinion on Transgender Care for Youth_Meeting Notes	Not public	5.2.1	Secretary	Transgender Care Committee	
310	2x 20260313-101-09.3 Background Document: Physical and Mental Health Outcomes	Not public	5.2.1	Secretary	Transgender Care Committee	
311	2x 20260313-101-09.4 Background Paper: Quitting, Regret, and Detransitioning	Not public	5.2.1	Secretary	Transgender Care Committee	
312	2x 20260313-101-09.5 Draft Report of the 8th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
313	Approved minutes of the 9th meeting, saved on April 17, 2026	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	
314	20260424-101-10.1 Agenda for the 10th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
315	4x 20260424-101-10.2 Draft Recommendation on Transgender Care for Youth_during and after the meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
316	20260424-101-10.3 Background Document: Physical and Mental Outcomes	Not public	5.2.1	Secretary	Transgender Care Committee	
317	20260424-101-10.4 Background Document: Stopping, Regret, and Detransitioning	Not public	5.2.1	Secretary	Transgender Care Committee	
318	20260424-101-10.5 Background Document: Legal Framework	Not public	5.2.1	Secretary	Transgender Care Committee	
319	20260424-101-10.6 Report on the Consultation on Transgender Care for Youth	Final report is public	5.2.1	Secretary	Transgender Care Committee	
320	20260424-101-10.7 Draft Report of the 9th Meeting	Not public	5.2.1	Secretary	Transgender Care Committee	
321	2x Draft report of the 10th meeting, saved on May 1, 2026	Full report not public; summary will be made public	5.2.1	Secretary	Transgender Care Committee	

322	20260428 Background Document: Physical and Mental Outcomes	Final document is public	5.2.1	Secretary	Transgender Care Committee	
323	20260428 Background Document: Legal Framework	Final document is public	5.2.1	Secretary	Transgender Care Committee	
324	20260428 Background Document: Stopping, Regret, and Detransitioning	Final document is public	5.2.1	Secretary	Transgender Care Committee	
325	20260428 Draft Recommendation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
326	20260428 Report on the Consultation on Transgender Care for Youth	Final document is public	5.2.1	Secretary	Transgender Care Committee	
327	2x 20260506 Background Document: Physical and Mental Outcomes	Final document is public	5.2.1	Secretary	Transgender Care Committee	
328	2x 20260506 Background Document: Legal Framework	Final document is public	5.2.1	Secretary	Transgender Care Committee	
329	2x 20260506 Background Document: Stopping, Regret, and Detransitioning	Final document is public	5.2.1	Secretary	Transgender Care Committee	
330	2x 20260506 Draft Recommendation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
331	2x 20260506 Background Memo on Draft Recommendation on Transgender Care for Youth	Not public	5.2.1	Secretary	Deliberation Group	
332	2x 20260506 Report on the Consultation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
333	20260528 Background Document: Physical and Mental Outcomes	Not public	5.2.1	Secretary	Transgender Care Committee	
334	20260528 Background Document: Legal Framework	Not public	5.2.1	Secretary	Transgender Care Committee	
335	20260528 Background Document: Stopping, Regret, and Detransitioning	Not public	5.2.1	Secretary	Transgender Care Committee	
336	20260528 Draft Recommendation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
337	20260528 Press Release: Transgender Care for Youth in Primary Education	Not public	5.2.1	GR - Communications & Editorial Department	Netherlands	
338	20260528 Feedback on BG's comments on the draft advisory opinion on transgender care for young people	Not public	5.2.1	Secretary	Deliberation Group	

339	20260528 Report on the Consultation on Transgender Care for Youth	Not public	5.2.1	Secretary	Transgender Care Committee	
340	2024.10.15-Ala.-Amicus-Br.-iso-TN-FINAL	Public		Citizen	GR	
341	20250601 Radboud report for the Executive Board and the Supervisory Board	Partially public	5.1.2e	Citizen	GR	
342	20251110 Letter—Response to the letter dated October 29	Partially public	5.1.2e	Citizen	GR	
343	FTC-The-Dangers-of-Gender-Affirming-Care-for-Minors-Transcript	Public		Citizen	GR	
344	Genspect Survey completed March 10, 2025, anonymously	Public		Citizen	GR	
345	Genspect Survey NL Jan 25 PDF	Public		Citizen	GR	
346	The Scottish Case	Public		Citizen	GR	
347	WPATH Files - Mia Hughes English	Public		Citizen	GR	
348	Q&A on Transgender Care	Public		Communication	Internal GR	
349	Shortcomings in the Dutch Gender Care Protocol	Partially public	5.1.2e	Citizen	GR	

001

From	5.1.2e
: To:	5.1.2e
Cc:	5.1.2e
Subject:	Invitation to the Health Council's Advisory Process
Date:	Thursday, September 26, 2024, 11:26:00
Attachments:	20240513 Request for Advice-GR-Transgender Care VWS 20240521 Edited.pdf image001.jpg

Dear 5.1.2e ,

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of the Ministry of Health, Welfare, and Sport (VWS) submitted a request for advice on this matter on May 13 (see attachment).
To respond to the request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your broad knowledge of the and your expertise in the field of 5.1.2e 5.1.2e , I would like to invite you to serve on this temporary committee.

Would it be possible to schedule a phone call with you shortly to explain the details?

I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e ,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague www.gezondheidsraad.nl
Present 5.1.2e

002

From	5.1.2e
: To:	5.1.2e
Cc:	5.1.2e
Subject:	Invitation to the Health Council's Advisory Process
Date:	Thursday, September 26, 2024, 11:11:00
Attachments:	image001.jpg

Dear 5.1.2e ,

My colleague and I recently spoke with you as part of our preliminary discussions for the advisory process on transgender care for young people. The board of the Health Council has decided to establish a temporary committee for this advisory process. Due to the social perspective of 5.1.2e and your unique perspective on the 5.1.2e , we would like to invite you to serve on this temporary committee.

Would it be possible to schedule a phone call with you shortly to explain the details?

I look forward to your response.

Best regards, also on behalf of my colleague 5.1.2e ,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague www.gezondheidsraad.nl
Present 5.1.2e

003

From	5.1.2e
: To:	5.1.2e
Cc:	5.1.2e
Subject:	Invitation to the Health Council's Advisory Process
Date:	Thursday, September 26, 2024, 11:23:00
Attachments:	20240513 Request for Advice-GR-Transgender Care VWS 20240521 Edited.pdf image001.jpg

Dear 5.1.2e,

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of the Ministry of Health, Welfare, and Sport (VWS) submitted a request for advice on this matter on May 13 (see attachment).
To respond to this request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your broad knowledge of 5.1.2e and your expertise in the field of 5.1.2e issues, I would like to invite you to serve on this temporary committee.

May I schedule a phone call with you shortly to explain the details?

I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague www.gezondheidsraad.nl
Present 5.1.2e

004

From	5.1.2e
: To:	5.1.2e
Cc:	5.1.2e
Subject:	Invitation to the Health Council's Advisory Process
Date:	Thursday, September 26, 2024, 11:25:00
Attachments:	20240513 Request for Advice-GR-Transgender Care VWS 20240521 Edited.pdf image001.jpg

Dear 5.1.2e,

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of the Ministry of Health, Welfare, and Sport (VWS) submitted a request for advice on this matter on May 13 (see attachment).
To respond to the request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your broad knowledge of 5.1.2e and your expertise regarding responsibilities for 5.1.2e, I would like to invite you to serve on this temporary committee.

Would it be possible to schedule a phone call with you shortly to explain the details?

I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague www.gezondheidsraad.nl
Present 5.1.2e

005

From 5.1.2e
: To: 5.1.2e
Cc: 5.1.2e
Subject: Invitation to the Health Council's Advisory Process
Date: Thursday, September 26, 2024, 10:58:00
Attachments: image001.jpg

Dear 5.1.2e,

My colleague and I recently spoke with you as part of our preliminary discussions for the advisory process on transgender care for young people. To address the advisory request, the Health Council's board has decided to establish a temporary committee. Given your extensive knowledge of the 5.1.2e and 5.1.2e and your expertise in the field of 5.1.2e , I would like to invite you to serve on this temporary committee.

Would it be possible to schedule a phone call with you shortly to discuss this further?

I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague www.gezondheidsraad.nl
Present 5.1.2e

006

From 5.1.2e
: To: 5.1.2e
Cc: 5.1.2e
Subject: Invitation to the Health Council's Advisory Process
Date: Thursday, September 26, 2024, 11:05:00
Attachments: image001.jpg

Dear 5.1.2e, Dear 5.1.2e

My colleague and I recently spoke with you as part of our preliminary discussions for the advisory process on transgender care for young people. To address the advisory request, the board of the Health Council has decided to establish a temporary committee. Given your extensive knowledge of 5.1.2e and the 5.1.2e and your expertise in the field of 5.1.2e , I would like to invite you to serve on this temporary committee.

Would it be possible to schedule a phone call with you shortly to explain the details?

I look forward to hearing from you.

Best regards, also on behalf of my colleague 5.1.2e,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague www.gezondheidsraad.nl
Present 5.1.2e

007

From	5.1.2e
: To:	5.1.2e
Cc:	5.1.2e
Subject:	Invitation to the Health Council's Advisory Process
Date:	Thursday, September 26, 2024, 11:15:00 a.m.
Attachments:	image001.jpg 20240513 Request for Advice—GR—Transgender Care, Ministry of Health, Welfare, and Sport 20240521 Edited.pdf

Dear 5.1.2e ,

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of the Ministry of Health, Welfare, and Sport (VWS) submitted a request for advice on this matter on May 13 (see attachment).
To respond to the request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your expertise in the area of 5.1.2e and 5.1.2e , I would like to invite you to serve on this temporary committee.

Would it be possible to schedule a phone call with you shortly to explain the details?

I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e ,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague www.gezondheidsraad.nl
Present 5.1.2e

008

From 5.1.2e
: To: 5.1.2e
Cc: 5.1.2e
Subject: RE: Invitation to the Health Council's Advisory Process
Date: Tuesday, October 1, 2024, 11:38:00
Attachments: image003.jpg

Dear 5.1.2e ,

Thank you very much for your response. It's completely understandable that this doesn't fit in with all your other work. If there's room in your schedule for this in the future, we'd be happy to take you up on your offer to take the lead in 5.1.2e .

Best regards,
5.1.2e

From: 5.1.2e <5.1.2e >
Sent: Tuesday, October 1, 2024, 9:29 AM
To: 5.1.2e <5.1.2e @gr.nl>
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: Re: Invitation to the Health Council's Advisory Process

Dear Ms. 5.1.2e

Thank you very much for this honorable invitation. I have given your request careful consideration over the past few days and have reviewed my annual schedule for 2025. Unfortunately, I have come to the conclusion that participating in this important advisory process does not fit into that schedule, given the various commitments I have already made and other plans I have for the coming year. However, I would be happy to take the lead van de Gr, I would be happy to take the lead in discussing of the final advisory report, should there be room for that. I hope you understand my reasoning.

Best regards and best of luck,
5.1.2e

From: 5.1.2e <5.1.2e @gr.nl>
Date: Thursday, September 26, 2024, at 11:26
To: 5.1.2e <5.1.2e 5.1.2e>
Cc: 5.1.2e <5.1.2e @gr.nl>
Subject: Invitation to the Health Council's Advisory Process

Dear 5.1.2e ,

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of Health, Welfare, and Sport submitted a request for advice on this matter on May 13 (see attachment).
To respond to the request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your broad knowledge of and your expertise in the area of 5.1.2e , I would like to invite you to serve on this ad hoc committee.

Would it be possible for me to schedule a phone call with you soon to go over the details

?

I look forward to hearing from you.

Sincerely, also on behalf of my colleague ,

Scientific Secretary

Tel. +31 6
Bezuidenhoutseweg 30, 2594 AV The Hague

Present

009

From: 5.1.2e
Bcc: 5.1.2e
Subject: Invitation to Join the Transgender Youth Care Committee
Date: Wednesday, November 6, 2024, 3:46:00 PM
Attachments: image001.png
20241106 Invitation Letter for the Transgender Care for Youth Committee—Dr. H. Ismaili M"hamdi.pdf
Declaration of Interests Form 5.1.2e pdf
Code-for-the-Prevention-of-Improper-Conflicts-of-Interest-Update-Jan2017.pdf Procedure for Digitally Signing Documents 20210712.pdf
20240513 Request for Advice—GR—Transgender Care, Ministry of Health, Welfare, and Sport 20240521 Edited.pdf Form for Providing Personal and Financial Information—101 Transgender Care.docx

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Dear 5.1.2e,

On behalf of the Chair of the Health Council, I am sending you several documents regarding your participation in the Committee on Transgender Care for Youth:

1. The invitation letter
2. The request for advice
3. A link to the *Information Brochure for committee members and the chair*, which also includes information about deliberation groups (the brochure is available on the website)
4. The Code for Preventing Undue Influence Due to Conflicts of Interest
5. The declaration of interests accompanying the code (completed based on your previous declaration of interests)
6. A form for providing personal information.

The Health Council uses a secure online collaboration platform. As a result, all committee documents are available digitally wherever you have internet access. You will not receive any documents by regular mail. You will soon receive an email containing, among other things, your login credentials.

I ask that you complete and return the declaration of interests and the (vacancy) form digitally, with your signature—which may be digital.

Points to note regarding the declaration of interests:

- Please read the introduction to the declaration of interests carefully first.
- Fill out each section as clearly and specifically as possible.
- Transparency regarding interests is essential to the work of the Health Council. Declarations of interest must therefore always be up to date and are published on the website.
- The chair, vice chair, and secretary-general of the Health Council will review the submitted declaration. If there are any potential conflicts of interest, you will be informed.

Submission:

- Save the completed declaration of interests on your computer. If changes are needed, you can then update your declaration yourself and email it again to the Health Council.
- Please sign both documents (digitally) and email them to cie.secretariaat@gr.nl **no later than November 20**. If you have any questions, please contact the committee secretariat using the contact information below.

The Health Council realizes that the above procedure may represent a considerable administrative burden for you, but we trust in your understanding and cooperation. Thank you in advance for your efforts.

If you have any questions, please contact the committee secretariat using the phone number or email address below.

Best regards,

5.1.2e
Project Assistant

tel. 06 5.1.2e
Bezuidennoutseweg 30 - 2594 AV - The Hague
www.gezondheidsraad.nl

010

From	5.1.2e
: To:	5.1.2e
Cc:	5.1.2e
Subject:	Invitation to the Health Council's Advisory Process
Date:	Tuesday, December 3, 2024, 4:20:02 PM
Attachments:	image001.jpg 20240513 Request for Advice-GR-Transgender Care VWS 20240521 Edited.pdf

Dear 5.1.2e

Some time ago, 5.1.2e and I spoke with you as part of our preliminary discussions for the advisory process on transgender care for young people. I have attached the request for advice to this email.

To address the advisory request, the chair of the Health Council has decided to establish a temporary committee. The members of this temporary committee represent the expertise needed to respond to the advisory request in a scientifically sound manner
. Given your expertise in 5.1.2e and, in particular, in 5.1.2e,
I would like to invite you to serve on this temporary committee. Would you be willing
?

Each committee member is invited in a personal capacity and participates in the advisory process without receiving instructions or consulting with others. To prevent any (appearance of) conflict of interest, all prospective committee members are asked to complete a declaration of interests. The board will then assess whether any declared interests preclude membership. If you are willing to serve on the temporary committee, our project coordinator will contact you to discuss, among other things, the declaration of interests.

Of course, I'd be happy to provide further clarification regarding this invitation. Best

regards, also on behalf of 5.1.2e

5.1.2e

5.1.2e
Scientific Secretary

tel. +31 6 5.1.2e 5.1.2e
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

011

From :	5.1.2e
Subject:	Meeting materials for the inaugural meeting on transgender care for youth in the collaborative space
Date:	Wednesday, January 29, 2025, 2:08:15 PM
Attachments:	Directions to Seats2meet Utrecht.pdf image001.png

Dear committee members and observer,

The meeting documents for the inaugural meeting of the Transgender Care for Youth Committee have just been posted in the collaboration space.
You can find the meeting materials here: 20250205 Inaugural Meeting - GR-net

The meeting will take place on Wednesday, February 5, from 10:00 a.m. to 12:30 p.m. at Seats2meet Utrecht CS, Hoog Catharijne, Boven Vredenburgpassage, Utrecht. Directions are included.

If you are unable to attend in person, please let us know via: 5.1.2e @gr.nl.

Sincerely, also on behalf of the secretaries,

5.1.2e
Project Assistant



Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague.
www.gezondheidsraad.nl

002

From:
To:
Cc:
Subject: RE: Consultation on the Health Council's Advisory Opinion on Transgender Care
Date: Thursday, July 11, 2024, 2:53:00 PM
Attachments: image001.jpg

Hello

Thank you very much for the referral; I'll get in touch with your colleagues shortly. Best regards,

From: @minvws.nl>
Sent: Thursday, July 11, 2024, 2:21 PM
To: @gr.nl>
CC: @gr.nl>; @minvws.nl>; @minvws.nl>
Subject: RE: Consultation Request Regarding Transgender Care from the Health Council

Hello

I'm glad you're getting started on this project. Unfortunately, I'm no longer involved in transgender care myself, so I'm forwarding you to my colleagues and (cc'd). Good luck!

Best regards,

From: @gr.nl>
Sent: Thursday, July 11, 2024, 12:02 PM
To: @minvws.nl>
CC: @gr.nl>
Subject: Follow-up regarding the Health Council's advisory request on transgender care

Dear ,

The Health Council has received a request for advice from the Ministry of Health, Welfare, and Sport (VWS) regarding transgender care in the Netherlands. My colleague, (cc), and I will be involved in this advisory process as secretaries. We would like to schedule a meeting to get to know each other and discuss the advisory request.

When would that work for you? We are available through July 23 and again starting August 22 (except on Wednesdays). We would be happy to come to the Ministry of Health, Welfare and Sport, but an online meeting is certainly also an option

Best regards,

Scientific Secretary



tel. +31 6 (MB through vûj)
Visiting address: Bezuidenhoutseweg 2594 AV Den HBBg
www.gezondheidsraad.nl

004

Van:
To:

Subject: RE: Health Council of the Netherlands – Transgender Care,
DaNil»: Thursday, July 18, 2024, 10:52:00
Attachments: imaneÜfl1 Inn

Hi

Thursday, August 22, is also fine with us. We are fully available between 9:30 a.m. and 1:30 p.m.

Best regards,

From: @minvws. nl>
Sent: Thursday, July 18, 2024, 10:48 a.m.
To: @gr.nl>
CC: @gr.nl>
Subject: RE: Contact with the Health Council regarding transgender care

Hi

We had previously scheduled this for August 20, but could we move it to August 22 instead? There really isn't a single room available at the Ministry of Health, Welfare, and Sport on August 20.
That won't work, but I know. We're available all day that day, so just let us know what time would work for you.
There's a room available on our floor between 9:30 a.m. and 1:30 p.m., so if you can make it within that time frame, that would be great. Then I can reserve it right away before someone else does ;)

Let me know!

Best regards,

From:
Sent: Thursday, July 18, 2024, 8:56 AM **To:**
CC: @Pr nl> /üRr nl>
Subject: RE: Contact with the Health Council regarding transgender care

Hi Great! I'll add it to the agendas later today.

Best
regard
s,

From: here nl>
Sent: Wednesday, July 17, 2024, 2:47 PM **To:**
CC: @Pr nl> @ minvws nl>

Subject: RE: Contact with the Health Council regarding transgender care

Hi ,

Tuesday, August 20, at 2:15 p.m. works perfectly for us! We'd be happy to come to the Ministry of Health, Welfare, and Sport then. And I think an hour will definitely be enough.

See you then!

5.1.2e

From: @minvws.nl>
Sent: Wednesday, July 17, 2024, 10:03 a.m.
To: @gr.nl>
CC: @gr.nl>
Subject: RE: Contact with the Health Council regarding

tra care Hi

August 20 between 2:00 p.m. and 3:30 p.m. would work best for us. How long do you think we'd need for this introductory meeting? Otherwise, I think it would be good to schedule it between 2:15 p.m. and 3:15 p.m., if that's okay with you.
Would you like to come to the Ministry of Health, Welfare, and Sport? If so, I can

reserve a room right away. Please let me know!

Best re

From: @gr.nl>
Sent: Tuesday, July 16, 2024, 2:50 PM
To: @minvws.nl>
CC: @gr.nl>; @minvws.nl>; @minvws.nl>
Subject: RE: Contact with the Health Council regarding transgender care

Hi ,

No problem—we'll find a date in August to meet. I previously mentioned August 22 as the first possibility, but Hilde and I are also available on August 20. We're available between 1:00 p.m. and 5:00 p.m. Would that work for you?

Best regards,

From: @minvws.nl>
Sent: Monday, July 15, 2024, 1:25 PM
To: @gr.nl>
CC: @gr.nl>; @minvws.nl>; @minvws.nl>

Subject: RE: Contact with the Health Council regarding

tran [redacted] care Hi

Unfortunately, next Tuesday doesn't work for one of us, so I think it would be best to schedule this introductory meeting after August 22.
If you'd like to come to the Resident, Tuesday is the best day.
Please let me know when it works for you. If you'd like to come to the Resident, I might be able to reserve a room in time for the introductory meeting.

Best regards,
[redacted]

From: [redacted]@gr.nl>
Sent: Thursday, July 11, 2024, 4:30 PM
To: [redacted]@minvws.nl>; [redacted] [redacted]@minvws.nl>; [redacted]@minvws.nl>
CC: [redacted]@gr.nl>
Subject: RE: Contact with the Health Council regarding transgender care

Hello [redacted] and [redacted],

Great that you're joining us, [redacted]! We look forward to meeting you all. Would next Tuesday (July 16) from 4:00–4:45 p.m. work for you? We can come to the Resident then.

Best regards,
[redacted]

From: [redacted]@minvws.nl>
Sent: Thursday, July 11, 2024, 3:20 p.m.
To: [redacted]@gr.nl>; [redacted]@minvws.nl>
CC: [redacted]@gr.nl>; [redacted] [redacted]@minvws.nl>
Subject: RE: Contact with the Health Council regarding transgender care

If you can find a moment sometime next week, that would be great. Otherwise, after August 22.
Perhaps you could coordinate with our intern to find a suitable time.

Gr
[redacted]

Sent with BlackBerry Work (www.blackberry.com)

From: [redacted]@gr.nl>
Date: Thursday, July 11, 2024, 2:59 PM

To: [redacted] @minvws.nl>, [redacted]
[redacted] @minvws.nl>
CC: [redacted] @gr.nl>
Subject: Contact with the Health Council regarding transgender care

Dear [redacted] and [redacted]

I understand from your colleague, [redacted] , that you are involved in transgender care. (cc) and I are [redacted] serving as secretaries for the advisory process on transgender care.
We would like to schedule a meeting with you to get to know each other and discuss the advisory request.

We are available through July 23, and otherwise starting August 22, except on Wednesdays. When would be convenient for you? The meeting can take place online, but we'd also be happy to come to the Ministry of Health, Welfare, and Sport (VWS).

Best regards,

[redacted]
Scientific Secretary

tel. +31 6 [redacted] (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

005

From:	5.1.2e
To:	5.1.2e
Cc:	5.1.2e
Subject:	RE: Introduction to GR - Ministry of Health, Welfare, and Sport (VWS) transgender care
DaNil»:	Monday, August 19, 2024, 4:07:00 PM
Attachments:	imaneÜfl1 nnci

Hi 5.1.2e

There's no need to read any documents in preparation for our meeting. We really just want to get to know each other. If necessary, we can explain the Health Council's working methods and process. The meeting is also a good opportunity for both sides to ask and answer any questions that may arise. So, no preparation is needed

See you Thursday. Best regards, 5.1.2e

From: 5.1.2e @minvws. nl>
Sent: Thursday, August 15, 2024, 11:14 a.m.
To: 5.1.2e @gr.nl>; 5.1.2e @gr.nl>
Subject: RE: Introduction GR - VWS transgender care

Hi 5.1.2e and 5.1.2e

This introductory meeting is scheduled for next week. We were wondering if this meeting will be purely an introduction, or if there's anything specific you'd like to discuss? And if there is something specific you'd like to discuss, we'll need to review certain materials or documents in preparation.

Please let me know, and thank you in advance.

Best regards,
5.1.2e

--Original appointment-----
From: 5.1.2e
Sent: Tuesday, July 23, 2024, 9:13 AM
To: 5.1.2e

cc: 5.1.2e
Subject: Introductory Meeting GR - Ministry of Health, Welfare, and Sport (VWS) on transgender care
Time: Thursday, August 22, 2024, 10:00–11:00 (UTC+01:00) Amsterdam, Berlin, Bern, Rome, Stockholm, Vienna.
Location: A14.27

Hi everyone,

I'm scheduling this introductory meeting regarding the advisory request on transgender care. It has been rescheduled for August 22 due to a lack of available space at the Ministry of Health, Welfare, and Sport on August 20.
I'll let you know the reserved room for this introductory meeting later.

@5.1.2e and @5.1.2e : I'll also sign you both in at the reception desk. You can pick up your visitor passes there, and I'll meet you there. If there are any issues with this on the 22nd, please give me a quick call (my phone number is in my signature).

See you then!

Best regards,

5.1.2e | 5.1.2e 5.1.2e | 5.1.2e
Transgender Care and Women's Health Issues |
Ministry of Health, Welfare, and Sports – Curative Care Directorate | Parnassusplein 5; 2511 VX The Hague | Mailing Address: P.O. Box 20350; 2500 EJ The Hague
Mobile: 06 5.1.2e | 5.1.2e @minvws.nl|

Not available on Mondays and Fridays during even weeks.

006

From : To:	5.1.2e
Cc:	5.1.2e 5.1.2e 5.1.2e
Subject:	RE: Exploratory Meeting with the Health Council
Date:	Friday, August 23, 2024, 12:01:54 PM
Attachments:	image001.jpg image002.gif

Dear 5.1.2e,

Thank you very much for your prompt and positive response.
I will contact your secretary to schedule an appointment. We look forward to speaking with you.

Best regards,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl
Available Mon, Tue, Thu, Fri.

From: 5.1.2e <5.1.2e>
Sent: Friday, August 23, 2024, 10:56 a.m.
To: 5.1.2e <5.1.2e @gr.nl>
CC: 5.1.2e <5.1.2e @gr.nl>; 5.1.2e <5.1.2e >
Subject: Re: Preliminary meeting with the Health Council

Dear Ms. 5.1.2e

Thank you for your invitation. I am willing to have a conversation.

Perhaps my secretary, Ms. 5.1.2e, help find a suitable time; perhaps you already have a suggestion? I'm usually most available on Mondays or Fridays,

Best regards,

5.1.2e

5.1.2e I Child and Adolescent Psychiatrist, Associate Professor, PI

5.1.2e

T: +31 20 5.1.2e / +31 2C5.1.2e | +31 20 5.1.2e E: 5.1.2e

5.1.2e

From: 5.1.2e ‹5.1.2e ter nl>
Sent: Thursday, August 22, 2024, 4:10 PM
To: 5.1.2e ‹5.1.2e I>
cc:5.1.2e ‹5.1.2e >
Subject: Exploratory Meeting with the Health Council

Dear Dr. 5.1.2e,

The Health Council has been asked by the Minister of Health, Welfare, and Sport to issue an advisory opinion on transgender care based on the “Dutch Protocol” methodology. The request specifically asks the Council to examine the physical and mental health outcomes of the protocol, as well as the number of individuals who have regretted their decision, and to compare these outcomes with those in European countries that follow different care standards or guidelines. The request for advice can be found on the Health Council of the Netherlands’ website: Transgender Care | Health Council of the Netherlands.

We are currently in an exploratory phase in preparation for the advisory process. During this phase, we are speaking with various experts to gain a better understanding of transgender care in the Netherlands. Given your extensive expertise with the Dutch Protocol, we would like to exchange ideas with you on this topic.

Would it be possible to schedule a meeting for this in the near future, whether in person or via video conference?

Best regards, also on behalf of my colleague 5.1.2e

5.1.2e
Scientific Secretary

Tel. +31 6
Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl
Available Mon, Tue, Thu, Fri.

5.1.2e

007

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e
Subject: Date: RE: Exploratory discussion on transgender care
Attachments: Tuesday, August 27, 2024, 4:12:00 PM
imanef)01 nnci

Hi 5.1.2e

Unfortunately, I have an appointment scheduled for the 6th earlier in the day, so I won't be able to make it to Leiden. Of course, the meeting can take place online. I'll send a calendar invitation with a Teams link shortly.

Best regards,
5.1.2e

From: 5.1.2e ‹5.1.2e >
Sent: Monday, August 26, 2024, 4:47 p.m. To:
5.1.2e ‹5.1.2e @gr.nl>
cc: 5.1.2e ‹5.1.2e @gr.nl>
Subject: RE: Exploratory discussion on transgender care

Noted!

It could possibly be in my room in the 5.1.2 setup, whichever you guys find most convenient.

Best regards,

5.1.2e

5.1.2e
5.1.2e

T: +31 65.1.2e I.5.1.2e
LinkedIn

From: 5.1.2e •5.1.2e ter nl>
Sent: Friday, August 23, 2024, 2:02 PM
To: 5.1.2e •5.1.2e >
Cc: 5.1.2e 5.1.2e (öPr nl>
Subject: RE: Exploratory discussion on transgender care

Dear 5.1.2e

Thank you for your prompt response and willingness to discuss this with us. Friday, September 6, works for us as well. Shall we schedule the meeting from 3:00 to 4:00 p.m.? We can hold the meeting via a Teams

meeting, but we can also come to Leiden if that's more convenient.

Best regards,
5.1.2e

From: 5.1.2e <5.1.2e>
Sent: Friday, August 23, 2024, 11:56 a.m.
To: 5.1.2e <5.1.2e @gr.nl>
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: Re: Exploratory discussion on transgender care

Dear 5.1.2e

I'd be happy to do that!
I'm available, for example, on September 6 between 10

a.m. and 12 p.m. or after 3 p.m. Best regards,

5.1.2e

Sent from Outlook for iOS

From: 5.1.2e <5.1.2e @gr.nl>
Sent: Thursday, August 22, 2024, 4:20:35 PM **To:**
5.1.2e <5.1.2e >
CC: 5.1.2e <5.1.2e >
Subject: Exploratory Discussion on Transgender Care

Dear 5.1.2e

The Health Council of the Netherlands has been asked by the Minister of Health, Welfare, and Sport to issue an advisory opinion on transgender care based on the "Dutch Protocol" methodology. The request specifically asks the Council to examine the physical and mental health outcomes of the protocol, as well as the number of individuals who regret their decision, and to compare these outcomes with those in European countries that follow different care standards or guidelines. The request for advice can be found on the Health Council of the Netherlands' website: Transgender Care | Care | Health Council of the Netherlands.

We are currently in an exploratory phase to prepare for the advisory process. During this phase, we are speaking with various experts to gain a better understanding of transgender care in the Netherlands. Given your experience with transgender care in your role as a pediatrician and your expertise in the field of medical ethics, we would very much like to exchange ideas with you on this topic.

Would it be possible to schedule an appointment for this in the near future, either in person or via video conference?

Best regards, also on behalf of my colleague 5.1.2e ,

5.1.2e
Scientific Secretary



Tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 2594 AV Den HBBg
www.gezondheidsraad.nl

008

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e
Subject: Date: RE: Exploratory meeting with the Health Council on August 23, 2024, at 3:21:42 PM
Attachments: image001.jpg

Dear 5.1.2e

Thank you very much for your prompt response and availability for a meeting.

Over the next two weeks, we are available for a Teams meeting at the following times: Thursday, August 29, 9:30–11:30 a.m., 12:30–5:00 p.m.
Friday, August 30, 9:00 a.m.–5:00 p.m. Tuesday, September 3, 12:00 p.m.–2:30 p.m. Monday, September 9, 9:30 a.m.–1:30 p.m.

Please let me know if any of these dates or times work

for you. Best regards,

5.1.2e
Scientific Secretary

Tel. +31 65.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
www.aezondheidsraad.nl
Available Mon, Tue, Thu, Fri

From: 5.1.2e ‹5.1.2e >
Sent: Friday, August 23, 2024, 2:00 PM
To: 5.1.2e ‹5.1.2e @gr.nl>
cc: 5.1.2e ‹5.1.2e @gr.nl>
Subject: Re: Exploratory meeting with the Health Council

Dear 5.1.2e

Thank you for this invitation. I am certainly willing to participate in a discussion, preferably via Teams. Given the different areas of expertise of my colleague 5.1.2e and myself, I believe that two separate interviews would best do justice to the complexity of this topic.

I am waiting for a proposal for a schedule for the meeting.

Best regards
5.1.2e

From: 5.1.2e <5.1.2e @gr.nl>
Date: Thursday, August 22, 2024, at 4:09 p.m.
To: 5.1.2e 5.1.2e >
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: Exploratory Meeting with the Health Council

Dear Dr. 5.1.2e

The Health Council has been asked by the Minister of Health, Welfare, and Sport to issue an advisory opinion on transgender care based on the "Dutch Protocol" methodology. The request specifically asks the Council to examine the physical and mental health outcomes of the protocol, as well as the number of individuals who regret their decision, and to compare these outcomes with those in European countries that follow different care standards or guidelines. The request for advice can be found on the Health Council of the Netherlands' website: Transgender Care | Care | Health Council of the Netherlands.

We are currently in an exploratory phase in preparation for the advisory process. During this phase, we are speaking with various experts to gain a better understanding of transgender care in the Netherlands. Given your recent research in this area 5.1.2e we would very much like to exchange ideas with you on this topic.

Would it be possible to schedule a phone call—or a video conference, if you prefer—in the near future? We have also reached out to your colleague, Professor 5.1.2e, for an exploratory discussion; we could potentially combine these meetings if that is your preference.

Best regards, also on behalf of my colleague 5.1.2e ,

5.1.2e
Academic Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl
Available Mon, Tue, Thu, Fri.

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009

From:	5.1.2e
To:	5.1.2e
Cc:	5.1.2e
Subject:	RE: Exploratory meeting with the Health Council on
Date:	August 23, 2024, at 9:59:43 a.m.
Attachments:	imanef)01 ino

Dear 5.1.2e,

Thank you very much for your prompt and positive response.

It's no problem to schedule a meeting after September 9. We are available that week on:

- Tuesday, September 10, 12:30–1:30 p.m., 3:30–5:00 p.m.
- Thursday, September 12, 9:30 a.m.–5:00 p.m.
- Friday, September 13, 9:00 a.m.–5:00 p.m.

Please let me know if any of these dates or times work for you.

Best regards,

5.1.2e
Scientific Secretary

Tel. +31 65.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
www.aezondheidsraad.nl
Available Mon, Tue, Thu, Fri.

From: 5.1.2e ‹5.1.2e >
Sent: Thursday, August 22, 2024, 5:04 p.m.
To: 5.1.2e ‹5.1.2e @gr.nl>
Subject: Re: Exploratory meeting with the Health Council

Dear *.1.2e (if I may address you informally).

I'd love to participate, but I won't be available until after September 9—is that still in time?

Best regards,
5.1.2e

From: 5.1.2e 5.1.2e ter nl> Date:
Thursday, August 22, 2024, at 4:08 p.m. To:
5.1.2e ‹5.1.2e >
cc: 5.1.2e 5.1.2e ter.nl>

Subject: Exploratory meeting with the Health Council

You will not receive an email from 5. 1 .2e r nl. More information is available why this is important

Dear Professor [1]

The Health Council of the Netherlands has been asked by the Minister of Health, Welfare, and Sport to issue an advisory opinion on transgender care based on the "Dutch Protocol" methodology. The Council was requested to examine the physical and mental health outcomes of the protocol, as well as the number of people who regret their decision, and to compare these outcomes with those in European countries that apply a different standard of care or guideline. The request for advice can be found on the Health Council of the Netherlands' website: Transgender Care | Care I Health Council of the Netherlands.

We are currently in an exploratory phase in preparation for the advisory process. During this phase, we are speaking with various experts to gain a better understanding of transgender care in the Netherlands. Given your recent research in this area 5.1.2e we would like to exchange ideas with you on this topic.

Would it be possible to schedule a phone call—or a video conference, if you prefer—in the near future? We have also reached out to your colleague, Dr. 5.1.2e, for an exploratory discussion; we could potentially combine these meetings if that is your preference.

Sincerely, also on behalf of my colleague 5.1.2e

5.1.2e
Scientific Secretary

Tel. +31 65.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
www.aezondheidsraad.nl
Available Mon, Tue, Thu, Fri

010

From: 5.1.2e
To: 5.1.2e : 5.1.2e
Cc: 5.1.2e
Subject: RE: Exploratory meeting with the Health Council on Friday,
Date: August 23, 2024, 10:01:23
Attachments: imaoe0fll 1lxl
imaoe0fl3.priq imaDe0n4 1lxl

Dear 5.1.2e

Thank you very much for your prompt and positive response.
I will contact your colleague to schedule an appointment. Best regards,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
•vv gezondheidsraad.nl
Available Mon., Tue., Thu.,
Fri.

from: 5.1.2e ‹5.1.2e >
Sent: Friday, August 23, 2024, 8:04 a.m.
To: Êi.1.2e 5.1.2e @gr.nl>; 5.1.2e ‹5.1.2e >
cc: 5.1.2e ‹5.1.2e @gr.nl>
Subject: RE: Exploratory meeting with the Health Council

Dear Ms. 5.1.2e
I am certainly willing to engage in a discussion with members of the Health Council
Please contact 5.1.2e to schedule a Teams meeting. Best regards
5.1.2e

Kind regards,

5.1.2e
Pediatric Endocrinologist,
5.1.2e

5.1.2e

5.1.2e

from: 5.1.2e 5.1.2e Apr
Sent: Thursday, August 22, 2024, 4:08 PM
To: 5.1.2e ‹5.1.2e >
cc: 5.1.2e ‹5.1.2e jr n >
Subject: Exploratory Meeting with the Health Council

Dear Professor 5.1.2e

The Health Council of the Netherlands has been asked by the Minister of Health, Welfare, and Sport to issue an advisory opinion on transgender care based on the “Dutch Protocol” methodology. The Council was asked to examine the physical and mental health outcomes of the protocol, as well as the number of people who regret their decision, and to compare these outcomes with those in European countries that follow a different standard of care or guideline. The request for advice can be found on the Health Council of the Netherlands’ website: Transgender Care | Care | Health Council of the Netherlands.

We are currently in an exploratory phase to prepare for the advisory process. During this phase, we are speaking with various experts to gain a better understanding of transgender care in the Netherlands. Given your expertise in the treatment of transgender individuals, we would like to exchange ideas with you on this topic.

Would it be possible to schedule a telephone appointment—or a video conference—in the near future?

Sincerely, also on behalf of my colleague 5.1.2e

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
•vv_gezondheidsraad.nl

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5.1.2e

From: 5.1.2e
Aah : 5.1.2e
Cc: 5.1.2e
Subject: Date: RE: Exploratory Meeting with the Health Council,
Attachments: September 27, 2024, 3:08:20 PM (imanef)01
info

Dear 5.1.2e

Thank you for your prompt response.
I understand that you have a busy schedule and that this doesn't fit in.
Are there any colleagues (within or outside 5.1.2e with a similar background (developmental psychology and epidemiology) whom you would recommend we contact regarding this matter?

Just to be sure, I'd like to briefly explain the advisory process, in case this is relevant to the selection of colleagues (or your own participation): we won't begin the advisory process until January 2025, during which the committee will hold approximately 6 meetings every 6 to 7 weeks. One week before each meeting, committee members will receive meeting materials to review. The scientific secretaries draft the meeting documents and the advisory report based on the meetings, with input from the committee members.

Best regards,
5.1.Ze

From: 5.1.2e ‹5.1.2e >
Sent: Friday, September 27, 2024, 12:46 p.m.
To: 5.1.2e ‹5.1.2e @gr.nl>
cc: 5.1.2e ‹5.1.2e @gr.nl>
Subject: Re: Exploratory Meeting with the Health Council

Dear 5.1.2e

Thank you for the email and your question.
Unfortunately, I'm too busy right now to be able to participate in this. Hopefully, I'll be able to help next time if you have a similar request.

Warm regards
5.1.2e

5.1.2e

5. 1 .2e Developmental Psychopathology

5.1.2e

From: 5.1.2e 5.1.2e to nl> **Sent:** Thursday, September 26, 2024, 11:28 a.m. **To:** 5.1.2e ‹5.1.2e > **cc:** 5.1.2e 5.1.2e ter nl>
Subject: Exploratory Meeting with the Health Council

Dear Professor 5.1.2e

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of Health, Welfare, and Sport submitted a request for advice on this matter on May 13 (see attachment).
To respond to this request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your broad knowledge of developmental psychopathology and your expertise in the field of epidemiology, we would very much like to exchange ideas with you on this topic. Would it be possible to schedule a telephone call—or a video conference—in the near future?

I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e

5.1.2e
Scientific Secretary

Tel. +31 65.1.2e
Bezuidenhoutseweg 30. 2594 AV The Hague
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Available Mon, Tue, Thu, Fri.

013

From: 5.1.2e
To: Subject: 5.1.2e ; 5.1.2e
Date: RE: Additional information
Attachments: Thursday, October 3, 2024, 9:30:01 AM
imaneÜ0? inn

Dear .1.2e

We are pleased to hear that you would like to participate in this temporary committee.
Over the next two to three weeks, we will be conducting interviews with the other (prospective) committee members. Afterward, we will discuss the committee's composition again with the board and get back to you.

Best regards,
5.1.Ze

From: 5.1.2e ‹5.1.2e >
Sent: Tuesday, October 1, 2024, 12:14 PM
To: 5.1.2e 5.1.2e @gr.nl>
cc:5.1.2e ‹5.1.2e @gr.nl> Subject:
Re: Further information

Dear 5.1.2e I've discussed this with my superiors: it would be best to transfer the honorarium to my personal account, as I'm doing this work in a personal capacity and on my own time. So yes, I do agree.

Best regards, 5.1.2e

5.1.2e

From: 5.1.2e 5.1.2e ter nie
Sent: Friday, September 27, 2024, 4:33 PM
To: 5.1.2e •5.1.2e >
CC: 5.1.2e ‹5.1.2e ter nl>
Subject: Further Information

Dear .1.2e

Thank you again for the pleasant conversation this morning. As promised, I'm following up

Regarding the attendance fee. I understand that this amounts to €275 per meeting, excluding any travel expenses incurred. It is quite common for this attendance fee to be transferred to the university (or its department) where one is employed.

We'd love to hear from you about whether—subject to approval by our board and the completion of the conflict of interest form—you'd like to serve on the temporary committee.

Wishing you a pleasant weekend.

Best regards,

5.1.2e
Academic Secretary

tel. +31 6 5.1.2e (mB Tim Vrij)
Visiting address: Bezuidenhoutseweg 3D, 2594 AV Den HBBg
www.gezondheidsraad.nl

015

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e 5.1.2e
Subject: Date: RE: Introduction to the transgender care consultation process, Tuesday, October 22, 2024, 5:23:00 PM
Attachments: imanef)01 ino

How silly of me. Thursday is, of course, October 31... But I'm glad Tuesday works! 5 1 2e and I will be in Leiden at 2:30 p.m. Where in Leiden will we meet? I'll send a calendar invite right away.

Best regards,
5.1.2e

From: 5.1.2e •5.1.2e >
Sent: Tuesday, October 22, 2024, 2:55 PM
To: 5.1.2e ‹5.1.2e @gr.nl>
cc: 5.1.2e ‹5.1.2e @gr.nl>; 5.1.2e
Subject: RE: Introduction to the transgender care consultation process

In that case, I'd still slightly prefer a live performance....
Tuesday, October 29 at 2:30 p.m.?
Best regards, 5 Ï.2e

From: 5.1.2e •5.1.2e ter nl>
Sent: Tuesday, October 22, 2024, 2:46 PM
To: 5.1.2e ‹5.1.2e >
cc: 5.1.2e •5.1.2e fo*er nl>
Subject: RE: Introduction to the transgender care consultation process

Dear 5 1 2e

Unfortunately, it's no longer possible to meet in person this coming Friday in 5.1.2e. An online introductory meeting is still an option, though—we can always meet in person later. 3:00 p.m. would work well then. If you'd still prefer to meet in person for now, 1 e and I would be available this coming Monday, October 28, Tuesday, October 29 starting at 12:00 p.m., or Thursday, November 1.

We'd love to hear what works best for you.

Best regards,
5.1.2e

From: 5.1.2e •5.1.2e >
Sent: Tuesday, October 22, 2024, 12:01 p.m.
To: 5.1.2e ‹5.1.2e to nl>
cc: 5.1.2e 5.1.2e @Pr nl>
Subject: RE: Introduction to the transgender care consultation process

How about Friday at 3:00 p.m.?

From: 5.1.2e 5.1.2e ter nl>

Sent: Tuesday, October 15, 2024, 2:15 PM
To: 5.1.2e <5.1.2e>
Cc: 5.1.2e 5.1.2e @gr.nl>
Subject: Introduction to the Transgender Care Advisory Process

Dear Professor 5.1.2e, Dear 5.1.2e

From 5.1.2e we understand that you would like to chair the temporary committee that will be drafting the advisory report on transgender care for young people in the Netherlands. We are delighted to hear that. My colleague, 5.1.2e, and I will serve as the secretaries of this committee. We think it would be a good idea—and a pleasure—to meet with you soon. Perhaps we could schedule an appointment for this in the near future? For example, 5.1.2e and I could come to 5.1.2e. An online meeting is, of course, also possible. For the sake of completeness, I have attached the request for advice.

Best regards, also on behalf of 5.1.2e

5.1.2e
Scientific Secretary

tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

016

Van: 5.1.2e
Aan: 5.1.2e
5.1.2e
Attachment: RE: Exploratory meeting on Health and Youth
Datum: Affairs, **Tuesday, October 22, 2024, 4:33**
Attachments: **p.m.** imanefi01 Inn

Specifi
cations

We recently held an exploratory meeting as part of the advisory process regarding transgender care for young people. We look back on a pleasant conversation. At this time, it has been decided not to include you on the committee. Although you bring an interesting perspective, we are still seeking additional expertise in the field of transgender care for young people for the committee. The Health Council would be happy to keep you in mind for any future work.

Best regards, also on behalf of

5.1.2e

From:
Sent: Thursday, October 17, 2024, 11:20 a.m.
“*” ”
CC: @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council

Scope

Thanks again for our conversation last week, and thank you for your message. We haven't spoken with Mr. [Name], but we're keeping an eye on him.

Best regards,

From: >
Sent: Monday, October 14, 2024, 9:32 AM To:
Mer nl>
CC: ter nl>
Subject: Re: Exploratory Meeting with the Health Council

Specifications, etc.
Do you have , , also discussed this? He can offer valuable input from a legal perspective:
NIB Bloe -
Hg
5.1.2e

5.1.2e

[redacted]
recent: 5.1.2e [redacted] I NTVG

On Fri, Sep 27, 2024 at 11:59 5.1.2e <5.1.2e > wrote:

Best5 1 ** and 5.1.2e

It's good that this is being addressed.

I'm really short on time, but I'm available on Monday, Oct. 7, or Tuesday, Oct. 8, at 10 a.m., or on Tuesday, Oct. 1, at 11 a.m.

Hg

5.1.2e

5.1.2e

recent: 5.1.2e I NTVG

On Thu, Sep 26, 2024 at 11:21 5.1.2e <5.1.2e per nl> wrote:

Dear Professor 5.1.2e

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of Health, Welfare, and Sport submitted a request for advice on this matter on May 13 (see attachment).
To respond to this request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your broad knowledge of special education and your expertise in the medicalization of (among other things) social problems, we would very much like to exchange ideas with you on this topic. Would it be possible to schedule a telephone call—or a video conference—in the near future?

I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague

> www.gezondheidsraad.nl
> Available Mon, Tue, Thu, Fri.

017

Fro 5.1.2e
m: 5.1a
To: 5.1.2e
Cc: **RE- Health Council - Feedback on exploratory meeting Thursday,**
Subject: **October 31, 2024, 11:00-26:00**
Date: imaneÜfi1 nnn
Attachments:

Dear Ms. 5.1.2e

I apologize for my late response; your email got held up for a while. We would like to thank you for your understanding and your suggestion. We will take this into consideration.

Best regards,
5.1.2e

From: 5.1.2e <5.1.2e >
Sent: Tuesday, October 22, 2024, 5:44 PM
To: 5.1.2e ‹5.1.2e @gr.nl>
cc: 5.1.2e 5.1.2e @gr.nl>
Subject: RE: Health Council - Feedback on exploratory meeting

Dear 5.1.2e and 5.1.2s

Thank you very much for the feedback. I fully understand that you are looking for someone with more clinical experience in **transgender care. voor jor I can wholeheartedly recommend my colleague 5.1.2e .” works** sinds 5.1.2e at the ii.1.2e **and has extensive experience in care and research involving transgender youth.**

Sincerely,

5.1.2e

From: 5.1.2e <5.1.2e raer nl>
Sent: Tuesday, October 22, 2024, 4:43 p.m.
To: 5.1.2e ‹5.1.2e >
CC: 5.1.2e ‹5.1.2e >
Subject: Health Council - Feedback on exploratory meeting

Dear Prof. 5.1.2e

We recently held an exploratory meeting as part of the advisory process on transgender care for young people. We look back on a pleasant discussion. It is clear that you have a great deal of expertise in transgender research. However, the board has decided not to appoint you to the committee. For the committee, we are seeking more clinical experience in transgender care for young people. The board would, however, like to keep you in mind for any future work of the Health Council.

Sincerely, also on behalf of 5.1.2e

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e (available on weekends)
Visiting address: Bezuidenhoutseweg 30, 2ü94 AV The Hague
www.gezondheidsraad.nl

5.1.2e

018

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e
Subject: RE: About Cass reView
Date: Thursday, October 31, 2024, 4:27:00 PM
Attachments: imanef)01 nnci

Hi 5.1.2e

That's a fair question! We read the interview with you in the 5.1.2e issue. That's how we found you

Best regards,
5.1.2e

From: 5.1.2e ‹5.1.2e >
Sent: Thursday, October 31, 2024, 4:09 PM
To: 5.1.2e ‹5.1.2e @gr.nl>
cc:*" ‹5.1.2e @gr.nl>
Subject: Re: About Cass review

Thank you so much.

A question from my followers :) —> How did you actually end up finding me?

Best regards,
‹.a

5.1.2e
5.1.2e doctor, psychologist

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On Oct. 31, 2024, at 3:51 p.m., 5.1.2e "5.1.2e wrote the following:" wrote:

Hi 5.1.2e

Thank you for forwarding the various publications; I really appreciate it.

Thank you again for the pleasant conversation earlier today.
We'll get back to you in about two weeks with feedback from the board.

Best regards,
5.1.Ze

From: 5.1.2e ‹5.1.2e >
Sent: Thursday, October 31, 2024, 1:04 PM
To: 5.1.2e ‹5.1.2e ter nl>
cc: 5.1.2e ‹5.1.2e ter nl>
Subject: About the Cass review

Oh, and I don't want to keep this from you:

<image001.jpg>

A response from Amsterdam UMC to the Cass review on transoenderzoro

Our practice fully agrees with this!

Best regards,
.‹.a

<image002.png>

5.1.2e

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On October 31, 2024, at 1:02 p.m., 5.1.2e
•5.1.2e > wrote the following:

Mr. 5 1.2e and 5.1.2e

Thank you for your time. It's a tough topic.

As promised, here are the links to various research studies:

Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study

https://pubmed.ncbi.nlm.nih.gov/20646177/

Psychological Outcomes in Young Adults After Puberty Suppression and Gender Reassignment

https://pubmed.ncbi.nlm.nih.gov/25201798/

A study investigated whether children can be “socially influenced” to the point of developing transgender feelings. The study found that this is not the case.

Turban, L. Jack; et al. (August 3, 2022). Sex Assigned at Birth Ratio Among Transgender and Gender Diverse Adolescents in the United States.

https://publications.aap.org/pediatrics/article/150/3/e2022056567/188709/Sex-Assigned-at-Birth-Ratio-Among-Transgender-and

---

Litman’s study is often cited to support the claim that children are influenced in developing trans feelings, among other things, by social media and other children. Researchers at Radboud University have confirmed to us that it cannot be concluded from that study that children come to believe they are transgender as a result of being exposed to the topic via social media or through interaction with other children.

Littman, L. (August 16, 2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria.

https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330

Researchers from VUmc and LUmc investigated the extent to which transgender youth are competent enough to make decisions regarding puberty blockers. The study found that 93.2% of transgender youth were competent enough to make decisions about puberty blockers according to the MDC standards, and 89.2% of transgender youth were competent enough to make decisions about puberty blockers according to the MacCAT-T standards.

Vrouwenraets, Lieke; J.J.J.; et al. (December 1, 2021). Assessing Medical Decision-Making Competence in Transgender Youth.

https://publications.aap.org/pediatrics/article/148/6/e2020049643/183482/Assessing-Medical-Decision-Making-Competence-in?autologincheck=redirected

---

The VUMC conducted a study on the number of people who regret hormone therapy. According to the study, 0.6% of trans women reportedly regret hormone therapy, and 0.3% of trans men reportedly regret hormone therapy.

Wiepjes, M. Chantal; et al. (April 4, 2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets.

https://academic.oup.com/jsm/article/15/4/582/6980345?login=false

---

A study of twelve different gender clinics in the U.S. found that 0.8% of transgender people regretted undergoing hormone therapy.

Deutsch, B. Madelief (May 2012). Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics.

https://www.researchgate.net/publication/241745100_Use_of_the_Informed_Consent_Model in the Provision of Cross-Sex_Hormone_Therapy_A_Survey_of_the_Practices_of_Selected_Clinics

---

A recent review analyzing multiple studies found that the percentage of people who regret gender-affirming surgery ranges from 0.3% to 3.8%.

Coleman, E.; et al. (September 15, 2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.

https://www.tandfonline.com/doi/full/10.1080/26895269.2022.2100644

Research by VUmc revealed that 98% of young people who began using sex hormones after puberty blockers were still using hormones years later.

Van der Loos, A.T.C. Maria (October 20, 2022). Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence: a cohort study in the Netherlands.

https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(22)00254-1/fulltext

---

A review analyzing multiple studies found that 1% of individuals who underwent gender-affirming surgery regretted their decision. The review also found that, in cases of regret, the social environment was a significant contributing factor.

Bustos, P. Valeria; et al. (March 19, 2021). Regret After Gender-Affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8099405/

You can also find a lot of useful information on the VU website; https://www.amsterdamumc.org/nl/vandaag/onderzoek-naar-transgenderzorg-voor-jongeren.htm

https://www.amsterdamumc.org/nl/vandaag/genderbevestigende-hormoontherapie-vermindert-psychische-klachten-bij-transgender-personen.htm

Best regards,
5.1.2e

<5.1.2e -logo-small.png>

5.1.2e
doctor, psychologist
5.1.2e

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On Oct. 28, 2024, at 4:02 p.m., 5.1.2e <5.1.2e @gr.nl> wrote the following:

Dav 5.1.2e

I just sent a meeting request for this coming Thursday at 12:00 p.m.

We look forward to speaking with you. Best

regards,
5.1.2e

From: 5.1.2e <5.1.2e >
Sent: Monday, October 28, 2024, 3:52 PM
To: 5.1.2e <5.1.2e @gr.nl>
Subject: Re: Exploratory Meeting with the Health Council

Yes, that works well. How about 12:00 PM?

Best regards,
5.1.2e

<image001.png>

5.1.2e
doctor, psychologist
5.1.2e

5.1.2e

www.check-in-genderzorg.nl

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On Oct. 28, 2024, at 3:31 p.m., 5.1.2e 5.1.2e @gr.nl> wrote the following:

Day 5.1.2e

Thank you very much for your quick response, and I'm glad we can speak so soon.
This coming Thursday between 10 a.m. and 5 p.m. would work well for us. Would a phone call of up to 45 minutes on that day work for you?

We look forward to

hearing from you. Best
5.1.2e
regards,

From: 5.1.2e
<5.1.2e>
Sent: Monday, October 28, 2024 3:23 PM
To: 5.1.2e <5.1.2e @gr.nl>
Subject: Re: Exploratory Meeting with the Health Council

Ha 5.1.2e

I'd love to do that myself—thank you for the invitation.
I'm very flexible this week—what would work for you?

Best regards,
5.1.2e



5.1.2e
doctor, psychologist
5.1.2e

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On Oct. 24, 2024, at 2:51 p.m., 5.1.2e <5.1.2e @gr.nl> wrote the following:

Dear Ms. 5.1.2e

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of Health, Welfare, and Sport submitted a request for advice on this matter on May 13 (see attachment).
To respond to the request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary.
Given your expertise in the field of transgender care, we would like to exchange ideas with you on this topic. Would it be possible to schedule a phone call—or

via video conference?

I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e ,

5.1.2e
Scientific Secretary

<image001.jpg>
Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl
Available Mon, Tue, Thu, Fri.

<20240513_Request_for_Advice-GR-transgender-care_VWS_20240521_Edited.pdf>

021

Van: 5.1.2e
Aan: 5.1.2e
5.1.2e
Onderwerp: Re: Feedback on the oremtererxJ discussion at the Health Council
Date: meeting on November 20, 2024, at 14:00:39
Attachments: -lrxx›-tlein nnn

Oh, that's great to hear—thank you all so much

Best regards,

5.1.2e
artsjor, psychologist
5.1.2e

Disclaimer: The information contained in this email is not intended as advice regarding the matters discussed. No liability is assumed for any information provided. If this email was sent to you by mistake and/or it is evident from the content of this email that it was not intended for you, please delete the email immediately. In the interest of data protection, you are strongly urged not to open this email or forward it. If necessary, please contact the sender to contact the organization

from whom this email was sent.

Op [redacted] Nov. 20, 2024, at 12:08 p.m. @gr.nl>
<5.1.2e wrote the following:

Dear Ms. specifications

We have now spoken with the board about your potential participation in the Transgender Care for Youth Committee. They would like to have you on the committee and, for the time being, see few obstacles to your participation. As we discussed during the introductory meeting, you will receive a statement of interests from our project coordinator shortly. Once you've filled it out, we'll discuss the form with the board, and they'll review it. You'll also receive a scheduling tool from our project coordinator to help plan the committee meetings.

If you have any questions, please feel free to contact us by phone or email. Best

regards, also on behalf of

5.1.2e
Scientific Secretary



tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

022

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e
Subject: Date: **RE: Exploratory Meeting with the Health Council - 5.1.2e**
Attachments: **Wednesday, November 20, 2024, 12:07:00**
imanef)01 ino

Dear Ms. 5.1.2e , Dear 5.1.2e

In addition to the email below dated the 1st, I would like to let you know that we have now spoken with the board about your potential participation in the Transgender Care for Youth Committee. They would like to have you on the committee and, for the time being, see few obstacles to your participation. As we discussed during the introductory meeting, you will soon receive a statement of interests from our project coordinator. Once you have completed it, we will discuss the statement with the board, and the board will review it. You will also receive a scheduling tool from our project coordinator to help plan the committee meetings.

If you have any further questions, please feel free to contact us by phone or email.

Best regards, also on behalf of *.1.2e
5.1.2e

From: 5.1.2e ‹5.1.2e @gr.nl>
Sent: Tuesday, November 12, 2024, 12:22 PM
To: 5.1.2e •5.1.2e >
cc: 5.1.2e ‹5.1.2e @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council - 5.1.2e

Dear 5.1.2e

Thank you for your feedback and interest in serving on the temporary committee.
Next week, we will discuss the committee's composition with the board, and a final decision will be made regarding your participation. We will then inform you of the board's decision. After the meeting with the board, the final committee members will receive an official invitation, which will include, among other things, a date picker and a form for the declaration of interests.
As mentioned earlier, participation on the committee is contingent upon the declaration of interests, which will be reviewed by our board.

Please let me know if you have any further questions.

Best regards,
5.1.Ze

From: 5.1.2e ‹5.1.2e >
Sent: Friday, November 8, 2024, 4:58 PM
To: 5.1.2e ‹5.1.2e @Pr nl>
CC: 5.1.2e ‹5.1.2e ter nl>
Subject: RE: Exploratory Meeting with the Health Council - 5.1.2e

Dear *-1.2e and 5.1.2e

Thank you for the invitation to see if I can join the committee; I would definitely be interested.

If you'd like to start the meetings as early as January, it would be great to hear the proposed half-days soon, as the schedules are already set through April...

I'd also like to know how things are progressing with the conflict of interest review. Regards, 5.1.2e

---

From: 5.1.2e <5.1.2e @gr.nl>
Sent: Tuesday, November 5, 2024, 2:59 PM
To: 5.1.2e 5.1.2e >
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council - 5.1.2e

Dear 5.1.2e

Thank you very much for the articles; we look forward to reading them. See

you soon,
5.1.2e

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl
Available Mon, Tue, Thu, Fri.

From: 5.1.2e <5.1.2e >
Sent: Tuesday, November 5, 2024, 1:20 PM
To: 5.1.2e <5.1.2e @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council - 5.1.2e

Please find attached the articles I mentioned. Best regards, 5.1.2e

-----Original message-----
From: 5.1.2e 5.1.2e @gr.nl>
Sent: Friday, October 25, 2024, 1:52 PM
To: 5.1.2e 5.1.2e 5.1.2e
Subject: Exploratory Meeting with the Health Council - 5.1.2e
Time: Tuesday, November 5, 2024, 12:15–1:00 p.m. (UTC+01:00) Amsterdam, Berlin, Bern, Rome, Stockholm, Vienna.
Location: Microsoft Teams meeting

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of the Ministry of Health, Welfare, and Sport submitted a request for advice on this matter on May 13 (see email).

To respond to the request for advice, the Health Council's board has decided to establish a temporary committee. Given your expertise in the field of transgender care and your research on this topic, we would like to exchange ideas with you on this subject.

Microsoft Teams Need help?

Join the meeting now Meeting ID: 5.1.2e Passcode: 8hC28z

Join using a video conferencing device

Tenant key:rijksoverheid@m.webex.com
Video ID: 5.1.2e
More information

For organizers: Meeting options

5.1.2e

023

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e 5.1.2e

Bijlagen: image001.jpg
image002.png
image003.png
image004.png
image005.png
image006.png

Dear 5.1.2e

Recently, he contacted you to schedule an exploratory meeting regarding transgender care for young people. Unfortunately, that meeting could not take place last Friday. In the meantime, they have spoken with several candidates, and the board has decided on the committee appointment, as expertise in epidemiology is sufficiently represented. We understand that your time is valuable and therefore want to let you know that it is not necessary to schedule a new meeting. We would like to thank you for the pleasant interaction and will keep you in mind for any future activities for the Health Council.

Sincerely,

From: 5.1.2e
Sent: Friday, November 18, 2024, 10:39 a.m.
To: 5.1.2e •5.1.2e
cc: 5.1.2e •5.1.2e ggr.nl>;5.1.2e 5.1.2e >
Subject: RE: Exploratory Meeting with the Health Council

Hello 5.1.2e

That could happen; thanks for letting us know.
We're waiting for a message from*+ .

Groet,
5.1.2e

From: 5.1.2e 5.1.2e >
Sent: Friday, November 15, 2024, 10:28 a.m.
To: 5.1.2e ï •5.1.2e hour nl>
cc: 5.1.2e •5.1.2e e r nl>; 5.1.2e •5. ï.2e
Subject: fte: Preliminary Meeting with the Health Council

Hello 8-J.2e, unfortunately, due to circumstances, I won't be able to join you shortly. I'll ask 5.12e to schedule another appointment for us.

Best regards and apologies,
5.1.2e

With kind regards,

5.1.2e

? ? ? ?

Bekijk onze (online) congressen, webinars, trainingen

Deze e-mail (en eventuele bijlagen) kan vertrouwelijke informatie bevatten. Indien u niet de beoogde ontvanger van deze e-mail bent, verzoeken wij u het bericht direct te verwijderen en contact op te nemen met de verzender. Elk gebruik van de inhoud van dit bericht en/of door een andere dan de beoogde ontvanger is onrechtmatig. Het 5.1.2e staat niet in voor de juiste en volledige overbrenging van de inhoud, noch voor tijdige ontvangst daarvan. Het 5.1.2e is gevestigd te Utrecht en is ingeschreven in het handelsregister onder het nummer 5.1.2e .

From: 5.1.2e .5.1.2e to nl> Sent:
Tuesday, November 5, 2024, 11:59 a.m. To:
5.1.2e •5.1.2e
cc: 5.1.2e •5.1.2e hour nl>; 5.1.2e •5.1.2e >
Subject: RE: Exploratory Meeting with the Health Council

Dear 5.1.2e

No problem at all. Here are a few suggestions for the week:

- Monday, November 11, 9 a.m.–1:30 p.m., 3–5 p.m.
- Tuesday, November 12, 9:00 a.m.–11:00 a.m., 12:30 p.m.–5:00 p.m.
- Thursday, November 14, 9 a.m.–5 p.m.
- Friday, November 9, 9 a.m.–5 p.m. Is there anything here that works for you?

Groet,
5.1.2e

From: 5.1.2e •5.1.2e >

Sent: Tuesday, November 5, 2024, 11:14 a.m.
To: 5.1.2e 5.1.2e @gr.nl>
CC: 5.1.2e 5.1.2e @gr.nl>; 5.1.2e 5.1.2e >
Subject: Re: Exploratory Meeting with the Health Council

Hello 5.1.2e

Unfortunately, I'm unavailable at all those times. This week is already very busy. Are there any options for you next week? I'll CC my secretary5.1.2e in cc. She manages my schedule.

Best regards,
5.1.2e

Best regards,

5.1.2e

Check out our (online) conferences, webinars, and training sessions

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---

From: 5.1.2e 5.1.2e @gr.nl>
Sent: Monday, November 4, 2024, 10:26 a.m.
To: 5.1.2e 5.1.2e >; 5.1.2e 5.1.2e >
CC: 5.1.2e 5.1.2e @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council

Dear 5.1.2e ,

Thank you very much for your response. It's great that we were able to speak briefly after all. Our availability this week is:

- Tuesday, November 5, 1:30–5:00 p.m.
- Thursday, November 7, 11 a.m.–5 p.m.
- Friday, November 8, 9:00 a.m.–12:00 p.m.

We expect that a half-hour meeting will be sufficient. Please let us know if any of these times work for you.

Best regards,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl
Available Mon, Tue, Thu, Fri.

From: 5.1.2e 5.1.2e >
Sent: Friday, November 1, 2024, 8:17 PM
To: 5.1.2e 5.1.2e @gr.nl>
CC: 5.1.2e 5.1.2e @gr.nl>
Subject: Re: Exploratory Meeting with the Health Council

Dear 5.1.2e

Thank you very much for this invitation. I'd be happy to get in touch, but I'm afraid I have little to no expertise on this specific topic. Please feel free to forward any follow-up emails to 5.1.2e . I check my 5.1.2e email only occasionally.

Best regards,

5.1.2e

From: ii.1.2e •5.1.2e @Pr nl> Sent:
Thursday, October 24, 2024, 1:06 AM To: 5.1.2e
•5.1.2e >
cc:5.1.2e •5.1.2e ver nl>
Subject: Exploratory Meeting with the Health Council

You don't often receive emails from 5.1.2ept nl. Find out where this email came from

CA.UTiO N: This email originated from outside of 5.1be . Do not click on links or open attachments unless you recognize the sender and know the content is safe.

Dear

The Health Council will begin an advisory process in early 2025 regarding gender-affirming care for young people in the Netherlands. Minister Dijkstra of the Ministry of Health, Welfare, and Sport submitted a request for advice on this matter on May 13 (see attachment).

In response to the request for advice, the board of the Health Council has decided to establish a temporary committee, of which I am the scientific secretary. Given your expertise in the field of epidemiological research, we would very much like to exchange ideas with you on this topic. Would it be possible to schedule a phone call—or a video conference—in the near future?

I look forward to your response.

Sincerely, also on behalf of my colleagues

5.he
Scientific Secretary

Tel. +31 6fj.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague

Available Mon, Tue, Thu, Fri.

024

From: 5.1.2e
To: 5.1.2e
Cc: Subject: 5.1.2e
Date: **RE: Exploratory Meeting with the Health Council,**
Attachments: **Friday, November 22, 2024, 3:55:06 PM**

image002.png
image003.png
image004.png
image005.png
image006.pncl
image007.pncl
image008.png
image009.png
image010.png
imaQe011.pno
imaoe012.png
imaoe013.jpcl

Hi 5.1.2e

No, Êi.1.2e has an extremely busy schedule. So this just happened to be the only slot that was still available. Let's just reschedule it for 9:45 a.m. anyway; then she'll join the other meeting a quarter of an hour later (so until 10:15 a.m.). Otherwise, it'll be pushed back to January.
Please send me the invitation, and I'll accept it.

Best regards,

5.1.2e

From: 5.1.2e ‹5.1.2e @gr.nl>
Sent: Friday, November 22, 2024, 3:50 PM
To: 5.1.2e ‹5.1.2e >
cc: 5.1.2e <5.1.2e @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council

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Caution: This email **originated from** outside the **organization. Do not** click on links or open attachments unless you recognize the sender and know the content is safe.

Dear Êï.1.2e

Unfortunately, Wednesday morning before 9:45 a.m. is not possible for us. Is Prof. 5.1.2e available at another time? Perhaps Tuesday afternoon, Thursday, or Friday?

Best regards,

5.1.2e

From: 5.1.2e ‹5.1.2e >
Sent: Friday, November 22, 2024, 8:55 AM
To: 5.1.2e ‹5.1.2e ter.nl>

Subject: RE: Exploratory Meeting with the Health Council

Good morning,

The preferred time is really 9:30–10:00 a.m.; she has another meeting scheduled for 10:00 a.m.
It could also be from 9:00–9:30 a.m.

I'd love to hear from you,

Best regards,

5.1.2e







From: 5.1.2e 5.1.2e @gr.nl>
Sent: Thursday, November 21, 2024, 10:26 AM **To:**
5.1.2e <5.1.2e >
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council

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Caution: This email originated from outside the organization. Do not click on links or open attachments unless you recognize the sender and know the content is safe.

Dear 5.1.2e

Thank you for your message. We're so glad that Prof. 5.1.2e is willing to speak with us. Would it also be possible to speak with her on Wednesday, November 27, from 9:45 to 10:15 a.m.?

Best regards,
5.1.2e

From: 5.1.2e <5.1.2e >
Sent: Wednesday, November 20, 2024, 3:51 PM

To: 5.1.2e <5.1.2e @gr.nl>
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council

Good afternoon, 5.1.2e

Thank you for the email.

Would Wednesday, November 27, from 9:30 to 10:00 a.m., work for you? Please let me know,

Best regards,

5.1.2e

From: 5.1.2e <5.1.2e @gr.nl>
Sent: Tuesday, November 19, 2024, 4:51 PM
To: 5.1.2e >
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: Exploratory Meeting with the Health Council

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Caution: This email originated from outside the organization. Do not click on links or open attachments unless you recognize the sender and know the content is safe.

Dear Professor 5.1.2e

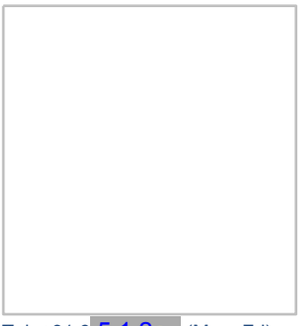
The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of Health, Welfare, and Sport submitted a request for advice on this matter on May 13 (see attachment).

To respond to this request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your expertise in the field of child psychiatry and your role as 5.1.2e we would very much like to exchange views with you on this topic. Would it be possible to schedule a phone call—whether via video conference or otherwise—in the near

future? I look forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e,

5.1.2e
Scientific Secretary



Tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

025

From 5.1.2e
: To: 5.1.2e
Cc: 5.1.2e
Subject: Re: Exploratory Meeting with the Health Council
Date: Thursday, November 28, 2024, 11:14:10
Attachments: image001.jpg

I see both a Teams link and a Webex link in the invitation. Which one should we use?

5.1.2e

From: 5.1.2e <5.1.2e >
Sent: Thursday, November 28, 2024, 11:04:19 AM
To: 5.1.2e <5.1.2e @gr.nl>
Cc: 5.1.2e <5.1.2e @gr.nl>
Subject: Re: Exploratory Meeting with the Health Council

Thanks, yes, that time works great.

5.1.2e

From: 5.1.2e 5.1.2e @gr.nl>
Sent: Thursday, November 28, 2024 10:07:53 AM **To:**
5.1.2e <5.1.2e >
Cc: 5.1.2e <5.1.2e @gr.nl>
Subject: RE: Exploratory Meeting with the Health Council

Dear 5.1.2e ,

Thank you for your prompt and positive response. We're delighted that you're willing to meet with us. Monday morning works well for us, too. Would 10:15 a.m. to 11:00 a.m. be convenient for you? If this time works for you, I'll send a meeting request with a link to Microsoft Teams.

Best regards,
5.1.2e

From: 5.1.2e <5.1.2e >
Sent: Wednesday, November 27, 2024, 8:33 p.m. **To:**
5.1.2e <5.1.2e @gr.nl>
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: Re: Exploratory Meeting with the Health Council Dear

5.1.2e

Thanks for your email! I'd be happy to schedule an online meeting. When

would be a good time for you?

For example, I'm available all morning on Monday (Dec. 2).

Best regards,

5.1.2e

From: 5.1.2e <5.1.2e @gr.nl> **Sent:** Wednesday, November 27, 2024, 4:27:12 p.m. **To:** 5.1.2e <5.1.2e>
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: Exploratory Meeting with the Health Council

Dear Professor 5.1.2e

The Health Council of the Netherlands will begin an advisory process in early 2025 regarding transgender care for young people in the Netherlands. Outgoing Minister Dijkstra of Health, Welfare, and Sport submitted a request for advice on this matter on May 13 (see attachment).

To respond to this request for advice, the Health Council's board has decided to establish a temporary committee, of which I am the scientific secretary. Given your expertise in the field of child and adolescent psychiatry and your role as 5.1.2e we would very much like to exchange views with you on this topic. Would it be possible to schedule a to schedule a phone call, or possibly a video conference, at short notice? I look

forward to your response.

Sincerely, also on behalf of my colleague 5.1.2e ,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

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027

From: 5.1.2e
To: 5.1.2e 5.1.2e
Cc: 5.1.2e)
Subject: RE: Introductory Meeting with Committee Chair
Date: Tuesday, December 17, 2024, 12:11:08 PM
Attachments: image001.jpg

Hi 5.1.2e and 5.1.2e
I had mentioned this briefly in my PO to our 5.1.2e . He mentioned that he'd like to attend this introductory meeting as well. Would you also be willing to send him an invitation?

Gr
5.1.2e

5.1.2e @minvws.nl>

From: 5.1.2e **Sent:** Monday, December 16, 2024, 4:48 PM
To: 5.1.2e @gr.nl>; 5.1.2e @minvws.nl>
CC: 5.1.2e @gr.nl>
Subject: RE: Introductory meeting with the committee chair

I'm available on January 28 and will be at the Ministry of Health, Welfare, and Sport (VWS) that day. On the 30th, I'm available from 10:00 a.m. to 12:00 p.m., but only online. Regards
5.1.2e

From: 5.1.2e @gr.nl>
Sent: Monday, December 16, 2024, 4:40 PM
To: 5.1.2e @minvws.nl>; 5.1.2e @minvws.nl>
CC: 5.1.2e @gr.nl>
Subject: Introductory Meeting with Committee Chair

To 5.1.2e and 5.1.2e

You should have received the invitations to the meetings of the Ad Hoc Committee on Transgender Care for Youth by now. The committee will meet for the first time on Wednesday, February 5. The committee chair has indicated to us that they would like to meet with you before then. This could take place at the following times:

- Tuesday, January 28, 2:30–5:00 p.m.
- Thursday, January 30, 10:00 a.m.–2:00 p.m.

Is there a time here that works for you? For now, we'd like to do this online and think half an hour will suffice. If you let me know your availability, I'll schedule a time and send you a meeting link.

Best regards,

5.1.2e

5.1.2e
Scientific Secretary



tel. +31 6 (Mon–Fri)
Visiting address: Bezuidenhoutseweg 3D, 2594 AV Den Haag
www.gezondheidsraad.nl

0Z8

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e
Subject: Date: Re: Feedback on exploratory meeting with the Health Council
Attachments: Tuesday, December 24, 2024, 2:08:26 PM
imanef)01 ino

Thanks for the feedback!

5.1.2e

From: 5.1.2e •5.1.2e @gr.nl>
Sent: Friday, December 20, 2024, 3:23:26 PM
To: 5.1.2e ‹5.1.2e >
Cc: 5.1.2e •5.1.2e @gr.nl>
Subject: Feedback on exploratory meeting with the Health Council

Dear Prof. 5.1.2e Dear *.1.2e

We recently held an exploratory meeting as part of the advisory process regarding transgender care for young people. I apologize that it has taken us so long to provide feedback. We look back on a pleasant conversation. Despite your extensive expertise in the field of child and adolescent psychiatry, the board has decided not to appoint you to the committee. They prefer a psychiatrist with more clinical experience in transgender care. The board would, however, like to keep you in mind for any future work of the Health Council.

Best regards, also on behalf of 5.1.2e

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

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029

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e ;5.1.2e ; 5.1.2e
Subject: RE: Response from NSC
DaNil»: wq January 17, 2025, 2:46:00 PM
Attachments: imaneÜfl1 Inn

Ha 5.1.2e

I can see that this is a topic of great interest, so I understand your question. After the committee is formed, its membership will be posted on the website. An introductory letter to be sent to the minister will also be published there in due course, stating that the committee has begun the advisory process. More information will therefore be available on the website in early to mid-February. I hope this sufficiently answers your question.

Best regards,
5.1.2e

From: 5.1.2e @minvws. nl>
Sent: Friday, January 17, 2025, 8:51 AM
To: 5.1.2e **@gr.nl>**
cc: 5.1.2e **@gr.nl>; 5.1.2e** **@gr.nl>;**
5.1.2e **@minvws.nl>**
Subject: RE: Response from NSC

Hi Ü.1.2e and 5 1.2e
Following up on a question from Wednesday: Would it perhaps be a good idea to provide a little more information on the website about what you sent me? I've received questions about it from several sources. This is a very active topic in the field. I regularly refer to the gr. in parliamentary questions.

Gr
5.1.2e

Sent with BlackBerry Work (www blaCkhorrv mm)

From: 5.1.2e @gr nl>
Date: Wednesday, Jan. 15, 2025, 1:00 PM
To: 5.1.2e @minvws nl>
CC: 5.1.2e o i>, 5.1.2e f er.nl>
Subject: Response to NSC

Dear 5.1.2e

From 5.1.2e, I understood that the NSC submitted a question regarding our advisory process on transgender care for young people. I am sending you a point-by-point response to that question:

- The Health Council is currently working on its advisory report regarding transgender care for young people. A balanced committee has recently been formed. This committee will be inaugurated in early February. The chair of the temporary committee on Transgender Care for Young People is Prof. Dr. O.M. Dekkers.
- In addition, the Health Council is working on thorough preparations for the committee,

including an extensive literature review.

I hope this information is helpful. Best

regards,
5.1.2e

5.1.2e
Scientific Secretary

tel. +31"6 (text or call, free)
Visiting address: Bezuidenhoutseweg 30, 2594 AV Den Haag
www.gezondheidsraad.nl

031

Van: 5.1.2e
Aan: 5.1.2e
5.1.2e
Onderwerp: RE: TGZ Committee
Date: Thursday, February 6, 2025, 4:41:00 PM

He

Thanks for pointing that out. Of course, also I immediately asked the communications team if they could add her name to the website. Good to hear that you've already received some feedback. You'll receive the minutes from the first meeting along with the materials for the next meeting.

Best regards,
5.1.2e

From: @minvws.nl>
Sent: Thursday, February 6, 2025, 3:50 PM
To: @gr.nl>
CC: @gr.nl>
Subject: RE: TGZ Committee

Thanks, maybe just a momen5.1.2e We're both
I've heard from the feedback thatvan 5.1.2e that it was a very interesting presentation with these are very good questions.
Looking forward to the next steps; I assume we'll receive a report.
Best regards, **and of course,** best of luck to you all as you continue this process.

I plan to include a short section in a letter to the House (that's my intention) where I'll mention the process, and I'll include a link.

Gr
5.1.2e

From: @er nl>
Sent: Thursday, February 6, 2025, 2:43 p.m.
To: @minvw nl>
CC: @Pr nl>
Subject: RE: TGZ Committee

Hello

The committee roster was posted on the website this afternoon. As promised, I'm sending you the link here. For the sake of completeness, I'm also sending you a link to the subject page of the advisory process.

Best regards,
5.1.2e

From: @minvws nl>
Sent: Monday, February 3, 2025, 3:01 PM
To: ter nl>
Subject: RE: TGZ Committee

Sure, go ahead!
5.1.2e will be there on Wednesday next
time

Sent with BlackBerry Work
(www.blackberry.com)

From: 5.1.2e @gr.nl>
Date: Monday, Feb. 3, 2025, 2:44 PM
To: 5.1.2e @minvws.nl>
CC: 5.1.2e @gr.nl>
Subject: RE: tgZ Committee

Hi 5.1.2e

After the first committee meeting, the committee's membership will be posted on our website, but no press release will be issued regarding this. Of course, we can let you know once the committee has been posted on the website.

Best regards,
5.1.2e

From: 5.1.2e @minvws.nl>
Sent: Friday, January 31, 2025, 3:01 p.m.
To: 5.1.2e gr.nl>; 5.1.2e @gr.nl>
Subject: tgZ Committee

If you're going to issue a press release about the tgZ Committee, could you let me know in advance?

That way, I can also give the communications

team a heads-up. Regards, 5.1.2e

Sent with BlackBerry Work
(www.blackberry.com)

042

From: 5.1.2e
To: 5.1.2e 5.1.2e ; 5.1.2e
Cc: 5.1.2e 5.1.2e
Subject: Re: Invitation Letter for Parents and Youth
Date: Thursday, March 20, 2025, 6:39:31 PM
Attachments: image001.jpg

Hello everyone,

This seems like a good letter to me, but one note: “Genderkind en Ouders (GO)” should be “Genderkind en ouders (Go).” A version adapted for young people would be very welcome.

Best regards,

5.1.2e

5.1.2e
5.1.2e
5.1.2e
5.1.2e
m: 5.1.2e
e: 5.1.2e
5.1.2e

On March 20, 2025, at 4:31 p.m., 5.1.2e wrote

> Dear 5.1.2e 5.1.2e en 5.1.2e
>
> We’d like to respond to your offer to review the invitation letter for parents and young people. We’ve addressed this letter to the parents, but please let us know if you think it would be helpful to create a version for the young people as well.
>
> We look forward to your feedback.
>
> Best regards,
> 5.1.2e
>
> Tel. +31 6 5.1.2e (Mon–Fri)
> Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
> www.gezondheidsraad.nl

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043

From: 5.1.2e
To: 5.1.2e J; 5.1.2e ; 5.1.2e
Cc: 5.1.2e 15.1.2e
Subject: Date: Re: Invitation letter to parents and students,
Attachments: Monday, March 24, 2025, 11:00:46 imanef)01_ino

Haflo5.1.2e 5.1.2e

The parents don't yet know which of them have registered, but we don't see a problem with you sharing the names of those invited to Session 1.
As you mentioned yourselves, please limit this to that group only.

Best regards,
5.1.2e

From: 5.1.2e •5.1.2e @gr.nl>
Sent: Friday, March 21, 2025, 4:01 PM
To: 5.1.2e ‹5.1.2e >; 5.1.2e ‹5.1.2e >;
5.1.2e •5.1.2e >
cc: 5.1.2e ‹5.1.2e @gr.nl>; 5.1.2e ‹5.1.2e @gr.nl>
Subject: RE: Invitation Letter for Parents and Youth

Dear " and *.1.2e

Thank you very much for your prompt responses and suggestions. Based on these, we have made some adjustments to the letter. In accordance with '*e's response, we have decided to send the letter only to the parents.

Thank you very much for providing the names and email addresses. As you may have read in the letter, we would like to include a guest list with the invitation. This list will at least include the names of those attending on behalf of the Health Council. Typically, the speakers are also listed in this document. Would it be acceptable for us to share the names of the parents, children, and Go staff members in this way with all attendees of Session 1? If you feel this is not appropriate, we will simply note on the guest list that five parents and their children, along with two Go staff members, will be present, without listing any names. This may be redundant, but I'd like to mention it just to be sure: the invitees for Sessions 2 and 3 have already received a guest list that does not include the names of the invitees for Session 1. This will not change in the run-up to the consultation.

Best regards, also on behalf of *.1.2e
5.1.2e

From: 5.1.2e ‹5.1.2e >
Sent: Friday, March 21, 2025, 10:22 a.m.
To: 5.1.2e ‹5.1.2e @gr.nl>; 5.1.2e
•5.1.2e >; 5.1.2e <‹5.1.2e
CC: 5.1.2e ‹5.1.2e @gr.nl>; 5.1.2e ‹5.1.2e @gr.nl>
Subject: Re: Invitation Letter for Parents and Youth

Hello 5.1.2e and 5.1.2e

A few comments (in addition to the earlier ones from 5.1.2e regarding the letter:

- At the end of the first introductory paragraph, you could add a sentence stating that participants must still formally confirm their attendance with your office (as explained at the end of the letter), so that they don't forget.
- I have some reservations about using PowerPoint presentations in Session 1, but you may still want to offer this as an option. Given the informal setting we discussed—which is desirable—I don't think PowerPoints are particularly appropriate. However, providing one A4 sheet per parent/child is certainly valuable.
- It's understandable that you'd first outline the formal matters (Health Council/Request for Advice on transgender care for young people/Committee drafting the advice) and then provide further information to the parents. Still, the letter could be made a bit more personal if, after the introductory paragraph, you were to include one or two transitional sentences before moving directly to the purpose and details of the consultation. After that, you can still include the three paragraphs covering the formal matters.

That concludes these comments. Please don't feel obligated to act on them.

We asked the parents if we could share their email addresses so the invitation could be sent directly to them, and the parents gave their consent to share them.

The addresses are as follows:

5.1.2e - 5.1.2e
5.1.2e - 5.1.2e
5.1.2e - 5.1.2e
5.1.2e - 5.1.2e
5.1.2e - 1.2e
5

And the Go coaches:

5.1.2e - 5.1.2e
5.1.2e - 5.1.2e

Note: Children sometimes have a different last name than their parents, so please do not address both with the same last name.
Also, in response to your question, it is not necessary to write to the young people separately.

Best regards,

5.1.2e
5.1.2e

m: 5.1.2e
e: 5.1.2e

5.1.2e

From: 5.1.2e •5.1.2e per nl>
Sent: Thursday, March 20, 2025, 4:31 PM
To: 5.1.2e ‹5.1.2e >; 5.1.2e ‹5.1.2e >;
5.1.2e •5.1.2e >
cc: 5.1.2e ‹5.1.2e ter nl>; 5.1.2e ‹5.1.2e ter nl>
Subject: Invitation Letter for Parents and Youth

Dear s ‘“ 5.1. E'n 5 1 *e

We'd like to respond to your offer to review the invitation letter for parents and young people. We've addressed this letter to the parents, but please let us know if you think it would be helpful to create a version for the young people as well.

We look forward to your feedback.

Best regards,
5.1. and 5.1.2e

Tel. +3 1 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

This message is intended solely for the addressee(s). If you have received this message in error, please contact us by replying to this email.

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This message is intended exclusively for the addressee(s). If you have received this message in error , please contact us by replying to this email. Access to, use of, and distribution of the contents of this message are reserved for the addressee or their authorized representative. We cannot guarantee nor do we accept liability for the accurate and complete transmission of the contents of a sent email message, nor for any viruses transmitted therein.

053

Fro m: 5.1.2e
To: **5.1.2e**
Cc:
Subject: RE: Follow-up on the advisory process regarding transgender care for youth Thursday, May 1, 2025, 2:48:00 PM
Datm»:

Hello“'“

Thank you once again for participating in the consultation. We certainly look back on a successful consultation. Thank you also for your offer to answer any follow-up questions and to put us in touch with people who have completed their transition. We will keep this in mind.

As for the timeline for the advisory process, the goal is indeed to publish the advisory report in the first quarter of 2026.

Best regards, 5.1.2e

From: 5.1.2e ‹5.1.2e >
Sent: Thursday, April 24, 2025, 2:51 PM
To: 5.1.2e W.1:2e @gr.nl>; 5.1.2e) ‹5.1.2e @gr.nl>
Subject: Follow-up on the advisory process regarding transgender

care for young people Hello 5.1.2e 5.1.2e

I hope the consultation on April 11 met your expectations and those of the committee. If you have any questions regarding the follow-up, please let me know.

As I briefly mentioned during Session 2, we at 5.1.2e ,
we've been in contact with a few people who have undergone detransitioning, but they do not meet the profile you requested (those who began treatment before age 18 and underwent detransitioning between the ages of 18 and 30).
If you still wish to speak with people who have completed their transition and are unable to find suitable candidates, please feel free to contact me again. Then we can see if there might still be a way to make it work. Please know that at 5.1.2e we recognize the existence of detransition and view this group as part of our target audience. At the same time, however, this really only concerns a very small portion of the people who have transitioned.

Finally, I had a question about the current timeline for the advisory process. I heard that the final report is scheduled to be published in Q1 2026.
Is that correct?

Best regards,

5.1.2e



5.1.2e

m: +5.1.2e
e: 5.1.2e

5.1.2e

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058

From 5.1.2e
: To: 5.1.2e ;5.1.2e
Cc: 5.1.2e
Subject: RE: Update on transgender care
Date: Friday, June 6, 2025, 5:23:38 PM
Attachments: image001.jpg

Hi,
If I check our calendars, that should work out. Could you send us a meeting request?
Have a great weekend!
5.1.2e

From: 5.1.2e @gr.nl>
Sent: Friday, June 6, 2025, 5:04 PM
To: @minvws.nl>; 5.1.2e @minvws.nl>
CC: 5.1.2e @gr.nl>
Subject: Update on transgender care

To 5.1.2e and 5.1.2e

The fifth meeting in the advisory process on transgender care for young people is scheduled for the end of this month. We think it would be a good idea to speak with each other (online) before then to catch up. Would you be available on Thursday, June 12, from 10:00–10:45 a.m. via Webex?

Have a great weekend. Best regards, also on behalf of
5.1.2e 5.1.2e

Tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

065

From 5.1.2e
: To: 5.1.2e ; 5.1.2e
Cc: 5.1.2e
Subject: RE: Update on Health Council of the Netherlands recommendation
Date: Tuesday, November 25, 2025, 1:12:00 PM

Ha 5.1.2e

Thank you very much for the feedback. It's good to hear that you have no issues with it. We'll draft a brief note shortly.

Best regards, also on behalf of 5.1.2e
5.1.2e

From: 5.1.2e @minvws.nl>
Sent: Tuesday, November 25, 2025, 9:04 AM
To: 5.1.2e @gr.nl>; 5.1.2e
@minvws.nl>; 5.1.2e @gr.nl>
Subject: RE: Update on Health Council of the Netherlands recommendation

Hi everyone,
Yesterday, I discussed a possible postponement with my management team member. We have no issues with it.
We'd rather have sound, well-considered advice and a thorough process than a rushed job.

It would be nice to receive official confirmation of the postponement in writing or via email. We do need to inform the House of Representatives.

Regards,
5.1.2e

-----Original Agreement-----
From: 5.1.2e @gr.nl>
Sent: Thursday, November 20, 2025, 4:17 PM
To: 5.1.2e ;5.1.2e ; 5.1.2e ;
5.1.2e
Subject: Update on Health Council of the Netherlands advice
Time: Monday, November 24, 2025, 10:00–10:30 (UTC+01:00) Amsterdam, Berlin, Bern, Rome, Stockholm, Vienna.
Location: Microsoft Teams meeting

Ha 5.1.2e and 5.1.2e

It's been a while since we last spoke. Hope you're all doing well. We'd like to briefly discuss two points that need to be presented to our board on Tuesday. Can we have a quick (video) call on Monday?

Best regards, also on behalf of 5.1.2e
5.1.2e

Microsoft Teams Need help?

Join the meeting now

Meeting ID: 320 379 812 096 28 Passcode:
QK6Qc9jh

Join on a video conferencing device

Tenant key:rijksoverheid@m.webex.com
Video ID: 129 589 342 2
More information

For Organizers: Meeting Options

071

From 5.1.2e
: To: 5.1.2e ; 5.1.2e
Cc: 5.1.2e
Subject: RE: Letter regarding postponement of publication
Date: Wednesday, December 17, 2025, 4:53:00 PM
Attachments: image001.jpg

Ha 5.1.2e

I don't know when the Dutch Healthcare Institute will announce this (or if it has already been announced), but that could indeed be the case. It is standard practice for a postponement letter to also be posted on our website. This has not yet been done, but it will be done shortly.

Best regards,
5.1.2e

From: 5.1.2e @minvws.nl>
Sent: Tuesday, December 16, 2025, 1:59 PM
To: 5.1.2e @gr.nl>; 5.1.2e @minvws.nl>
CC: 5.1.2e @gr.nl>
Subject: RE: Letter regarding postponement of publication

Thank you,
We'll discuss internally how to inform the House of Representatives about this.
I was thinking of doing that at the same time as the announcement from the Healthcare Institute that the quality standard for somatic transgender care will be released later.

Gr
5.1.2e

From: 5.1.2e @gr.nl>
Sent: Monday, December 15, 2025, 4:24 PM
To: 5.1.2e @minvws.nl>; 5.1.2e @minvws.nl>
CC: 5.1.2e @gr.nl>
Subject: Letter regarding postponement of publication

Section 5.1.2e and 5.1.2e

Some time ago, we informed you that we expect to publish in Q2 instead of Q1, as stated in the introductory letter. The minister has just been informed of this in a letter. I am enclosing the letter in question for your information.

Best regards,
5.1.2e

5.1.2e
Scientific Secretary



tel. +31 6 (Mon–Fri)
Visiting address: Bezuidenhoutseweg 3D, 2594 AV Den Haag
www.gezondheidsraad.nl

075

From 5.1.2e
: To: 5.1.2e ; 5.1.2e
Cc: 5.1.2e
Subject: RE: Letter regarding postponement of publication
Date: Friday, December 19, 2025, 11:52:00
Attachments: image001.jpg

Ha 5.1.2e

Thank you for your feedback. I completely agree with you that the minister must be informed first, and I want to avoid duplicating efforts. In this case, the minister is our client, which is why last Monday's letter was sent directly to him. If all goes well, he should already be aware of the letter. But I understand if you'd like to provide further clarification on that. In the interest of transparency, we believe it's important not to wait too long to post the letter online. Would it be a good idea to aim for the first week after the Christmas break?

Wishing you a very happy holiday season! Best regards,
5.1.2e

From: 5.1.2e @minvws.nl>
Sent: Thursday, December 18, 2025, 5:37 PM
To: 5.1.2e @gr.nl>; 5.1.2e @minvws.nl>
CC: 5.1.2e @gr.nl>
Subject: RE: Letter regarding postponement of publication

Hi 5.1.2e
I just discussed this with my management team member. We believe the minister should be informed first before you post this on your website.
Shall we just handle that properly in early January first, and then have you post it?

We'll draft a memo for him so he's informed. Regards, 5.1.2e

Sent with BlackBerry Work
(www.blackberry.com)

From: 5.1.2e @gr.nl>
Date: Monday, Dec. 15, 2025, 4:23 PM
To: 5.1.2e @minvws.nl>, 5.1.2e @minvws.nl>
CC: 5.1.2e @gr.nl>
Subject: Letter regarding postponement of publication

Day 5.1.2e and 5.1.2e

Some time ago, we informed you that we expect to publish in Q2 instead of Q1, as stated in the status letter. The minister has just been informed of this in a letter. Please find attached the letter in question for your information.

Danique

5.1.2e
Scientific Secretary

Tel. +31 6 (Ms. Tim Vrij)
Visiting address: Bezuidenhoutseweg 3D, 2594 AV Den Haag
www.gezondheidsraad.nl

081

From:	**5.1.2e**
To:	**5.1.2e**
Cc:	5.1.2e ; 5.1.2e ; 5.1.2e ; 5.1.2e ; 5.1.2e
Subject: Date:	**RE: Parliamentary questions from the SGP and ChristenUnie regarding**
Attachments:	**the GR investigation Tuesday, January 13, 2026, 4:57:U0 p.m.**
	imaneÜf/1 nnn

Day 5.1.2e

Thank you for forwarding the parliamentary questions. We are, of course, willing to provide input for the responses to the questions pertaining to the Health Council. Could you let us know on which points you need our input?

Best regards, also on behalf of 5.1.2e
5.1.2e

From: 5.1.2e @minvws. nl>
Sent: Tuesday, January 13, 2026, 3:03 PM
To: 5.1.2e @minvws.nl>
cc: 5.1.2e @minvws.nl>; 5.1.2e
@gr.nl>; Vroling, 5.1.2e @gr.nl>
Subject: Parliamentary questions from the SGP and ChristenUnie regarding the GR investigation

Date 5.1.2e

I have received parliamentary questions regarding an investigation at the GR.

My first question was whether these should be answered by the GR account manager or by the policy department. You already indicated that it is customary for the policy department to handle this.

Could you please indicate which questions you are able to answer?

5.1.2e **And for** 5.1.2e, **could you please provide some input on the questions below?**

We'll work together to answer 5.1.2e. They're currently listed under CZ, but if you think they belong under PZo, I'll move them over.

Best regards

5.1.2e

2026Z00341
(submitted January 13, 2026)

Questions from members Diederik van Dijk (SGP) and Bikker (ChristenUnie) to the Minister of Health, Welfare, and Sports regarding the Health Council of the Netherlands' study on the prescribing of puberty blockers to minors with gender dysphoria

1. Are you familiar with the article by Prof. J.L. Smeehuijzen, "The Health Council of the Netherlands and the Regulatory Climate Surrounding Puberty Blockers for Minors," published in the Nederlands Juristenblad?[1]

2. What is your response to Prof. Smeehuijzen's findings regarding the independence and the appearance of conflicts of interest among the members of the Health Council committee investigating the health law and medical aspects of the use of puberty blockers in minors with gender dysphoria?

3. In your view, how does the composition of the aforementioned committee align with the "Code for the Prevention of Undue Influence Due to Conflicts of Interest," which requires the Health Council to compose its committees in such a way that the risk of judgment being skewed by institutional, professional, or personal interests is minimized and the credibility of the advice remains assured?

4. In particular, how do you respond to the fact that half of the committee has a substantial connection to the intervention it is tasked with evaluating?

5. Could you explain how the Health Council's internal control mechanisms are organized with regard to the independence of its studies and the researchers involved?

6. How do you assess the very limited legal expertise that, as evidenced by the committee's composition, is present within the committee? Are you confident that the committee is capable of rendering a well-founded judgment on how current practices in the Netherlands align with the applicable health law framework?

7. What is your response to the concerning remarks made by Prof. Smeehuijzen regarding the broader Dutch regulatory climate surrounding puberty suppression? Given the close intertwining of clinical care, research, and policymaking, how is the independence and impartiality of scientific research ensured?

8. As Minister of Health, Welfare, and Sport, how do you safeguard your own position in this matter? In addition to your contacts with the relevant University Medical Centers (UMCs), are you also engaging in dialogue with doctors and scientists who are critical of Dutch practices regarding puberty blockers? If so, how is this taking shape, and to what extent?

9. Can you specify exactly what the current status of the Health Council's study is? When does the committee expect to complete the study?

10. Is it the intention that the revision of the Quality Framework for Transgender Care will not be completed until the Health Council's advisory report is issued?

[1] Nederlands Juristenblad 2025/2811, Lodewijk Smeehuijzen, "The Health Council and the Regulatory Climate Surrounding Puberty Blockers for Minors," pp. 3464–3471.

Best regards

5.1.2e

5.1.2e | Ministry of Health, Welfare, and Sport |
Ministry of Health, Welfare, and Sport – Curative Care Directorate
Parnassusplein 5; 2511 VX The Hague; Mailing Address: P.O. Box 20350; 2500 EJ The Hague
Phone: (070) 5.1.2e | Cell: 06 5.1.2e | 5.1.2e @minvws.nl|

5.1.2e .

089

From: 5.1.2e
Aan: 5.1.2e
Onderwerp: RE: Health Council | Consultation on the Advisory Report on Transgender Care by Jorlgereu
Subject: Friday, February 20, 2026, 3:59:00 PM
Bijlagen: ima0e€02

Hello

Thank you very much for your quick and positive response! We'll send you the advice via this channel in due time. We'll also be in touch to schedule an online meeting.

Have a great weekend! Best regards,

Yan 5.1.2e
Sent: Thursday, February 19, 2026, 9:00 PM
To: @gr.nl>
Subject: RE: Health Council | Consultation on Advice Regarding Transgender Care for Youth

I'd be happy to, !

Please send it to this address in early April. Best

regards,
5.1.2e

From: 5.1.2e vnl»
Written by: donderdag 19 februari 2026 15:34
To: 5.1.2e
Subject: Gezondheidsraad | Raadpleging advies Transgender Care for Youth

You don't often receive emails from 5.1.2e waarom dit belangrijk is
CAUTION: This email originated from 5.1.2e Do not click links or open attachments unless you recognize the sender and know the content is safe.

Dear ,

The Health Council of the Netherlands is currently working on a recommendation regarding transgender care for children and adolescents. The request for advice stems from two motions asking to assess whether the Quality Standard for Transgender Care—Somatic fits within the legal framework for healthcare, what is known about physical and mental health outcomes, and what is known about regret following treatment according to the Dutch protocol. The request for advice has been assigned to the temporary committee on Transgender Care for Youth.

The committee would like to verify its views and assess whether it has overlooked any relevant legal insights in its advisory opinion. Your expertise and extensive experience with the work of the Health Council are indispensable in this regard. We would like to ask you, as an expert consulted on an ad hoc basis, to review an advanced draft of the advisory opinion. We would appreciate receiving your findings via an online discussion with the committee secretaries, the chair, and a committee member who is a legal expert. We also have asked them to review it as well.

We could send you the advisory opinion on April 3, after which we hope to schedule an online meeting on Tuesday, April 14, or Wednesday, April 15.

Are you willing to provide feedback on the committee's draft recommendation? I look forward to your response.

Sincerely,

Scientific Secretary

Tel.
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

100

From: 5.1.2e
To: 5.1.2e ; 5.1.2e
Cc: 5.1.2e ; 5.1.2e
Subject: **RE: GR Briefing on Transgender Care for vcor**
Date: **Youth, Thursday, May 21, 2026, 09:13:15**

I think I'll send you a short message ï

Sent via BlackBerry Work
(www.blockberry.con)

From: 5.1.2e a>
Date: Thursday, May 21, 2026, 9:07 AM
Aan: 5.1.2e @minvws nl>, 5.1.2e
@gr nl>
Kopie: 5.1.2e @minvws nl>, 5.1.2e
@minvws nl>
Subject: RE: GR Briefing on Transgender Care for Youth

Hi 5.1.2e

Sure. It's standard practice during briefings on our recommendations that we give a presentation lasting no more than 10 minutes. Afterward, there will be time for questions and discussion.
However, preparing the materials for the minister's briefcase is your responsibility.

See you this afternoon,
512e

From: 5.1.2e @minvws. nl>
Sent: Wednesday, May 20, 2026, 8:14 PM
To: 5.1.2e **@gr.nl>; 5.1.2e** @gr.nl>
cc: 5.1.2e **@minvws.nl>; 5.1.2e**
@minvws.nl>
Subject: RE: GR Briefing on Transgender Care for Youth

Hi 5.1.2e and 5 1.2e
I assume you'll be handling the
preparations for this.

Gr
5.1.2e

Maybe we could be copied on the preparation materials

Sent with BlackBerry Work
(www.blackberrv.com)

From: 5.1.2e @minvws nl>

Date: Wednesday, May 20, 2026, 3:25 PM
To: 5.1.2e @minvws.nl>
CC: 5.1.2e @minvws.nl>, 5.1.2e @minvws.nl>, 5.1.2e @minvws.nl>, 5.1.2e @minvws.nl>, 5.1.2e @minvws.nl>
Subject: GR Briefing on Transgender Care for Youth

Good afternoon,

On **Monday, June 22, 2026, from 9:30 a.m.** to **10:00 a.m.**, the GR briefing on transgender care for youth (101) is scheduled to take place in Minister Hermans' office.

Please let us know who from CZ will be attending, and please submit your preparation materials by *Friday, June 19,* at *12:00 p.m.* at the latest.

Best regards, 5.1.2e

5.1.2e
Secretariat of Minister of Health, Welfare, and Sports Sophie Hermans M 06
5.1.2e

101

From: 5.1.2e
To: 5.1.2e
Cc: 5.1.2e ; 5.1.2e
Subject: SGP's Responses to Parliamentary Questions
Date: Thursday, June 4, 2026, 5:15:35 PM
Attachments: Parliamentary Questions Answers DRAFT.docx

Ha 5.1.2e

Following up on our phone conversation yesterday. We'd really appreciate it if you could help us. In a number of answers, we refer to the GR advisory opinion. I'd like to ask you to check whether that's correct and whether that reference might conflict with the confidentiality of the advisory opinion's content, as we had discussed. I've included your name in the comments for those documents. If you notice any other inaccuracies, please let me know.

Feel free to call me if you have any questions

about this. Best regards,

5.1.2e

Curative Care Directorate – Team A
Ministry of Health, Welfare, and Sports Available: Mon–Fri
+316
5.1.2e minvws.nl

102

From 5.1.2e
: 5.1.2e
To: 5.1.2e
Cc: ; 5.1.2e
Subject: Date: RE: Chamber Questions and Notes DRAFT
Attachments: Thursday, June 11, 2026, 3:53:00 PM
Chamber Questions and rçïen DRAFT
5.1.2e

Subject: Êi.1.2e

Thank you for sending the draft answers. We have reviewed the answers for factual inaccuracies; please find our response below.

Best
regards,
5.1.2e

From: 5.1.2e @minvws.nl>
Sent: Tuesday, June 9, 2026, 9:08 a.m.
To: 5.1.2e @minvws.nl>; 5.1.2e
@gr.nl>
cc: 5.1.2e @minvws.nl>; 5.1.2e @minvws.nl>
Subject: RE: Answers to Parliamentary Questions (DRAFT)

Hi Ö.1.2e and 5.1.2e

Here is the input from 1 2e and me. Please let us know if you have any further questions.

Best
regard
s,
5.1.2e

From: 5.1.2e @minvws nln
Sent: Monday, June 8, 2026, 2:21 PM
To: 5.1.2e ter nl>; 5.1.2e
Éöminvwr nl>
CC: 5.1.2e (öminvws nl>
Subject: Answers to Parliamentary Questions (DRAFT)

I've added a few more details to the questions in 5.1.2e

Gr
5.1.2e

From: [redacted]
To:
Cc:
Subject: RE: Urgent Concerns Regarding the Independence of the Temporary Committee on Transgender Care for Youth
Date: Wednesday, October 29, 2025, 12:33:49 PM
Attachments: 20251029 GR Response to Email [redacted] iz Transgender Care for Youth Committee signed.pdf image001.jpg

---

Dear Sir [redacted]
Please find attached a letter in response to your emails. I trust this

has provided you with sufficient information.

Sincerely,

[redacted]



Bezuidenhoutseweg 30 - 2594 AV - The Hague
www.gezondheidsraad.nl

From: [redacted] <[redacted]@gmail.com>
Sent: Friday, October 10, 2025, 12:04 PM **To:**
[redacted] <[redacted]@gr.nl>
Subject: Re: Urgent concerns regarding the independence of the temporary committee Transgender Care for Youth

Dear Madam [redacted]

Thank you very much for your response. I look forward to your further reply.

I understand and respect the request not to contact committee members individually. I would like to explain why I nevertheless feel the need to bring my concerns directly to your attention.

In recent years, I have repeatedly indicated to the "[redacted]" that parents should also be involved in the hearings. Unfortunately, this request has not been heeded to date. The limited speaking time allotted at the time to [redacted] and [redacted] does not, in my opinion, adequately reflect the complexity and social relevance of this sensitive topic.

Below you will find my previous request to the [redacted] (sent over half a year ago), in which I asked to be given a voice. This request was rejected at the time.

I am now, along with another individual, investigating the legal options against the clinic where our children are being subjected to hormonal and possibly surgical interventions that we consider unjustified, accompanied by a serious health risk. This is also relevant to your committee because one of the committee members is also the director of one of the gender clinics involved.

To prevent further escalation, I would prefer not to engage in a dialogue with the committee. My impression is that a large portion of the members is likely insufficiently familiar with recent and international developments in the gender care debate, including:

- The **Cass Review,** the WPATH **Files,** and the recent **HHS report:**
- Maisha11's **amicus brief** to Tennessee and the **FTC conference;**
- the publications and analyses **by A Wider Lens, Beyond Gender, SEGN,** and **Genspect.**

In addition, I have delved into older Dutch- and German-language literature by authors such as **Kuiper, Gooren, De Cuypere, Bockting, Van Leeuwen, and Pfäffchen,** which formed the basis of the current international discourse. Upon closer examination of these highly out-of-print books, I have identified significant methodological shortcomings and inconsistencies that raise questions about the scientific justification for somatic care, even for adults.

I am currently collaborating with international researchers (including [redacted] to digitize and publish these older sources so that they can be re-evaluated. In the coming months, I will participate in a closed meeting under **Chatham House Rules** with domestic and international experts on this subject.

Given the urgency and the legal implications, it seems advisable for me to personally brief the committee on these findings and their potential implications for the revision of somatic health care. I would also like to hold such a meeting with [redacted] also assisted me in a similar matter regarding the Raad van Bestriur and [redacted] Raad van Toezicht van [redacted]. I also had a similar conversation with e[redacted] met de directie van [redacted] omdat ik daar de gezonden [redacted] four sentences that are misleading and highly inaccurate regardi[redacted] zeer ontrust gelegend zijn door de [redacted].

May I kindly ask you to share this message and explanation with the other committee members, as a supplement to my previous correspondence and requests for consultation? Perhaps it would also be appropriate to inquire with th[redacted] why my earlier urgent request was so flatly rejected.

Sincerely,

[redacted]

[redacted]

Dear [redacted],

Thank you for your message. We have registered your inquiry via email under reference number [redacted] *. We will respond to your inquiry within 5 business days. If we are unable to respond within this timeframe, we will contact you.*

Description of your inquiry:

Sender: [redacted]

Date sent: Mar 14, 2025 8:12 AM

To: [redacted]

Subject: Request for a meeting with the committee regarding an update on transgender care

Hello, staff member of the [redacted]

Could you please forward this request to the committee currently working on an update to the transgender care protocol?

We, a group of concerned parents, are reaching out to you with an urgent request to have a face-to-face meeting regarding the current state of transgender care and the recent evaluations that are taking place. We are ***deeply concerned*** *about the way care for transgender youth is currently being provided and, as parents, feel that we are not being heard or taken seriously when we* ***voice criticism*** *of the care offered and the policies of the clinics involved.*

As parents, we increasingly find that ***critical questions and concerns*** *about our children's medical and psychological treatments are not appreciated and are even ignored. We are often dismissed as* ***"opponents"*** *of the care, even though our concerns do not stem from a lack of understanding, but from* ***genuine worry*** *about the* ***long-term effects*** *of certain treatments. We have recently gathered a great deal of evidence that, in our view, demonstrates that there are* ***systemic problems*** *with the way transgender care is provided and that insufficient consideration is given to the* ***long-term consequences*** *for the young people involved and their families. Family breakdown is all too common in our group.*

We are currently a group of about ***50 parents*** *who connect through a private Facebook group that has only been in existence for one year. The group grows weekly with new members, all sharing the same concerns and experiences. Most parents in our group are experiencing* ***significant stress****, feel* ***at their wits' end****, and feel powerless in the face of the current situation. We are seeing a trend of* ***burnout and frustration*** *that is only exacerbated by a lack of transparency and communication. Many of us feel* ***rejected by the clinics*** *as soon as we voice our concerns and are afraid that our children will be unjustly placed on treatment pathways that* ***ultimately are not in their best interest****.*

Given the seriousness of the situation, we would greatly appreciate the opportunity to ***share our concerns and findings*** *with the committee currently working on updating transgender care guidelines. We hope that an open dialogue can take place, during which we can emphasize*
what ***important and urgent questions*** *parents have, and how we can work together to find a* ***more balanced, transparent, and thoughtful approach*** *to transgender care.*
We believe it ***is crucial that parents, as stakeholders and sources of information, have a voice*** *in the evaluation and future direction of this care.*
We sincerely hope that the Zorginstituut will take our request seriously and that we will soon be able to schedule a meeting.
We look forward to your
response. Sincerely,
[redacted]
On behalf of a group of concerned parents of transgender children

If you have any questions or comments, please reply to this email. Please make sure to keep the reference number in the subject line.

Sincerely,

[redacted]

On Thu, Oct 9, 2025, at 8:13 AM, [redacted] <[redacted]@gr.nl> wrote:

> Dear Sir [redacted]
>
> We have received your email forwarded to us by Mr. [redacted], a member of the Health Council's Ad Hoc Committee on Transgender Care for Youth. We are reviewing your inquiry and will send you a response within the specified timeframe of 15 business days. We kindly ask that you refrain from contacting committee members directly and instead always address the Health Council directly if you have any questions regarding the committee's work or the Council's recommendations.
>
> Sincerely,
> [redacted]

Bezuidenhoutseweg 30 - 2504 AV - The Hague
www.gezondheirlsrBBd.nl

From: all co >
Sent: Monday, October 6, 2025, 2:40:1P9M
Aan: [redacted]
Subject: Urgent concerns regarding the independence of the temporary committee on transgender care for young people

Dear Mr. .

I am writing to you in light of your appointment to the Ad Hoc Committee on Transgender Care for Youth, which was established to respond to the request for advice from the Ministry of Health, Welfare, and Sport. The committee was inaugurated on February 5, 2025.

After carefully reviewing the commission's terms of reference, I have serious concerns about the independence of its members. A significant number of the commission members are directly involved as specialists at various clinics. This raises fundamental questions about the objectivity and impartiality of the advice the commission will provide.

Personally, I am involved in an ongoing conflict with the .
My experience has given me insight into the risks and problems that can arise for critical families in the context of transgender care. This issue has been known for decades and has been extensively documented, among other *places,* in the book **1-fry*, by* Riekje van Leeuwen (1992), which describes how transsexuality places a heavy emotional burden on the immediate social circle and clearly highlights the inaccuracy of the early Dutch protocol. The approach for (young) adults has never been adapted to the gender-critical perspective presented in the book.

My own intervention, using **a broadened hetero-anamnesis** (see Appendix: Genspect Survey NL) has shown that the clinic's account is not entirely accurate. Together with [redacted] held discussions with the Board of Directors and the Supervisory Board of the [redacted]. Together with my attorney, I am currently investigating the best strategy to have these errors corrected.
[redacted] has also sent a number of letters to the boards of directors of other large hospitals that have gender clinics.

In addition, I have already found about ten parents who were also misled by various clinics and who have evidence of misconduct. As a result, meetings will soon be taking place in [redacted], and a parent from the northern part of the country

followed my strategy involving the hetero-anamnesis and is also consulting with a lawyer. Based on these experiences, there appears to be systematic deception of parents, with potential financial and legal consequences such as insurance fraud.

Attached you will find my findings, presented during a meeting in Vienna under the Chatham House Rules, which was aimed at parent groups and lawyers who are critical of current gender care practices. This letter has also been submitted to the Board of Directors and the Supervisory Board of [redacted] ADF International, SEGM, and Genspect support my actions, are closely monitoring my case, and are guiding me with their expertise and knowledge.

Given the significant interests at stake and the potential systemic issues within current practice, I consider it of the utmost importance that the committee's independence be carefully safeguarded. I ask that you give this matter the highest priority.

I also recommend [redacted] contact me to schedule a personal meeting.

If you would like, I would also be happy to consult with you.

Could you please provide a response?

Sincerely,
[redacted]

[redacted]

[redacted]

148

Health Council

To Mr. 5.1.2e

by email: 5.1.2e @gmail.com

Date: October 29, 2025 Your reference: - Our reference: 4262968-4262977 5.1.2e Gen.
Phone: 070 5.1.2e Email: 5.1.2e @gr.nl Attachments: -

Subject: Your email regarding the independence of the Temporary Committee on Transgender Care for Youth

Dear Mr. 5.1.2e

On October 9, 2025, I received the message you sent to several members of the Transgender Care for Youth Committee. I would like to thank you for taking the time to express your concerns about the advisory process to us. In your correspondence, you indicate that you have concerns about the independence of the Transgender Care for Youth Committee. You also question whether the perspective of critical parents is sufficiently taken into account in the response to the advisory request. I would first like to explain the process for forming committees at the Health Council of the Netherlands. I will then address your question regarding the perspective of critical parents.

The Health Council of the Netherlands is a scientific advisory body that advises the government and parliament on public health and health care. The Council's recommendations are based on an unbiased, transparent evaluation of scientific data, facts, and opinions. We ensure the quality and independence of our recommendations in various ways:

- The board, in consultation with the scientific secretariat, assesses which areas of expertise are necessary within the committee to address the specific advisory question.
- The committee consists of experts in their respective fields.
- When forming the committee, care is taken to ensure that the experts come from various university medical centers, universities, and research institutions.
- The committee has a multidisciplinary composition to incorporate as many viewpoints and perspectives as possible when addressing the advisory request.
- As the Health Council, we value our independence. To safeguard this independence, we maintain a strict policy regarding (apparent) conflicts of interest. In this regard, we follow the *Code for the Prevention of Improper Influence Due to Conflicts of Interest*. Prospective committee members are asked to complete a declaration of interests and to provide insight into their potential intellectual interests, financial interests, personal relationships, reputation management, and externally funded research. The board assesses whether there are any (apparent) conflicts of interest that would prevent participation in the committee as a full member. Please refer to our website, which describes how we handle conflicts of interest.

Based on the *Code for the Prevention of Undue Influence Due to Conflicts of Interest*, two individuals on the Committee on Transgender Care for Youth have been appointed as regularly consulted experts rather than committee members. The interests of the committee members and regularly consulted experts are public and are listed on the Health Council of the Netherlands' website.

In your letter, you also indicate that you wish to bring the perspective of critical parents to our attention. Furthermore, you draw our attention to recent and international developments within the gender care debate.

Visiting address
Bezuidenhoutseweg 30
2594 AV The Hague

e. 5.1.2e
Tel. 070 5.1.2e
www.gezondheidsraad.nl

The committee bases its advice on the available scientific literature and research reports. The reports you refer to, such as the *Cass review* and the HHS report, are also part of the literature review and the committee's deliberations.

In the context of transgender care for young people, the Health Council considers it important to take into account perspectives that are not, or hardly, found in the literature, such as expert opinions, practical knowledge, and experiential knowledge from, among others, young people and parents. For this reason, the Council organized a consultation earlier this year, to which stakeholders and experts by experience (both children and parents) with both positive and negative experiences with transgender care were invited. In addition to that consultation, the committee will discuss your email so that all committee members can take note of it.

We hope this information is sufficient.

Sincerely,

5.1.2e

Dr. I.D. de Wolf,
General Secretary-Director

149

Fro m: 5.1.2e
To: 5.1.2e ; 5.1.2e
Subject: Re: Urgent Concerns Regarding the Independence of the Temporary Committee on Transgender Care for Youth
Date: Monday, November 10, 2025, 3:01:34 PM
Attachments: image001.jpg
Response to the letter of October 29.pdf
WPATH Files - Mia Hughes English.pdf
WPATH Files - Mia Hughes Dutch.pdf
FTC-The-Dangers-of-Gender-Affirming-Care-for-Minors-Transcript.pdf
FTC-The-Dangers-of-Gender-Affirming-Care-for-Minors-Transcript.en.nl.pdf
2024.10.15-Ala.-Amicus-Br.-iso-TN-FINAL.pdf
2024.10.15-Ala.-Amicus-Br.-iso-TN-FINAL.en.nl.pdf

Dear Ms. 5.1.2e

Here is my response to the letter from your colleague, Dr. I.D. de Wolf.
I am copying Chair 5.1.2e on this email because the letter concerns her committee.

You will also find several PDF files attached. These have been included because they are referenced in the letter and are important legal documents related to the subject the committee is currently investigating. I have also included machine translations of these documents to make them easier and faster to read.

I look forward to your response.

Sincerely,
5.1.2e

On Wed, Oct 29, 2025, at 12:33, 5.1.2e wrote <5.1.2e @gr.nl>:

> Dear Mr. 5.1.2e
>
> Please find attached a letter in response to your emails.
>
> I trust that this has provided you with sufficient information.
>
> Sincerely,
>
> 5.1.2e
>
> 5.1.2e

Bezuidenhoutseweg 30 - 2fi94 AV - The Hague

www.gezondheidsrBad.nl

From: 5.1.2e 5.1.2e Email cnm>
Sent: Friday, October 10, 2025, 12:04 p.m.
To: 5.1.2e •5.1.2eper nie
Subject: Re: Urgent concerns regarding the independence of the Temporary Commission on Transgender Care for Youth

Dear Ms. 5.1.2e

Thank you very much for your response. I look forward to your further reply.

I understand and respect the request not to contact committee members individually. I would like to explain why I nevertheless feel the need to bring my concerns directly to your attention.

In recent years, I have indicated to the Dutch Healthcare Institute on multiple occasions that parents should also be involved in the hearings. Unfortunately, this request has not been heeded to date. The limited speaking time allotted at the time to 5.1.2e and Prof. 5.1 .2e is, in my opinion, insufficient to do justice to the complexity and social relevance of this controversial topic.

Below is my earlier request to the 5.1.2e (sent half an hour ago), in which I requested the opportunity to be heard. This request was rejected at the time. In the meantime, along with another parent, I am exploring the legal options against the clinic where our children are being harmed—both psychologically and possibly surgically—in a way we consider unjustified, accompanied by severe family disruption. This is also relevant to your committee because one of the committee members is also the director of a gender clinic involved in this matter.

To prevent further escalation, I would like to engage in a dialogue with the committee. My impression is that a large number of the members may be insufficiently familiar with recent and international developments within the gender care debate, including:

the **Cass Review,** the WPATH **Files,** and the recent **HHS report;**

- Marshall's **amicus brief** to Tennessee and the **FTC conference;**
- the publications and analyses by A **Wider Lens, Beyond Gender, SEGM,** and **Genspect.**

Therefore, I have delved into the older Dutch-language and German literature by, among others**, Kuiper, Gooren, De Cuypere, Bockting, Van Leeuwen**, and **Pfäffchen,** which formed the basis of the current international treatment model. Upon studying these highly sold-out books, I have encountered significant methodological shortcomings and inconsistencies that raise serious questions about the scientific justification for somatic care, even for adults.

I am currently collaborating with international researchers (wnnionder to digitize and translate these older sources so they can be reevaluated. Next Monday, I will participate in a closed-door meeting under **the Chatham House Rules** with domestic and international experts on this subject.

Given the urgency and the legal implications, I believe it would be advisable for me to personally brief the committee on these findings and their potential implications for the revision of somatic gender care. I would like to schedule such a meeting in accordance with Article 5. .2e who also assisted me during my meeting with the Executive Board and Supervisory Board of Radboud Hospital. Dr. 5.1 .2e will also soon have a similar meeting with the management of 5. 1 .2e, because I have found four families there who were misled and treated very unfairly by the .1.2e

May I kindly ask you to share this email and explanation with the other committee members, as a supplement to my previous correspondence and requests for action Perhaps it would also be appropriate to inquire with 5.1.2e why my earlier urgent request was so categorically rejected.

Sincerely,
5.1.2e

Nerlerlrutrl Healthcare Institute .5. 1 .2e

Dear 5.1.2e

Thank you for your message. We have registered your request under A-Kiai/reference number S.1.2e *We will respond to your inquiry within 5 business days. If* we *are unable to respond to your inquiry within this timeframe,* we *will*
.

Summary *of your inquiry:*

Sender: 5.1.2e *@gmail.com*
Date sent: Mar 14, 2025 8:12 AM
*To: vragenaanzin@*5.1.2e*.nl*
Subject: Request for a meeting with the committee regarding updates on transgender care

Hello, staff member of 5.1.2e ,
Could you please forward this request to the committee currently working on an update to the transgender care protocol?
We, a group of concerned parents, are reaching out to you with an urgent request to have a face-to-face meeting regarding the current state of transgender care and the recent evaluations taking place. We are ***deeply concerned*** *about the way care for transgender youth is currently being provided and, as parents, feel that we are not being heard or taken seriously when we* ***voice criticism*** *of the care offered and the policies of the clinics involved.*
As parents, we increasingly find that ***critical questions and concerns*** *about our children's medical and psychological treatments are not appreciated and are even ignored. We are often dismissed as* ***"opponents"*** *of the care, even though our concerns do not stem from a lack of understanding, but from* ***genuine worry*** *about the* ***long-term effects*** *of certain treatments. We have recently gathered a great deal of evidence that, in our view, demonstrates there are* ***systemic problems*** *with the way transgender care is provided and that insufficient consideration is given to the* ***long-term consequences*** *for the young people involved and their families. Family breakdown is all too common in our group.*
We are currently a group of about ***50 parents*** *who connect through a private Facebook group that has existed for just one year. The group grows weekly with new members, all sharing the same concerns and experiences. Most parents in our group are experiencing* ***significant stress****, feel* ***at their wits' end****, and feel powerless in the face of the current situation. We see a trend*
of ***burnout and frustration*** *that is only exacerbated by a lack of transparency and communication. Many of us feel* ***rejected by the clinics*** *as soon as we voice our concerns and are afraid that our children will be unjustly placed on treatment pathways that* ***ultimately are not in their best interest****.*
Given the seriousness of the situation, we would greatly appreciate the opportunity ***to share our concerns and findings*** *with the committee currently working on updating transgender care. We hope that an open dialogue can take place, during which we can highlight the* ***important and urgent questions*** *on parents' minds, and how we can work together to find*
a ***more balanced, transparent, and careful approach*** *to transgender care.*
We believe it ***is crucial that parents, as stakeholders and sources of information, have a voice*** *in the evaluation and future direction of care. We sincerely hope that the Zorginstituut takes our request seriously and that we can schedule a meeting soon.*
We look forward to your
response. Sincerely, 5.1.2e

On behalf of a group of concerned parents of transgender children

If you have any questions or comments, please reply to this email. Please make sure to keep the reference number in the subject line.

Sincerely,

5.1.2e

On Thu, Oct 9, 2025, at 8:13 AM, 5.1.2e wrote <5.1.2e @gr.nl>:

Dear Mr. 5.1.2e

We have received your email, which was forwarded to us by Mr. 5.1.2e, a member of the Health Council's Ad Hoc Committee on Transgender Care for Youth. We are reviewing your inquiry and will respond within the specified timeframe of 15 business days. We kindly ask that you refrain from contacting committee members directly and instead always address the Health Council when you have a question about the committee's work or a recommendation from the council.

Sincerely,

5.1.2e

5.1.2e



Bezuidenhoutseweg 30 - 2594 AV - The Hague

www.gezondheidsraad.nl

From: 5.1.2e <5.1.2e @gmail.com>
Sent: Monday, October 6, 2025, 2:40:19 PM
To: 5.1.2e <5.1.2e >

Subject: Urgent Concerns Regarding the Independence of the Temporary Commission on Transgender Care for Youth

Dear Mr. 5.1.2e ,

I am writing to you in connection with your appointment to the Ad Hoc Committee on Transgender Care for Youth, which was established to respond to the request for advice from the Ministry of Health, Welfare, and Sports. The committee was inaugurated on February 5, 2025.

After carefully reviewing the committee's composition, I have serious concerns about the independence of its members. A significant number of committee members are directly involved as specialists at various clinics. This raises fundamental questions about the objectivity and impartiality of the advice the committee will issue.

Personally, I am involved in an ongoing conflict with Radboud Hospital. My experience provides insight into the risks and problems that can arise for critical families in the context of transgender care. This issue has been
decades and has been extensively documented, among other places, in the book **Hij, anders zij** by Riekje van Leeuwen (1992), which describes how transsexuality often places a heavy emotional burden on the immediate social circle and how the
flaws in the early Dutch protocol are already clearly evident. The
approach for (young) adults has never been adapted to address the fundamental criticisms raised in the book.

My own intervention, using **an expanded hetero-anamnesis** (see Appendix: Genspect Survey NL), has shown that the clinic's account is not entirely accurate. Together with Dr. 5.1.2e , I have been in consultation with the Board of Directors and the Supervisory Board of Radboud Hospital. Together with my attorney, I am
the best strategy to have these errors corrected.
Dr. 5.1.2e has also sent a number of letters to the Boards of Directors of other major hospitals that have gender clinics.

In addition, I have already been able to find about ten parents who have also been misled by various clinics and who have evidence of misconduct. For example, meetings will soon take place at 5.1.2e in Amsterdam West, and a parent from the northern part of the country followed my strategy regarding the heterosexual anamnesis and is also consulting with a lawyer. Based on these experiences, there appears to be systematic deception of parents, with potential financial and legal consequences such as insurance fraud.

Attached you will find my findings, presented during a meeting in Vienna under the Chatham House Rules, which was aimed at parent groups and lawyers who are critical of current gender care practices. This letter has also been submitted to the Board of Directors and the Supervisory Board of Radboud Hospital. ADF International, SEGM, and Genspect support my actions, are closely monitoring my case, and are guiding me with their expertise and knowledge.

Given the significant interests at stake and the potential systemic issues within current practice, I consider it of the utmost importance that the committee's independence be carefully safeguarded. I ask that you give this your highest priority

.

I also recommend that Dr. 5. 1 .2e for a personal meeting.

If you don't mind, I'd also like to discuss this with you. Could you

please let me know your thoughts?

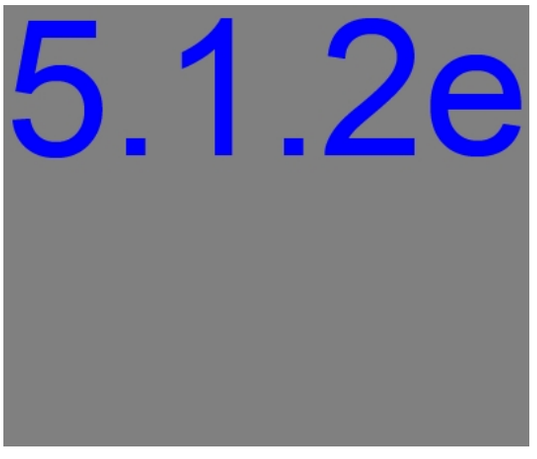
Best regards.

5.1.2e



5.1.2e





15\

Health Council

To Mr. 5.1.2e

by email: 5.1.2f2 t&gmail.com

Date November 26, 2025 Your reference number. Our reference number: 4301006/43010085.1 2e
Phone: 070s.1.2e Email. 5.1.Ze @gr.nl Att achments

Subject: Your letter of November 10, 2025, regarding the composition of the committee and the weighting of the literature

Dear Mr. 5.1.2e

On November 10, I received your response to my letter of October 29, in which I responded to your email of October 9 regarding the independence of the temporary committee on transgender care for youth. I would like to thank you once again for taking the time to share your concerns with us. In your letter of November 10, you point out an incomplete multidisciplinary composition of the committee, an incomplete consideration of relevant literature, and limited representation of parental perspectives. Below, I will briefly address your concerns.

You express concern about a potentially one-sided approach due to the lack of certain expertise. In my previous letter, I explained how the Health Council of the Netherlands assembles its committees. We carefully assembled the Ad Hoc Committee on Transgender Care for Youth, taking into account all relevant scientific, clinical, cultural, and psychological expertise.

You have expressed reservations regarding the comprehensiveness of the committee's literature review. For every advisory opinion issued by the Health Council, the literature is systematically reviewed, including both scientific sources and gray literature.

In your letter, you also indicate that critical parents are only represented to a limited extent in the advisory process. I previously informed you about the consultation the committee conducted. In addition, I have promised to present your letter at the next committee meeting.

In accordance with our standard procedure, I will make no further statements regarding the process or its content during the ongoing committee proceedings, other than what I have already stated. I will send you the advisory report as soon as it is published.

Sincerely,

5.1.2e

Dr. I.D. de Wolf,
General Secretary – Director

Visiting Address:
Bezuidennoutseweg 30,
2594 AV The Hague

e. 5.1.2e
t. 070 5..1.2è
www.gezondheidsraad.nl

Fro 5.1.2e
m: **5.1.2e**
To: 5.1.2e
Cc:
Subject: RE- GR Recommendation
Date: Thursday, June 19, 2025, 5:19 PM: LI4ï
Attachments: imaneÜfi1 im

Dear 5.1.2e

Thank you very much for the feedback. We will relay this new completion date to the committee, noting that it is not yet final.

Best regards,

5.1.2e
Scientific Secretary

Tel. +315.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
w Health Council of the Netherlands
Available Mon, Tue, Thu, Fri

From: 5.1:2e ‹5.1.2e @zinl.nl> Sent: Thursday, June 19, 2025, 1:43 PM To: 5.1.2e ‹5.1.2e. @gr.nl>; 5.1.2e ‹5.1.2e @gr.nl>
Subject: RE: GR Recommendation

Dear 5.1.2e

I just received a message from KIMS regarding the revision and finalization of the quality standard for somatic transgender care. The quality standard is included in the Dutch Healthcare Institute's (Zorginstituut) Multi-Year Agenda. The Multi-Year Agenda lists quality standards that are prioritized, for example, because they affect many people. A deadline is agreed upon for each product. The current deadline for the quality standard for somatic transgender care is September 2025. However, KIMS had indicated that they would likely not be able to meet this deadline. I have since received a proposed new deadline from them: June 2027. The delivery date is not yet final and must first be submitted to the Board of Directors for approval. In any case, it is unlikely that the quality standard will be delivered in the foreseeable future.

5.1.2e
5.1.2e

h4edisch Team—Specialized Care
Department
Netherlands Healthcare Institute
Willem Dudokhof 1 1 1112 ZA I Diemen P.O.
Box 320] 1110 AH I Diemen
.....
5.1.2e
http://v.zorginstituutneder1and.nl
.....
Guaranteed quality care
No **more than necessary** and **no less** than **required**

From: 5.1.2e
Sent: Wednesday, June 18, 2025, 2:15 PM
To: 5.1.2e ‹5.1.2e r« »!•:5.1.2e <5.1.2e @gr nl>
Subject: RE: GR Recommendation

Dear 5.1.2e

I'll be in touch with you as soon as I receive a response from KIMS. I expect to receive it sometime in the next two weeks.

5.1.2e
5.1.2e

.....
Team ?•gedisch-Specialized Care
Healthcare Department
Netherlands Healthcare Institute
Willem Dudokhof 1 1 1112 ZA I Diemen
P.O. Box 320 | 1 110 AH I Diemen
.....
5.1.2e @zinl.nl
http://www.zorginstituutnederland.nl
.....
Guaranteed Quality Care
No more than necessary and no **less** than **required**

From: 5.1.2e ‹5.1.2e /u*nr nl> Sent:
Friday, June 13, 2025, 9:33 a.m. To: 5.1.2e
‹5.1.2e *+sent! l•;5.1.2e <5.1.2e @gr nl>
Subject: RE: GR Recommendation

Dear 5.1.2e

Thank you very much for your prompt response.
To address your original question: we have not heard from KIMS that they will await the GR's advice. Whether the opposite is true is for our committee to determine. This depends on a number of factors, including the expected publication date of the quality standard. We would therefore appreciate knowing that. Should we wait for your email on this matter once you have received a response from KIMS, or would it be advisable for us to contact your contact person there directly?

Thank you very much
in advance.

Best regards,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
w Health Council of the Netherlands Available
Mon, Tue, Thu, Fri

From: 5.1.2e ‹5.1.2e r › if I n I> Sent: Thursday, June 12, 2025, 3:37 p.m. To: 5.1.2e ‹5.1.2e mr : I>; 5.1.2e <5.1.2e @gr nl>
Subject: RE: GR Advisory Opinion

B t 5.1.2e

Thank you for your response. In principle, I am available on June 24 after 2:00 p.m., but neither I nor the Healthcare Institute (Zorginstituut) are directly involved in the substantive rewriting of the healthcare standard. If you have questions regarding the content, it is best to contact the Knowledge Institute (KIMS) of the Federation of Medical Specialists (FMS). If necessary, I can refer you to my contact person at KIMS.

Regarding your question about the publication date, I am still awaiting a message from KIMS with an expected completion date.

With Best regards,

5.1.2e
b.1.ye

.....
Team fl4edisch—Specialized Care
Department, Care Division
Netherlands Healthcare Institute
Willem Dudokhof 1 1 1112 ZA I Diemen P.O. Box 320 | 1110 AH I Diemen
.....
5.1.2e ‹ï›zïnl.nl
http://'v›v\v.zorginstituutnederland.
.....
Guaranteed quality care
No more than necessary and no less than essential

From: 5.1.2e <5.1.2e @gr nl>

Sent: Thursday, June 12, 2025, 11:58 a.m.
To: 5.1.2e ‹5.1.Êe. (« * inE »I>; 5.1.2e <5.1.2e @pr nl>
Subject: RE: GR Recommendation

Dear 5.1.2e

Thank you very much for your email.
Perhaps it would be helpful to schedule an online meeting? Is Tuesday afternoon, June 24, an option?
In the meantime, do you have any idea when the quality standard for somatic transgender care will be published?

Best regards, also on behalf of 5.1.2e

5.1.2e
Scientific Secretary

Tel. +315.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
'u Health Council of the Netherlands Present
Mon, Tue, Thu, Fri.

From: 5.1.2e ‹5.1.2e inl nl>
Sent: Tuesday, June 10, 2025, 1:10 PM
To: 5.1.2e ‹5.1.2e Pr I>; 5.1.2e <5.1.2e @gr nl>
Subject: FW: GR Recommendation

B t 5.1.2e **, 5.1.2e**

I would like to bring the following emails to your attention once again. Thank

you in advance.

Sincerely,

5.1.2e
5.1.2e

.....
Team fl4edisch—Specialized Care
Department of Care
Netherlands Healthcare Institute
Willem Dudokhof 1 1 1112 ZA I Diemen P.O. Box 320 | 1110 AH I Diemen
.....
5.1.2e 'rzinl.nl
http:// v.'›vv/.zorginntituutn=derland.nl
.....

Guaranteed quality care
No more than necessary and no less than essential

From: 5.1.2e <5.1.2e @minvws.nl>
Sent: Tuesday, April 1, 2025, 12:20 p.m.
To: 5.1.2e <5.1.2e @zinl.nl>
CC: 5.1.2e <5.1.2e @minvws.nl>; 5.1.2e <5.1.2e @gr.nl>; 5.1.2e <5.1.2e @gr.nl>
Subject: RE: GR Advice

5.1.2e Thank you for your email.
You're asking valid questions, and I don't know the answers.
The GR is independent; we submitted a request for advice, and they are reviewing it.
We attend the committee meetings as observers.
You can find all the documents at Transgender Care for Youth | Care | Health Council
It might be best to direct these questions to the secretaries.
I've already been in touch with 5.1.2e and 5.1.2e about this, so they're aware of it.

Best regards
5.1.2e

The secretaries are:

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

5.1.2e
Scientific Secretary

Tel. +315.1.2e
Bezuidenhoutseweg 30, 2594 AV The Hague
Health Council of the Netherlands
Available Mon, Tue, Thu, Fri

From: 5.1.2e ‹5.1.2e r ›zinl nl>
Sent: Tuesday, April 1, 2025, 10:53 a.m.
To: 5.1.2e ‹5.1.2e r ›n invvvr nl>
Subject: GR Recommendation

Dear 5.1.2e

I noticed that an introductory letter was recently sent to the Ministry of Health, Welfare, and Sport (VWS) regarding the Health Council's advisory opinion on transgender care. It states: *"This committee was established* **to** *issue* **an** *advisory opinion on whether the guidelines for somatic transgender care fit within the* **legal** *framework* **for health care** *and* **on** *what* **is** *known* **about** *the physical and mental* **health risks** *and about regret following treatment according to the Dutch* **protocol."**

I was wondering what that will look like. The current standard is, of course, being revised now. Will the GR be compared to the current standard? That doesn't seem advisable to me if it's no longer going to be used. Or are they waiting for the further development of KIMS on this point, or is KIMS actually waiting for the GR?

Best regards,
S.1&

153

From: 5.1.2e
To: Subject: 5.1.2e
Date: RE: Addendum to my case regarding gender-specific care
Attachments: Wednesday, April 22, 2026, 5:56:00 AM
70?fiD47? Response to GR's email 5.1.2e from ft anril rxlf imaneN01 Inn

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Dear Mr. 5.1.2e
Please find our response attached.

Sincerely, 5.1.2e

From: 5.1.2e •5.1.2e @gr.nl> Sent: Thursday, April 16, 2026, 9:28 AM To: 5.1.2e ‹5.1.2e @gmall.COMA CC: 5.1.2e ‹5.1.2e @gr.nl>
Subject: RE: Follow-up to my case regarding gender-affirming care

Dear Mr. 5.1.2e
Thank you for your message. I see that you have not yet received an acknowledgment of receipt; please accept my apologies. We are reviewing your message and attachments and will do our best to respond within 15 business days, no later than May 6.

Sincerely, 5.1.2e

From: 5.1.2e ‹5.1.2e Aemail com>
Sent: Wednesday, April 8, 2026, 3:10 PM
To: 5.1.2e ‹5.1.2e ter nl>; 5.1.2e <5.1.2e Aminvws nl>
Subject: Follow-up to my case regarding gender-affirming care

Dear Ms. 5.1.2e, Ms. 5.1.2e, and Ms. 5.1.2e,
Dear 5.1.2e, 5.1.2e, and Ü.1.2e

Dear members of the committee,

With this letter, I am submitting a further supplement to my previously filed complaint regarding gender care, specifically as it is provided by the 5.1.2e Please find attached my report titled “Shortcomings in Dutch Gender Healthcare.” This report contains a comprehensive analysis of structural problems in diagnostics, informed consent, and the scientific basis of current healthcare practices. I kindly request that you take this supplement, including the attached report, into account in the ongoing reassessment of gender healthcare.

Rebuttal of Transvisie’s Argument as a Representative
In previous correspondence, I requested that the committee engage in a dialogue

with a group of parents who have serious concerns about current care practices. I wished to speak on behalf of this group of approximately 60 parents. In response, it was stated that consultation with 5.1.2e had taken place and that this organization would sufficiently represent the parents' perspective. I wish to emphasize that I, like many other parents with whom I am in contact, do not share this view.

Our concerns include, among other things, the limited attention paid to thorough differential diagnosis—including a comprehensive hetero-anamnesis of the immediate social environment—for adolescents and young adults with gender-related issues. In our experience, these concerns are not reflected within the framework and positions of 5.1.2e For this reason, we do not consider this organization to be representative of the full spectrum of parental perspectives.

5.1.2e supports parents who, while they may have concerns, do support their child in the somatic care process. We firmly believe that this a medical error and that somatic care for our children is the wrong choice. In the attached report, I highlight a wide range of shortcomings that support that conviction.

Conflict of interest and bias within the committee

In addition, I would like to draw attention to the composition of the committee. To the best of my knowledge, several committee members have professional ties to gender clinics. Although expertise from the field is obviously valuable, I believe it is important that, when reassessing an internationally controversial and rapidly evolving area of care, explicit safeguards are put in place to ensure that independent and critically scientific perspectives are also taken into account.

In that context, I previously proposed that we also take into account the insights of international researchers and clinicians who have published critically on gender-affirming treatment, particularly among adolescents and young adults. To the best of my knowledge, this proposal has not been acted upon. Furthermore, to my knowledge, relevant whistleblowers, people who have had second thoughts, and individuals who have suffered harm as a result of somatic treatments remain overlooked.

In my report, you will find chapters that provide an overview of relevant publications, reports, and specialists who point to potential risks and shortcomings of gender-affirming treatment. I am submitting this information to you with the request that you review its content and incorporate it into your work.

This report as a form of the right to be heard

I have been informed that my personal complaint regarding the 5.1.2e will be discussed within the committee. Because you refuse to engage in dialogue with me, you have not provided me with a right to be heard. As a result, I have no way of verifying how seriously my 5.1.2e complaint is being assessed, what your findings are, and how your conclusions will be reflected in your publication.

Because you refuse to engage in dialogue with me, I am compelled to share my insights with you in writing. This publication is the result of that and should be viewed as further substantive support for the 5.1.2e which you promised to address with the full team of your committee.

Contents of the Report

I understand that 250 pages with 500 pages of appendices can be quite overwhelming. On pages 1 and 2 of the report, you will find a brief summary. Below is an even more concise overview so that you can get a quick impression. The report highlights:

- **20 deceased individuals** who are currently not being tracked by the clinics and specialists. This shocking fact alone underscores the urgency of this report

- **Conflicts of interest and circular references** via WPATH SoC-8, in which Flemish and Dutch specialists (including De Cuypere, Tsjoen, De Vries, and Steensma) played a prominent role. This conflict of interest is so deeply institutionalized that it even extends to the composition of the current Gender Commission and, as a result, cannot be separated from the Health Council itself. (Art. 5.18, Art. 5.19, Art. 5.20)

- **Serious inconsistencies in older publications** that still serve as supporting evidence (including work by Griet De Cuypere from 1995 and Bram Kuiper from 1991), such as selective data interpretation and unexplained outcomes (such as mortality). These flaws in the foundation cannot be underestimated. The reanalysis I conducted calls into question whether somatic care for adults (and thus also for children) is even sustainable as a care model in its entirety. (Art. 2.1 through Art. 2.10)

- **Parents' practical experiences and communication with experts and clinics** demonstrate that, in practice, diagnostics in Flanders and the Netherlands often fall short. The case of Aero from Kortrijk illustrates the severity of this situation in the most extreme terms. Although Dutch clinics indicate that they operate more carefully than some other centers, the report shows that the care model, structured around administrative procedures and protocols, nevertheless exhibits significant shortcomings in practice and proves to be insufficiently robust. (Art. 3.1, Art. 3.2, Art. 3.8, Art. 4.1, Art. 4.2, Art. 4.4, Art. 4.5, the pattern in Art.
  5.1 through Art. 5.9, Art. 5.13, Art. 5.16, Art. 5.18

- Due to various **breaches in the chain of trust,** which are highlighted in this report, the implementing specialist faces an increased risk of joint and several liability in the event of future claims for buyer's remorse or personal injury. Ignoring a documented and substantiated warning such as this may be interpreted in subsequent legal proceedings involving buyer's remorse or personal injury as a deliberate risk assessment.

Checklist

In the report, you'll find a series of critical questions after each subsection. Of course, I don't expect you to answer every single one. The purpose of these questions is to serve as a checklist that prompts you to consider whether the form of care is being provided carefully and safely—not only for the patient's sake, but also from a legal standpoint for the

practicing specialist.

Interim Version

As noted on the cover, this is an interim version of the report, prepared under time constraints. The content has since been submitted to various independent experts and professors. They have largely confirmed the analysis and describe the report as thorough and valuable, particularly because of the newly added information and insights. Only a few minor corrections have been suggested. In the coming months, I will further refine the report into a final version. Your comments and any reports of shortcomings are most welcome. I am fully open to constructive feedback and revisions.

Copies Sent

Various Flemish authorities are also receiving this report. Flemish child and adolescent psychiatrist Sophie Dechêne and Brussels-based general practitioner Hannah Demaerel endorse this submission. At a later stage, I will also submit the final report to a number of Dutch physicians and specialists with a request for their co-signature, provided they agree with the content and wording.
Copies of the report will also be sent to the Dutch Healthcare Authority (NZa), the Health and Youth Care Inspectorate (IGJ), the Federation of Medical Specialists (FMS), the Dutch Institute of Psychologists (NIP), and other relevant Dutch and international parties.

Request for Feedback

I ask that you confirm receipt of this publication and that it will be taken into account in the reassessment.
Could you please provide a response?

Sincerely,
5.1.2e

On Thu, Nov 27, 2025, at 9:05 AM, 5.1.2e •5.1.2e Jr. n >: wrote

> Dear Mr. 5.1.2e
>
> Please find attached our response to your letter of November 10. I
>
> trust this has provided you with sufficient information.
>
> Sincerely,
>
> 5.1.2e
> 5.1.2e

Bezuidenhoutseweg 30 - 2594 AV - The Hague
www.aezondheidsraad.nl

From: S.1.2e
Sent: Thursday, November 13, 2025, 4:11 p.m. To:
5.1.2e •5.1.2e ‹a›gmail com>
cc: 5.1.2e •5.1.2e jr n >
Subject: RE: Urgent Concerns Regarding the Independence of the Temporary Commission on Transgender Care for Youth

Dear Mr. 5.1.2e
I hereby confirm, with apologies for the delay, that I have received your letter and its attachments. I hope to be able to send you a response within two weeks.

I have also reviewed your email correspondence with 5.1.2e . Ü.1.2e is an observer representing the Ministry of Health, Welfare, and Sport, which requested the advisory opinion. An observer has no substantive input and no voting rights on the committee but attends the meetings to explain, if desired, the rationale behind the request for advice and the policy context.

I hope this has provided you with sufficient information.

Best regards,

5.1.2e
5.1.2e

Bezuidenhoutseweg 30 - 2594 AV - The Hague
www.aezondheidsraad.nl

From: 5.1.2e ‹5.1.2e ‹a›omail com>
Sent: Monday, November 10, 2025, 2:59 PM
To: 5.1.2e •5.1.2e jr nl>; 5.1.2e
5.1.2e ‹a›minvws nl>
Subject: Re: Urgent concerns regarding the independence of the temporary Transgender Care Committee for Youth

Dear Ms. 5.1.2e

Here is my response to the letter from your colleague, Dr. I.D. de Wolf.
I am copying Chair 5.1.2e on this email because the letter concerns her committee.

You will also find several PDFs attached. These have been included because they are cited in the letter and are important legal documents regarding the subject the committee is currently investigating. I have also included machine translations of them for easier and quicker reading.

I look forward to your response.

Sincerely,
5.1.2e

On Wed, Oct 29, 2025, at 12:33, 5.1.2e wrote
•5.1.2e jr nl>:

> Dear Mr. 5.1.2e
> Please find attached a letter in response to your emails. I trust this
>
> has provided you with sufficient information.
>
> Sincerely,
>
> 5.1.2e
> 5.1.2e

Bezuidenhoutseweg 30 - 2594 AV - The Hague
www.oezondheidsraad.nl

From: 5.1.2e <5.1.2e @gmail.com>
Sent: Friday, October 10, 2025, 12:04 p.m. **To:** 5.1.2e <5.1.2e @gr.nl>
Subject: Re: Urgent concerns regarding the independence of the temporary committee on transgender care for young people

Dear Ms. 5.1.2e

Thank you very much for your response. I look forward to your further reply.

I understand and respect the request not to contact committee members individually. I would like to explain why I nevertheless feel the need to bring my concerns directly to your attention.

In recent years, I have indicated on several occasions to the 5.1.2e that parents should also be involved in the hearings. Unfortunately, this request has not been heeded to date. The limited speaking time allotted at the time to 5.1.2e and 5.1.2e does not, in my opinion, adequately reflect the complexity and social relevance of this sensitive topic.

Below is my previous request to the 5.1.2e (sent well over half a year ago), in which I requested the opportunity to be heard. This request was rejected at the time. In the meantime, along with another parent, I am exploring the legal options against the clinic where, in our view, our children are being unjustly harmed through hormonal and possibly surgical interventions, accompanied by severe family disruption. This is also because one of the committee members is also 5.1.2e .

To prevent further escalation, I would like to engage in a dialogue with the committee. My impression is that a large number of the members may not be sufficiently familiar with recent and international developments within the gender care debate, including:

- the **Cass Review**, the **WPATH Files**, and the recent **HHS report**;
- Marshall's **amicus brief** to Tennessee and the **FTC conference**;
- the publications and analyses by **A Wider Lens**, **Beyond Gender**, **SEGM** and **Genspect**.

In addition, I have studied the older Dutch-language and German literature by authors such as **Kuiper, Gooren, De Cuypere, Bockting, Van Leeuwen**, and **Pfäffchen**, which formed the basis of the current international treatment model. Upon studying these highly sought-after books, I have identified significant methodological shortcomings and inconsistencies that raise questions about the scientific justification for somatic care, even for adults.

International researchers (including
are working on digitizing and translating these older sources so they can be reevaluated. Next Monday, I will participate in a closed-door meeting under **Chatham House** Rules with domestic and international experts on this subject.

Given the urgency and the legal implications, I believe it would be advisable for me to personally brief the committee on these findings and their potential implications for the revision of somatic gender care. I would like to arrange such a meeting with Dr. 5.1.2e who also assisted me during my meeting with the Board of Directors and the Supervisory Board of Radboud Hospital. Dr. 5.1.2e will also soon have a similar meeting with the management of 5.1.2e because I have found four families there who were misled and treated very unfairly by the
5.1.2e

May I kindly ask you to share this email and explanation with the other committee members, as a supplement to my previous correspondence and requests for consultation?
Perhaps it would also be appropriate to inquire with 5.1.2e why my earlier urgent request was so categorically rejected.

Sincerely,
5.1.2e

5.1.2e 5.1.2e

Dear 5.1.2e

Thank you for your message. We have *registered your inquiry via email under* reference number 5.1.2e . *We will respond to your inquiry within 5 business days. If we are unable to respond within this timeframe, we* will *contact you regarding this matter.*

***Description** of your inquiry:*
Sender: 5.1.2e ‹a›omail com
Date sent: *Mar 14,* 2025, *8:12 AM*
To.
Subject: Request for a meeting with the committee *regarding updates to transgender care*

Hello, staff member of /?et5.1.2e
Could you bring this request to the attention of the committee that is currently working on an *update to the transgender care protocol?*
“Wj,” a group of concerned parents, are writing to you with an urgent request to have a personal conversation about the current state of transgender care and the recent *evaluations that are taking place. We are deeply concerned about* the way *in which care for transgender youth is* currently *being provided*, and *as parents*, *we* do not *feel heard or taken seriously when we express criticism of the care offered* and *the policies of*

the clinics involved.
*As parents, we increasingly find that **critical questions and concerns** about our children's medical and psychological treatments are not appreciated and are even ignored. We are often dismissed as **"opponents"** of the care, even though our concerns do not stem from a lack of understanding, but from **genuine worry** about the **long-term effects** of certain treatments. We have recently gathered a great deal of evidence that, in our view, demonstrates that there are **systemic problems** with the way transgender care is provided and that insufficient consideration is given to the **long-term consequences** for the young people involved and their families. Family breakdown is all too common in our group.*
*We are currently a group of about **50 parents** who connect through a private Facebook group that has existed for just one year. The group grows weekly with new members, all sharing the same concerns and experiences. Most parents in our group are experiencing **significant stress**, feel **at their wits' end**, and feel powerless in the face of the current situation. We're seeing a trend of **burnout and frustration** that is only exacerbated by a lack of transparency and communication. Many of us feel **rejected by the clinics** as soon as we voice our concerns and are afraid that our children **will be** unjustly placed on treatment pathways that **ultimately aren't in their best interest**.*
*Given the seriousness of the situation, we would greatly appreciate the opportunity to **share our concerns and findings** with the committee currently working on the update to transgender care. We hope that an open dialogue can take place, during which we can highlight the **important and urgent questions** on parents' minds, and how we can work together to find a **more balanced, transparent, and careful approach** to transgender care.*
*We believe it **is crucial that parents, as stakeholders and sources of information, have a voice** in the evaluation and future direction of care. We sincerely hope that the* 5.1.2e *will take our request seriously and that we can schedule a meeting soon.*
We look forward to your response. Sincerely, 5.1.2e
On behalf of a group of concerned parents of transgender children

If you have any questions or comments, please reply to this email. Please make sure to keep the reference number in the subject line.

Sincerely,

5.1.2e

On Thu, Oct 9, 2025, at 8:13 AM, 5.1.2e wrote
•5.1.2e jr n >:

Dear Mr. 5.1.2e

We have received a forward of your email from Mr. 5.1.2e, a member of the Health Council's Ad Hoc Committee on Transgender Care for Youth. We are reviewing your inquiry and will send you a response within the specified timeframe of 15 business days. We kindly ask that you refrain from contacting committee members directly and instead always address the Health Council directly if you have any questions regarding the committee's work or a recommendation issued by the Council.

Sincerely,
5.1.2e
5.1.2e

Bezuidenhoutseweg 30 - 2594 AV - The Hague
www.gezondheidsraad.nl

From: 5.1.2e ‹5.1.2e ‹a›omail com>
Sent: Monday, October 6, 2025 2:40:19 PM To:
5.1.2e
‹5.1.2e >
Subject: Urgent Concerns Regarding the Independence of the Temporary Commission on Transgender Care for Youth

Dear Mr. 5.1.2e

I am writing to you in connection with your appointment to the Ad Hoc Committee on Transgender Care for Youth, which was established to respond to the request for advice from the Ministry of Health, Welfare, and Sports. The committee was inaugurated on February 5, 2025.

After carefully reviewing the composition of the committee, I have serious concerns about the independence of its members. A significant number of the committee members are directly involved as specialists at various clinics. This raises fundamental questions about the objectivity and

impartiality of the advice the committee will issue.

Personally, I am involved in an ongoing conflict with Radboud Hospital. My experience provides insight into the risks and problems that can arise for critical families in the context of transgender care. These issues have been known for decades and are extensively documented, among other places, in the book **Hij, anders zij** by Riekje van Leeuwen (1992), which describes how transsexuality often places a heavy emotional burden on the immediate social circle and already clearly highlights the flaws in the early Dutch protocol. The approach for (young) adults has never been adapted to address the fundamental criticisms raised in the book.

My own intervention, using **an expanded hetero-anamnesis** (see Appendix: Genspect Survey NL), has shown that the clinic's account is not entirely accurate. Together with Dr. 5.1.2e consulted with the Board of Directors and the Supervisory Board of Radboud Hospital. Together with my attorney, I am currently exploring the best strategy to have these errors corrected.
Dr. 5.1.2e has also sent a number of letters to the Boards of Directors of other major hospitals that have gender clinics are located.

In addition, I have already been able to find about ten parents who have also been misled by various clinics and who have evidence of misconduct. For example, meetings will soon take place at 5.1.2e in Amsterdam West, and a parent from the northern part of the country followed my strategy regarding the heterosexual anamnesis and is also consulting with a lawyer. Based on these experiences, there appears to be systematic deception of parents, with potential financial and legal consequences such as insurance fraud.

Attached you will find my findings, presented during a meeting in Vienna under the Chatham House Rules, which was aimed at parent groups and lawyers who are critical of current gender care practices. This letter has also been submitted to the Board of Directors and the Supervisory Board of Radboud Hospital. ADF International, SEGM, and Genspect support my actions, are closely monitoring my case, and are guiding me with their expertise and knowledge.

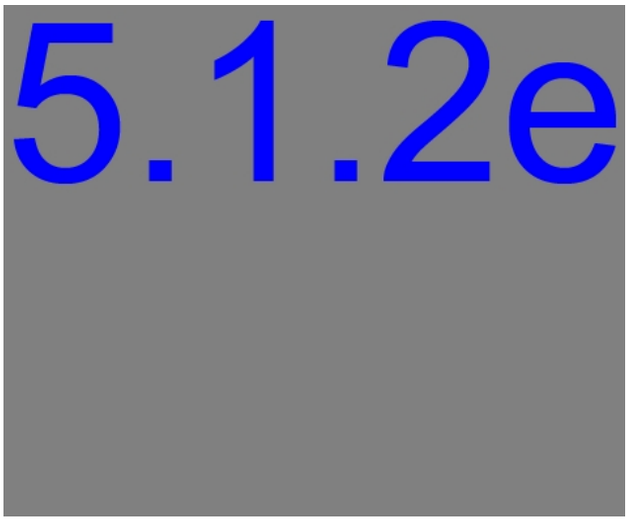
Given the significant interests at stake and the potential systemic issues within current practice, I consider it of the utmost importance that the committee's independence be carefully safeguarded. I ask that you give this matter your highest priority.

I also recommend contacting Dr. 5.1.2e for a personal meeting.

If you would like, I would also be happy to consult with you.

Could you please provide a response?

Sincerely,
5.1.2e



154

Health Council

To Mr. 5.1.2e

by email: 5.1.2e 6qmail.com

Date. April 22, 2026
Phone: 0705.1.2e
Your reference number.
Email. 5.1.2e @gr.nl
Our reference number: 4377381/43780235.1
2e Alg Attachments.

Subject: Your email regarding an update to your case concerning transgender care

Dear Mr. 5.1.2e

On April 8, I received an email from you with various attachments, including your report *"Shortcomings in Dutch Gender Care,"* as a supplement to your case regarding transgender care. I would like to inform you that these documents have been brought to the attention of the Ad Hoc Committee on Transgender Care for Youth.

As indicated in a previous letter, we do not make any statements regarding the process or the content of the recommendation while the committee proceedings are ongoing. We therefore acknowledge receipt of your email and documents dated April 8. Should you contact us again regarding this matter, we will also acknowledge receipt of your communication. You will not receive any further response from us.

I hope this has provided you with sufficient information.

Best regards,

5. .2e

5.1.2e
Dr. I.D. de Wolf, General Secretary - Director

Visiting Address:
Bezuidennou1seweg 30,
2594 AV The Hague

e. 5.1.2e
Tel. 070 5.1.2e
www.gezondheidsmad.nl

155

Fro m: 5.1.2e
To: 5.1.2e ; 5.1.2e
Subject: Re: Update on my case regarding gender-affirming care
Date: Monday, June 22, 2026, 11:00:56
Attachments: image001.jpg

Dear 5.1.2e and 5.1.2e and members of the Ad Hoc Committee on Transgender Care for Youth,

In addition to my previous correspondence, and in light of the upcoming publication of your advisory report, I would like to bring a few developments to your attention.

First, the group of parents who identify with the issues I have outlined has now grown from approximately 60 to 146 parents. These parents feel that they and other members of the immediate social circle are not sufficiently involved in practice and that their concerns are regularly viewed as obstructive or irrelevant. This reinforces my earlier assertion that there is a substantial parental perspective that does not feel represented by the organizations with which the committee has spoken.

In addition, I have become aware of an individual case involving a person who, in the spring of 2026 (or possibly late 2025), underwent the euthanasia process following serious complications from a phalloplasty. Without drawing general conclusions from this individual case, I do consider it a relevant signal in the context of the discussion regarding long-term outcomes, serious surgical complications, and potential bodily harm.

Finally, I would like to draw attention to recent events in Meerstad. Although the facts and background of this case are still under investigation by the authorities and no conclusions can be drawn at this time, I note that I have already described two international cases in my report that, in my opinion, exhibit very similar patterns in certain structural aspects. I mention this solely in the context of pattern recognition as elaborated in my report, and not as an interpretation of the specific circumstances of the case in question.

I do not expect a substantive response, but I ask that you bring this additional observation, just like my previous documents, to the attention of the committee.

Sincerely,

5.1.2e

On Wed, Apr 22, 2026, at 3:56 PM, 5.1.2e wrote <5.1.2e @gr.nl>:

> Dear Mr. 5.1.2e
>
> Please find our response attached.
>
> Sincerely,
>
> 5.1.2e

From: 5.1.2e <5.1.2e @gr.nl>
Sent: Thursday, April 16, 2026, 9:28 AM **To:**
5.1.2e <5.1.2e @gmail.com>
CC: 5.1.2e <5.1.2e @gr.nl>
Subject: RE: Update on my case regarding gender-affirming care

Dear Mr. 5.1.2e

Thank you for your message. I see that you have not yet received an acknowledgment of receipt; please accept my apologies. We are reviewing your message and its attachments and will do our best to respond within 15 business days, no later than May 6.

Sincerely,

5.1.2e

From: 5.1.2e <5.1.2e @gmail.com>
Sent: Wednesday, April 8, 2026, 3:10 PM
To: 5.1.2e <5.1.2e @gr.nl>; 5.1.2e
<5.1.2e @minvws.nl>
Subject: Follow-up to my case regarding gender-specific healthcare

Dear Ms. 5.1.2e, Ms. 5.1.2e, and Ms. 5.1.2e,

Dear 5.1.2e, 5.1.2e, and 5.1.2e

Dear Members of the Committee,

With this letter, I am submitting a further supplement to my previously filed complaint regarding gender care, specifically as it is provided by the 5.1.2e
Attached you will find my report **titled "Shortcomings in Dutch Gender Care**." This report contains a comprehensive analysis of structural problems in diagnostics, informed consent, and the scientific basis of current care. I kindly request that you take this supplement, including the attached report, into account in the ongoing reassessment of gender care.

Rebuttal of Transvisie's Argument as a Representative
In previous correspondence, I asked the committee to engage in dialogue with a group of parents who have serious concerns about current care practices. I wished to speak on behalf of this group of approximately 60 parents. In response,

it was stated that a consultation with 5.1.2e had taken place and that this organization would sufficiently represent the parents' perspective. I wish to emphasize that I, like many other parents with whom I am in contact, do not share this view.
Our concerns include, among other things, the limited attention paid to thorough differential diagnosis—including a comprehensive hetero-anamnesis of the immediate social environment—for adolescents and young adults with gender-related issues. In our experience, these concerns are not reflected within the framework and positions of 5.1.2e For this reason, we do not consider this organization to be representative of the full spectrum of parental perspectives.
5.1.2e supports parents who, while they may have concerns, do support their child in the somatic care process. We firmly believe that a medical error has occurred and that somatic care for our children is the wrong choice. In the attached report, I highlight a wide range of shortcomings that support this conviction.

Conflict of interest and bias within the committee
In addition, I would like to draw attention to the composition of the committee. To the best of my knowledge, several committee members have professional ties to gender clinics. Although expertise from the field is obviously valuable, I believe it is important that, when reassessing an internationally controversial and rapidly evolving area of care, explicit safeguards are put in place to ensure that independent and critically scientific perspectives are also taken into account.
In that context, I previously proposed that we also take into account the insights of international researchers and clinicians who have published critical views on gender-affirming treatment, particularly among adolescents and young adults. To the best of my knowledge, this proposal has not been acted upon. Furthermore, to my knowledge, relevant whistleblowers, people who have had second thoughts, and individuals who have suffered harm as a result of somatic treatments continue to be overlooked.
In my report, you will find chapters that provide an overview of relevant publications, reports, and specialists who point to potential risks and shortcomings of gender-affirming treatment. I am submitting this information to you with the request that you review its content and incorporate it into your work.

This report as a form of the right to be heard
I have been informed that my personal complaint regarding the 5.1.2e will be discussed within the committee. Since you refuse to engage in dialogue with me , you have not provided me with an opportunity to be heard. As a result, I have no way of verifying how seriously my 5.1.2e complaint is being assessed, what your findings are, and how your conclusions will be reflected in your publication.
Because you refuse to engage in dialogue with me, I am compelled to views with you in writing. This publication is the result of that and should be viewed as further substantive support for the 5.1.2e issue, which you committed to addressing with the full team of your committee.

Contents of the Report
I understand that 250 pages with 500 pages of appendices is quite

overwhelming. On pages 1 and 2 of the report, you will find a brief summary. Below is an even more concise summary so that you can get a quick impression. The report points out:

- **20 deceased individuals** who are currently not being tracked by the clinics and specialists. This shocking fact alone underscores the urgency of this report

- **Conflicts of interest and circular references** via WPATH SoC-8, in which Flemish and Dutch specialists (including De Cuypere, Tsjoen, De Vries, and Steensma) played a prominent role. This conflict of interest is so deeply institutionalized that it even extends to the composition of the current Gender Commission and, as a result, cannot be separated from the Health Council itself. (Art. 5.18, Art. 5.19, Art. 5.20)

- **Serious inconsistencies in older publications** that still serve as supporting evidence (including work by Griet De Cuypere from 1995 and Bram Kuiper from 1991), such as selective data interpretation and unexplained outcomes (such as mortality). These flaws in the foundation cannot be underestimated. The reanalysis I conducted calls into question whether somatic care for adults (and thus also for children) is even sustainable as a care model in its entirety. (Art. 2.1 through Art. 2.10)

- **Parents' practical experiences and communication with experts and clinics** demonstrate that, in practice, diagnostics in Flanders and the Netherlands often fall short. The case of Aero from Kortrijk illustrates the severity of this situation in the most extreme terms. Although Dutch clinics indicate that they operate more carefully than some other centers, the report shows that the care model, structured around administrative procedures and protocols, nevertheless exhibits significant shortcomings in practice and proves to be insufficiently robust. (Art. 3.1, Art. 3.2, Art. 3.8, Art. 4.1, Art. 4.2, Art. 4.4, Art. 4.5, the
pattern in Art. 5.1 through Art. 5.9, Art. 5.13, Art. 5.16, Art. 5.18

- Due to various **breaches in the chain of trust,** which are highlighted in this report, the implementing specialist faces an increased risk of joint and several liability in the event of future claims for buyer's remorse or personal injury. Ignoring a documented and substantiated warning such as this may be interpreted in subsequent legal proceedings involving buyer's remorse or personal injury as a deliberate risk assessment.

Checklist

In the report, you will find a series of critical questions after each subsection. Of course, I do not expect you to answer every single one. The purpose of the questions is to serve as a checklist that prompts you to consider whether the form of care is indeed being provided with due care and safety—for the patient, but also from a legal standpoint for the treating specialist.

Interim Version

As noted on the cover, this is an interim version of the report, prepared under time constraints. The content has since been submitted to various independent experts and professors. They have largely confirmed the analysis and describe the report as thorough and valuable, particularly due to the newly added information and insights. Only a few minor corrections have been suggested. In the coming months

, I will further refine the report into a final version. Your comments and any reports of shortcomings are most welcome. I am fully open to constructive feedback and revisions.

Copies Sent
Various Flemish agencies are also receiving this report. The Flemish child and adolescent psychiatrist 5.1.2e and the Brussels general practitioner 5.1.2e endorse this submission. At a later stage, I will also
submit the final report to a number of Dutch physicians and specialists with a request for their co-signature, provided they agree with the content and wording. Copies of the report will also be sent to the Dutch Healthcare Authority (NZa), the Health and Youth Care Inspectorate (IGJ), the Federation of Medical Specialists (FMS), the Dutch Institute of Psychologists (NIP), and other relevant Dutch and international parties.

Request for Feedback

I ask that you confirm receipt of this publication and that it will be taken into account in the reassessment.
Could you please provide a response?

Sincerely,
5.1.2e

On Thu, Nov 27, 2025, at 9:05 AM, 5.1.2e wrote
<5.1.2e @gr.nl>:

> Dear Mr. 5.1.2e
>
> Please find attached our response to your letter of November 10.
>
> I trust this has provided you with sufficient information.
>
> Sincerely,
>
> 5.1.2e
>
> 5.1.2e

Bezuidenhoutseweg 30 - 2594 AV - The Hague

www.gezondheidsraad.nl

From: 5.1.2e
Sent: Thursday, November 13, 2025, 4:11 p.m. To:
5.1.2e ‹5.1.2e ‹a›omail com>
cc: 5.1.2e ‹5.1.2e nl>
Subject: RE: Urgent Concerns Regarding the Independence of the Temporary Commission on Transgender Care for Youth

Dear Mr. 5.1.2e

I hereby confirm—and apologize for the delay—that I have received your letter and its attachments. I hope to be able to send you a response within two weeks.

I have also reviewed your email correspondence with 5.1.2e .
5.1.2e is an observer representing the Ministry of Health, Welfare, and Sport, which requested the advisory opinion. An observer has no substantive input and no voting rights on the committee but attends the meetings to explain, if desired, the rationale for the request for advice and the policy context.

I hope this has provided you with sufficient information.

Sincerely,

5.1.2e

5.1.2e

Bezuidenhoutseweg 30 - 2594 AV - The Hague

www.oezondheidsraad.nl

From: Ü.1.2e •5.1.2e aamail com>
Sent: Monday, November 10, 2025, 2:59 PM
To: 5.1.2e •5.1.2e jr n >; 5.1.2e •5.1.2e ‹a›minvws nl>
Subject: Re: Urgent Concerns Regarding the Independence of the Temporary Commission on Transgender Care for Youth

Dear Ms. Ü.1.2e

Here is my response to the letter from your colleague, Dr. I.D. de Wolf.

I am copying Chair 5.1.2e on this email because the letter concerns her committee.

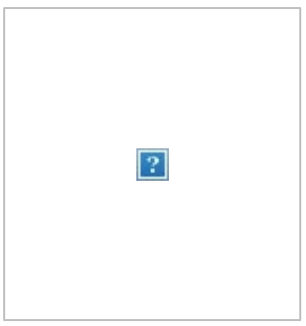
You will also find several PDFs attached. These have been included because they are cited in the letter and are important legal documents related to the subject the committee is currently investigating. I have also included machine translations of them for easier and faster reading.

I look forward to your response.

Sincerely,

5.1.2e

On Wed, Oct 29, 2025, at 12:33, 5.1.2e wrote
<5.1.2e @gr.nl>:

> Dear Mr. 5.1.2e
>
> Please find attached a letter in response to your emails.
>
> I trust this has provided you with sufficient information.
>
> Sincerely,
>
> 5.1.2e
>
> 5.1.2e
>
> 
>
> Bezuidenhoutseweg 30 - 2594 AV - The Hague
>
> www.gezondheidsraad.nl

From: 5.1.2e <5.1.2e @gmail.com>
Sent: Friday, October 10, 2025, 12:04 p.m. **To:** 5.1.2e <5.1.2e @gr.nl>
Subject: Re: Urgent concerns regarding the independence of the temporary committee on transgender care for young people

Dear Ms. 5.1.2e

Thank you very much for your response. I look forward to your further reply.

I understand and respect the request not to contact committee members individually. I would like to explain why I nevertheless feel the need to bring my concerns directly to your attention.

In recent years, I have indicated on several occasions to the 5.1.2e that parents should also be involved in the hearings. Unfortunately, this suggestion has not been heeded to date. The limited speaking time allotted at the time to 5.1.2e and 5.1.2e does not, in my opinion, adequately reflect the complexity and social relevance of this sensitive topic.

Below is my previous request to the 5.1.2e (sent well over half a year ago), in which I requested the opportunity to be heard. This request was rejected at the time. In the meantime, along with another parent, I am exploring the legal options against the clinic where, in our view, our children are being unjustly harmed through hormonal and possibly surgical interventions, accompanied by severe family disruption. This is also of also of interest to your committee, because one of the committee members 5.1.2e .

To prevent further escalation, I would like to engage in a dialogue with the committee. My impression is that a large number of the members may not be sufficiently familiar with recent and international developments within the gender care debate, including:

- the **Cass Review**, the **WPATH Files**, and the recent **HHS report**;
- Marshall's **amicus brief** to Tennessee and the **FTC conference**;
- the publications and analyses by **A Wider Lens**, **Beyond Gender**, **SEGM,** and **Genspect**.

In addition, I have studied the older Dutch-language and German literature by authors such as **Kuiper, Gooren, De Cuypere, Bockting, Van Leeuwen**, and **Pfäffchen**, which formed the basis of the current international treatment model. Upon examining these long-out-of-print books, I have found significant methodological shortcomings and inconsistencies

that raise questions about the scientific justification for somatic care, even for adults.

I am currently collaborating with international researchers (including to digitize and translate these older sources so that they can be re-evaluated. Next Monday, I will participate in a closed-door meeting under Chatham House Rules with domestic and international experts on this subject.

Given the urgency and the legal implications, I believe it would be advisable for me to personally brief the committee on these findings and the potential consequences for the revision of somatic gender care. I would like to have such a meeting with Dr. 5.1.2e who also assisted me during my meeting with the Board of Directors and the Supervisory Board of Radboud Hospital. Dr. 5.1.2e will also be having a similar meeting shortly with the management of 5.1.2e, as I have found four families there who were misled and treated very unfairly by 5.1.2e

May I kindly ask you to share this email and explanation with the other committee members, as a supplement to my previous correspondence and requests for consultation?
Perhaps it would also be appropriate to inquire with 5.1.2e why my earlier urgent request was so categorically rejected.

Sincerely,
5.1.2e

5.1.2e 5.1.2e

Dear 5.1.2e

Thank you for your message. We have recorded your inquiry via email under reference number 5.1.2e *We will respond to your inquiry within 5 business days. If we are unable to respond to your inquiry within this timeframe, we will contact you regarding this matter.*

Description of your inquiry:
Sender: 5.1.2e *a›amail com*
*Date sent: Mar 14, 2025 8:*12 *AM*
To: vraaenaanzir,5.1.2e *nl*
Subject: *Request for a meeting with the committee regarding an update transgender care*

Hello, 5.1.2e *staff member*
Could you please forward this request to the *committee currently working on an update to* the *transgender care protocol?*
We, a *group of concerned parents, are reaching out to you with an urgent request to have* a *personal conversation about the current state of transgender care and the recent* evaluations *taking place. We are* **deeply concerned** *about* the *way in which care for*

transgender youth is currently being provided, and as parents, we do not feel heard or taken seriously when we ***express criticism*** *of the care offered and the policies of the clinics involved.*
As parents, we increasingly find that ***critical questions and concerns*** *about the medical and psychological treatments our children receive are not appreciated and are even ignored. We are often dismissed as* ***"opponents"*** *of the care, even though our concerns do not stem from a lack of understanding, but from* ***genuine worry*** *about the* ***long-term effects*** *of certain treatments. We have recently gathered a great deal of evidence that, in our view, demonstrates that there are* ***systemic problems*** *with the way transgender care is provided and that insufficient consideration is given to*
the ***long-term consequences*** *for the young people involved and their families. Family breakdown is all too common in our group.*
We are currently a group of about ***50 parents*** *who connect through a private Facebook group that has existed for just one year. The group grows weekly with new members, all sharing the same concerns and experiences. Most parents in our group are experiencing* ***significant stress****, feel* ***at their wits' end****, and feel powerless in the face of the current situation. We see a trend of* ***burnout and frustration*** *that is only exacerbated by a lack of transparency and communication. Many of us feel*
rejected by the clinics *as soon as we voice our concerns and are afraid that our children* ***will be*** *unfairly placed on treatment pathways that* ***ultimately aren't in their best interest****.*
Given the seriousness of the situation, we would greatly appreciate the opportunity to ***share our concerns and findings*** *with the committee currently working on updating transgender care. We hope that an open dialogue can take place, during which we can highlight the* ***important and urgent questions*** *on parents' minds, and how we can work together to find a* ***more balanced, transparent, and careful approach*** *to transgender care.*
We believe it ***is crucial that parents, as stakeholders and sources of information, have a voice*** *in the evaluation and future direction of care. We sincerely hope that the* 5.1.2e
will take our request seriously and that we can schedule a meeting soon. We look forward to your
response. Sincerely, 5.1.2e

On behalf of a group of concerned parents of transgender children

If you have any questions or comments, please reply to this email. Please make sure to keep the reference number in the subject line.

Sincerely,

5.1.2e

On Thu, Oct 9, 2025, at 8:13 AM, 5.1.2e wrote
<5.1.2e @gr.nl>:

> Dear Mr. 5.1.2e
>
> We have received your email, which was forwarded to us by Mr. 5.1.2e, a member of the Health Council's Ad Hoc Committee on Transgender Care for Youth. We are reviewing your inquiry and will respond within the specified timeframe of 15 business days. We kindly ask that you refrain from contacting committee members directly and instead always address the Health Council when you have a question about the committee's work or a recommendation from the council.
>
> Sincerely,
>
> 5.1.2e
>
> 5.1.2e
>
> Bezuidenhoutseweg 30 - 2594 AV - The Hague
>
> www.gezondheidsraad.nl

From: 5.1.2e •5.1.2e a›omail com>
Sent: Monday, October 6, 2025, 2:40:19 PM
To: 5.1.2e
•5.1.2e >
Subject: Urgent Concerns Regarding the Independence of the Temporary Commission on Transgender Care for Youth

Dear Mr. f:i.1.2e

I am writing to you in connection with your appointment to the Ad Hoc Committee on Transgender Care for Youth, which was established to respond to the request for advice from the Ministry of Health, Welfare, and Sports. The committee was inaugurated on February 5, 2025.

After carefully reviewing the committee's composition, I have serious concerns about the independence of its members. A significant number of committee members are directly involved as specialists at various clinics. This raises fundamental questions about the objectivity and impartiality of the advice the committee will issue.

Personally, I am involved in an ongoing conflict with Radboud Hospital. My experience provides insight into the risks and problems that can arise for critical families in the context of transgender care. These issues have been known for decades and are extensively documented, among other places, in the book **Hj", anders zj"** by Riekje van Leeuwen (1992), which describes how transsexuality often places a heavy emotional burden on one's immediate social circle and already clearly highlights the flaws in the early Dutch protocol. The approach for (young) adults has never been adapted to address the fundamental criticisms raised in the book.

My own intervention, using **an expanded hetero-anamnesis** (see Appendix: Genspect Survey NL), has shown that the clinic's account is not entirely accurate. Together with Dr. 5.1.2e , I have consulted with the Board of Directors and the Supervisory Board of Radboud Hospital. Together with my attorney, I am currently exploring the best strategy to have these errors corrected.
Dr. 5.1.2e has also sent a number of letters to the Boards of Directors of other major hospitals that have gender clinics.

In addition, I have already been able to find about ten parents who have also been misled by various clinics and who have evidence of misconduct. For example, meetings will soon take place at .1.2e in Amsterdam West, and a parent from the northern part of the country followed my strategy involving the hetero-anamnesis and is also consulting with a lawyer. Based on these experiences, there appears to be systematic deception of parents, with potential financial and legal consequences such as insurance fraud.

Attached you will find my findings, presented during a meeting in Vienna under the Chatham House Rules, which was aimed at parent groups and lawyers who are critical of current gender care practices. This letter has also been submitted to the Board of Directors and the Supervisory Board of Radboud Hospital. ADF International, SEGM, and Genspect support my actions, are closely monitoring my case, and are guiding me with their expertise and knowledge.

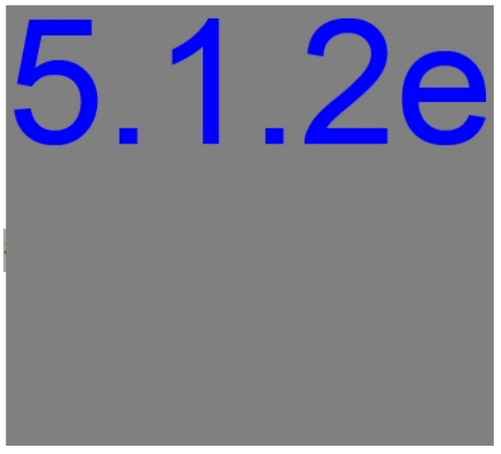
Given the significant interests at stake and the potential systemic issues within current practice, I consider it of the utmost importance that the committee's independence be carefully safeguarded. I ask that you give this matter your highest priority.

I also recommend contacting Dr. for a personal meeting.

If you would like, I would also be happy to consult with you.

Could you please provide a response?

Sincerely,


5.1.2e

203

From 5.1.2e
: To: 5.1.2e
Subject: **RE: Gezorxlhe!dsraad I Advisory Committee on Transgender Care for Youth Tuesday,**
Date: **March 10, 2026, 4:26:00 PM**
Attachments: **imaoe0 1 ipg**

Dear Ms. 5.1.2e,

Thank you very much for your response. No problem at all—emails can sometimes get lost in the shuffle. We're very pleased to hear that you're willing to review the draft recommendation. I'll ask my colleague, 5.1.2e
, to schedule a meeting on April 14 or 15 and will let him know that you prefer the morning.

Best regards.
5.1.2e

From: 5.1.2e ‹5.1.2e >
Sent: Tuesday, March 10, 2026, 4:15 PM
To: 5.1.2e ‹5.1.2e @gr.nl>
Subject: RE: Health Council | Consultation on Advice Regarding Transgender Care for Youth

Dear 5.1.2e

I completely overlooked your previous email and noticed that it had ended up in the digital trash folder (unread, no less!). My sincere apologies!

I'd be happy to read and contribute my thoughts on the advisory report, so please send it my way when it's ready. I'm also unavailable online on April 14 or 15, but I'm available on both days, preferably in the morning.

Best regards,

5.1.2e

5.1.2e

5.1.2e

5.1.2e

5.1.2e

5.1.2e

5.1.2e

5.1.2e

From: Ü.1.2e •5.1.2e last month n1>
Date: Tuesday, March 10, 2026, 4:01 p.m.

To: 5.1.2e <5.1.2e>
Subject: RE: Health Council | Consultation on Advice Regarding Transgender Care for Youth

Dear Ms. 5.1.2e,

Last month, I sent the email below asking if you would be willing to provide feedback on the draft advisory opinion on transgender care for young people. I would like to know if you have had a chance to consider this request and whether we may submit the advisory opinion to you for consultation.

I am, of course, available to explain this request in person.

Sincerely,
5.1.2e

From: 5.1.2e **Sent:** Thursday, February 19, 2026, 3:36 PM **To:** 5.1.2e <5.1.2e>
Subject: Health Council | Consultation on the Advisory Opinion on Transgender Care for Youth

Dear Ms. 5.1.2e,

The Health Council is currently working on an advisory opinion regarding transgender care for children and adolescents. The request for this advisory opinion stems from two motions asking the Council to assess whether the Quality Standard for Transgender Care—Somatic fits within the legal framework for healthcare, what is known about physical and mental health outcomes, and what is known about regret following treatment according to the Dutch protocol. The request for advice has been assigned to the Ad Hoc Committee on Transgender Care for Youth.

The committee would like to verify its views and assess whether it has overlooked any relevant legal insights in its advisory opinion. Your expertise and extensive experience with the work of the Health Council of the Netherlands are indispensable in this regard. We would like to ask you, as an ad hoc expert consultant, to review an advanced draft of the advisory opinion. We would appreciate hearing your findings during an online meeting with the committee secretaries, the chair, and a committee member who is a lawyer. We have also asked 5.1.2e to review the draft as well.

We could send you the advisory opinion on April 3, after which we hope to schedule an online meeting on Tuesday, April 14, or Wednesday, April 15.

Would you be willing to provide feedback on the committee's draft recommendation? I

look forward to your response.

Sincerely,

5.1.2e
Scientific Secretary

Tel. +31 6 5.1.2e (Mon–Fri)
Visiting address: Bezuidenhoutseweg 30, 2594 AV The Hague
www.gezondheidsraad.nl

From: Health Council of the Netherlands Press Office
To: 5.1.2e
Subject: RE: NRC Inquiry
Date: Thursday, May 21, 2026, 8:04:00 AM
Attachments: image001.jpg

Good morning, 5.1.2e

Great, then we'll go with the 23rd; I'll have it scheduled here in the calendar for 11 a.m. Please let me know if you'd prefer to do the interview online or at our office. I'll be on vacation the week before, but I'll ask my colleague from 5.1.2e to share the advice with you around June 18 (under strict embargo).

As for a sneak peek: the committee concludes that transgender care for young people in the Netherlands is carefully organized.

Best regards,
5.1.2e

From: 5.1.2e
Sent: Wednesday, May 20, 2026, 1:15 PM
To: Health Council Press Office < @gr.nl>
Subject: RE: Question from NRC

Hi 5.1.2e, 5.1.2e and I are available on the 23rd.
Also: can you give us a little hint yet? We're wondering if we need to write an additional piece besides the interview. What direction is the advice heading in? Is it far-reaching regarding gender-affirming care for young people?

Warm regards, also
on behalf of 5.1.2e
5.1.2e

From: Health Council Press Office < @gr.nl>
Sent: Tuesday, May 19, 2026, 4:19 p.m.
To: 5.1.2e
Subject: RE: Question from NRC

Yes, I read your articles at the time with great interest, which is why I'm so pleased that you're now also willing to focus on our advice!
5.1.2e is available for an interview on June 23 sometime between 11 a.m. and 1 p.m.—does that work for you as well? And would you prefer to come here or do it online? Of course, we'll send you the advice in time under embargo.

Best regards,
5.1.2e

From: 5.1.2e
Sent: Tuesday, May 19, 2026, 4:06 PM
To: Health Council Press Office < @gr.nl>
Subject: RE: Question from NRC

Absolutely, my colleague 5.1.2e and I worked together for a long time at the outpatient clinic in Amsterdam back then, and for that reason we'd like to do an interview together and discuss the advisory opinion in NRC. Perhaps you could suggest a date? It would be great if we could have a few days before the interview to thoroughly review the advisory opinion. We can, of course, make arrangements regarding the timing of publication,

You can also call: 5.1.2e,

Best regards,

5.1.2e

From: Health Council of the Netherlands Press Office < @gr.nl>
Sent: Tuesday, May 19, 2026, 3:59 PM
To: 5.1.2e
Subject: RE: Question from NRC

Dear 5.1.2e,

Good to hear from you; I was planning to email you this week as well. We'll be publishing on June 30. In the meantime, our new vice chair, 5.1.2e is currently working on the advisory report. As we discussed earlier, we can arrange for you to review the advisory report before publication and, if you'd like, to have an interview with 5.1.2e.

Best regards,
5.1.2e

From: 5.1.2e
Sent: Tuesday, May 19, 2026, 3:54 PM
To: Health Council Press Office < @gr.nl>
Subject: RE: Question from NRC

Dear 5.1.2e

I was trying to figure out my schedule and was wondering if you already have a specific publication date in mind?

Best regards,

5.1.2e
5.1.2e

From: Health Council Press Office < @gr.nl>
Sent: Monday, January 19, 2026, 12:49 p.m.
To: 5.1.2e
Subject: RE: Question from NRC

Dear 5.1.2e,

We agreed last year that you could conduct an exclusive interview before the publication date. If you'd like, that offer still stands, of course. We don't have a specific publication date yet, but as soon as one is set, I'll contact you.

Best regards,
5.1.2e

From: Health Council of the Netherlands Press Office **Sent:** Thursday, January 8, 2026, 2:32 PM **To:** 5.1.2e
Subject: RE: NRC Inquiry

Good afternoon, 5.1.2e,

In the absence of 5.1.2e I am responding to the inquiry below. No specific publication date has been set yet. As for the other question, I'd rather not comment 5.1.2e since you've already been in contact about it; could we hold off on this question until she returns? She'll be back starting Monday, January 19.

Best regards,

5.1.2e
5.1.2e

Bezuidenhoutseweg 30 - 2594 AV - The Hague
www.gezondheidsraad.nl

From: 5.1.2e
Sent: Thursday, January 8, 2026, 12:32 p.m.
To: Health Council Press Office < @gr.nl>
Subject: FW: Question from NRC

Hello 5.1.2e,

A year ago, we were in touch regarding the study on gender-affirming care for young people. I see that the recommendations have been postponed and are now expected in the second quarter of 2026. Is there a specific date yet? Or is there anyone we could speak with in the meantime?

Thank you in advance,
Best regards
5.1.2e
5.1.2e

From: Health Council of the Netherlands Press Office < @gr.nl>
Sent: Monday, March 10, 2025, 11:43 **To:**
5.1.2e
Subject: RE: Question from NRC

Hello 5.1.2e,

That was an informative and comprehensive article last weekend; thank you for bringing it to our attention last week!

You also had a question last week about how the committee operates and whether, for example, you could observe a committee member during the committee process. Regarding the first point, I always emphasize that the Health Council itself does not conduct research, but issues recommendations based on the current state of scientific knowledge. We do not wish to allow you to shadow committee members, because the committee process and the content of the advisory opinion are confidential until the time of publication, and the committee members (who volunteer their expertise to the Health Council without compensation) must be able to rely on this confidentiality. However, I can imagine that we could arrange for you to have an interview with our chair, Karien Stronks, in due course before the advice is published. Would that work for you?

Best regards,
5.1.2e

From: 5.1.2e
Sent: Monday, February 3, 2025, 12:39 p.m.
To: Health Council Press Office < @gr.nl>
Subject: RE: Question from NRC

Great, thank you very much 5.1.2e for the response! Best regards, 5.1.2e

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From: Health Council of the Netherlands Press Office 5.1.2e @gr.nl>
Sent: Monday, February 3, 2025, 11:53 a.m.
To: 5.1.2e
Subject: RE: Question from NRC

Dear 5.1.2e,

Apologies for the delay; it was due to my colleague's busy schedule. I have since heard back from her. The Health Council of the Netherlands frequently assesses the current state of scientific knowledge or what is scientifically known regarding treatments for certain diseases, conditions, disorders, etc. Examples:
Fibromyalgia: Background Document on the Effectiveness/Efficacy of Interventions for People with Fibromyalgia, accompanying the advisory report on Fibromyalgia | Advisory Reports | Health Council of the Netherlands
Early treatment of eating disorders: Advisory Opinion on the Prevention and Early Treatment of Eating Disorders | Advisory Opinions | Health Council of the Netherlands
Dementia: See the fourth bullet point in the advisory request: Advisory Request from the Minister of Health, Welfare, and Sport on Early Detection of Dementia | Advisory Request | Health Council of the Netherlands; the advisory has not yet been published.

Best regards,
5.1.2e

From: 5.1.2e
Sent: Friday, January 24, 2025, 3:43 PM
To: Health Council Press Office 5.1.2e @gr.nl>
Subject: RE: NRC Inquiry

Thank you very much!

From: Health Council Press Office < @gr.nl>
Sent: Friday, January 24, 2025, 2:52 PM **To:**
5.1.2e
Subject: RE: NRC Inquiry

Dear 5.1.2e,

I've asked my colleague to look into this over the next week; I'll get back to you as soon as possible.

Best regards,
5.1.2e

From: 5.1.2e
Sent: Friday, January 24, 2025, 1:42 PM
To: Health Council Press Office < @gr.nl>
Subject: RE: Question from NRC

Dear 1.2e,

Thank you very much for your response. I've looked at the page, and I have one more general question:

- Has the Health Council conducted similar research before? Specifically, regarding the scientific basis of a treatment and whether it meets the standard of care?

Best regards, 5.1.2e

From: Health Council Press Office < @gr.nl>
Sent: Thursday, January 23, 2025, 12:44 PM
To: 5.1.2e
Subject: RE: Question from NRC

Dear 5.1.2e

The committee that will be addressing this issue will be established in mid-February. Starting then, you can find information about the further process and the committee's composition on this page of our website. We expect the recommendation itself to be ready by the end of this year or early next year, but that naturally depends on the committee's progress. Only once the recommendation is finalized and published will we be able to provide substantive information about its content.

Best regards,

5.1.2e
5.1.2e

Phone: 5.1.2e
Address: Bezuidenhoutseweg 30 – 2594 AV The Hague
www.gezondheidsraad.nl

From: Health Council of the Netherlands Press Office **Sent:** Wednesday, January 22, 2025, 11:58 **To:** 5.1.2e
Subject: RE: Question from NRC

That's perfectly fine. I'll pass it on to 5.1.2e

Best regards,
5.1.2e

From: 5.1.2e
Sent: Wednesday, January 22, 2025, 11:49 a.m.
To: Health Council Press Office < @gr.nl>
Subject: RE: Question from NRC

Great, that works fine. Tomorrow is going to be a busy day, but if that doesn't work out, I'll be easily reachable on Friday,
Best regards, 5.1.2e

From: Health Council of the Netherlands Press Office < @gr.nl>
Sent: Wednesday, January 22, 2025, 11:48 **To:**
5.1.2e
Subject: RE: NRC Inquiry

Good morning, 5.1.2e,

5.1.2e is absent today. Since you've discussed this previously, I suggest that you call him tomorrow. 5.1.2e

Best regards,

5.1.2e
5.1.2e

Bezuidenhoutseweg 30 - 2594 AV - The Hague
www.gezondheidsraad.nl

From: 5.1.2e
Sent: Wednesday, January 22, 2025, 10:48 a.m.
To: Health Council Press Office < @gr.nl>
Subject: Question from

NRC Dear 5.1.2e

I work as a journalist for NRC. A few months ago, we spoke about a Health Council of the Netherlands study on gender-specific healthcare. I have a few questions about that—would it be possible to ask them over the phone?

You can also reach me at: 5.1.2e ,

Thank you in advance,
Best regards,

5.1.2e

Recommendations from 5.1.2e as submitted to the Health Council on April 11, 2025

As representatives of women—who, as a group, are disproportionately affected by the medicalization of gender confusion (particularly girls who are fleeing from their femininity)—we make the following recommendations:

Stop referring the multitude of identity issues and other pathologies to so-called "gender" clinics, which are often linked to clinics for people with DSDs and endocrinological conditions. Internalized homophobia, autism, grief and divorce issues, self-harm, and sexual trauma have absolutely nothing to do with DSDs or with a supposed "gender identity," which is an immeasurable metaphysical concept. Body dysmorphia is also treated with talk therapy and behavioral therapy; we do not resolve it by sending patients to a cosmetic surgeon. What we refer to by the umbrella term "gender dysphoria" is the only psychological condition in which we attempt to alleviate mental suffering by tinkering with the body. As if there were something wrong with that body. Especially in cases of sexual trauma that go unaddressed, a victim thus becomes a victim twice over: first at the hands of the perpetrator, then at the hands of practitioners with tunnel vision.

Stop medicalization entirely. Return to the fundamentals of psychotherapy. Make psychological counseling mandatory, focused on strengthening resilience within one's own body

Therefore, **immediately stop the use of GnRHa's in minors**, given the irreversible damage and the lack of evidence for their efficacy.[iiiiii]

Depathologize gender-nonconforming behavior in children who act in ways we stereotypically associate with the opposite sex. There is, in fact, nothing wrong with it. More often than average, it indicates a child who will later be homosexual, and there is nothing wrong with that either. It does not make a child "trans" [iv]! The DSM is wrong regarding the criteria that pathologize this behavior.

Stop facilitating a child's delusion through "social transition" [v], whether as a society, a healthcare provider, a school, a parent, or a sports club. By going along with social transition, we are acting as if that child's body does not exist. But people are their bodies. Going along with this sends the message to the child that her or his body is wrong. You must not convey that message to vulnerable people. It is unethical. Moreover, it is a form of gaslighting directed at the parents. They are forced to go along with it by lying about gender, or else face conflict with the child, the clinic, their social circle, or their workplace. As a result, the parents are betrayed by society[vi] .

The Netherlands must distance itself from WPATH: an organization that prioritizes wishful thinking and ideology over science and neglects the safeguarding of children. Dutch healthcare providers must immediately withdraw their membership; WPATH lacks credibility as a serious, ethical, scientific organization[viiviiiixxxixii] .

End subsidies to activist organizations: Withdraw Ministry of Health, Welfare, and Sport (VWS) funding for groups such as Transvisie, which encourage irresponsible access to medications such as GnRH agonists through entities like GenderGP, even for minors[xiii] .

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[i] https://web.archive.org/web/20220822105037/https://lesbians-united.org/organizationMaterials/Puberty%20Suppression%20Medicine%20or%20Malpractice.pdf

[ii]https://www.youtube.com/watch?v=uNyaoJn00Mo

[iii] https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143642/https://cass.independent-review.uk/
[iv]https://genspect.org/resources/gender-dysphoria-support-tool/
[v] https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143642/https://cass.independent-review.uk/
[vi] Stephen Levine at the Genspect Conference, Lisbon: https://www.youtube.com/watch?v=VzZ5jIzs2ZU
[vii]https://www.humanistischverbond.be/blog/1416/the-wpath-files-de-ideologische-mars-door-de-medische-instellingen/
[viii]https://environmentalprogress.org/big-news/wpath-files
[ix]https://www.supremecourt.gov/DocketPDF/23/23-477/323970/20240903160238352_United%20States%20v.%20Skrmetti%20-%20Amicus%20Brief.pdf
[x]https://segm.org/The-Economist-WPATH-Research-Trans-Medicine-Manipulated
[xi]https://www.bmj.com/content/bmj/387/bmj.q2227.full.pdf
[xii]https://genspect.org/wpaths-annus-horribilis/
[xiii]https://transvisie.nl/volwassenen/hormonen/zelfmedicatie/

Sources cited in the presentation:
[xiii]https://x.com/wrenske/status/1907160906015834490
[xiii] https://research.vu.nl/en/publications/toediening-van-puberteitsremmers-aan-minderjarigen-met-genderdysf
[xiii] https://web.archive.org/web/20220822105037/https://lesbians-united.org/organizationMaterials/Puberty%20Suppression%20Medicine%20or%20Malpractice.pdf
[xiii] Domenico Di Ceglie et al., “Children and adolescents referred to a specialist gender identity development service: clinical features and demographic characteristics,” International Journal of Transgenderism 6/1 (2002): https://www.researchgate.net/publication/276061306_Children_and_Adolescents_Referred_to_a_Specialist_Gender_Identity_Development_Service_Clinical_Features_and_Demographic_Characteristics
[xiii]https://www.volkskrant.nl/kijkverder/v/2023/the-dutch-approach-transgender-jongeren-onder-vuur~v656797/
[xiii]https://www.transgendertrend.com/children-change-minds/
[xiii]https://www.voorzij.nl/transspijt-is-mogelijk-33/
[xiii]https://pubmed.ncbi.nlm.nih.gov/31762394/

Dear Committee Members,

We would like to thank you for the opportunity to contribute to the consultation on transgender care for young people. You have asked us to outline the key points of our position regarding one or more of the sub-questions in the request for advice. While we do not wish to downplay the importance of your advisory questions, we would like to use this opportunity primarily to express our concerns about the future of transgender care for young people in the Netherlands and to draw your attention to the broader context in which this discussion is taking place.

We fear that transgender care is disproportionately subject to strict scientific requirements compared to other medical treatments for young people. For example, the lack of randomized controlled trials (RCTs) is often cited as a shortcoming in gender-affirming care. However, this overlooks the fact that RCTs are both methodologically and ethically unfeasible for the treatment with puberty blockers. Furthermore, a large portion of standard medical care for young people is also not supported by RCT evidence but by observational research (McNamara et al., 2024).

Why should care for transgender and gender-diverse youth be held to different standards? This selective application of scientific requirements does not contribute to the quality of care—on the contrary, it hinders access to it. Instead of further calling this care into question, we ask that you recognize the lack of access to transgender care in the Netherlands. For example, there are very few places where young people can turn for help, and municipalities provide insufficient funding through Youth Care, leading to the disappearance of small, specialized, regional mental health care providers. In the international debate, the ethical principle of "*do no harm*" is often cited to cast doubt on gender-affirming care at a young age. As experts by experience, we can tell you that, above all, the lack of care can cause serious harm to (mental) health.

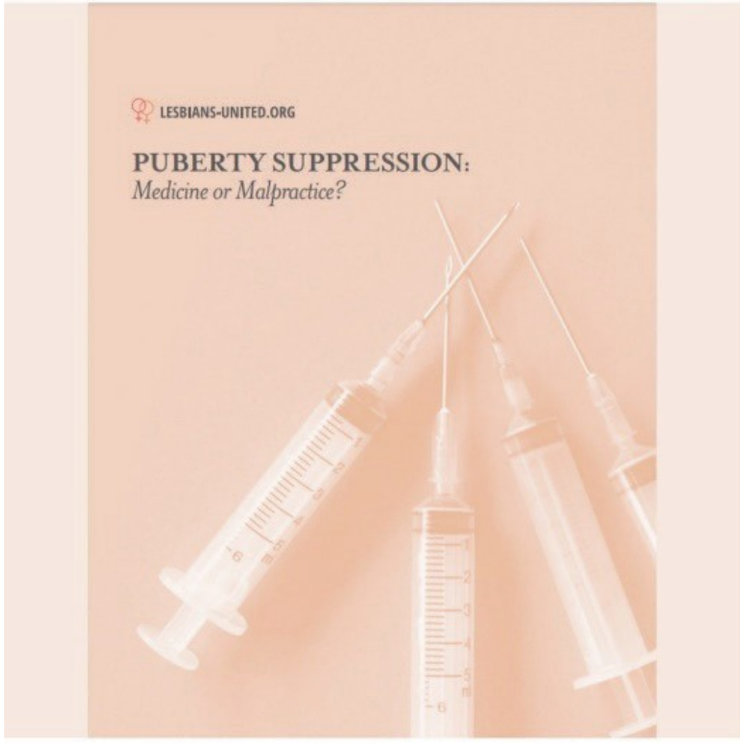
While we can only encourage the importance of long-term research, we ask you, above all, to consider the motivation and timing of this request for advice. Globally, there is a rise in politically, religiously, and ideologically motivated opposition to gender-affirming care—particularly for young people—which negatively impacts the lives of trans individuals and their loved ones. We ask that you be mindful of this and that you prioritize the needs of transgender youth *themselves* in your advisory opinion.

As trans historian Jules Gill-Peterson emphasizes, "We need to really learn to say we want trans children. Not that we want *all* children to be trans, but [that] it's not something we wish we could have prevented." Transgender youth exist. They themselves know best who they are. Their existence and autonomy should not be questioned or judged. The attempts—both international and national—to undermine the best available care for them cannot be refuted solely on scientific grounds. Precisely because it is not science, but ideology, that drives this attack. We appreciate your commitment to this issue, but above all, we hope to make you understand that your temporary committee is a result of this ongoing undermining, which has already had serious consequences for transgender youth and their loved ones outside the Netherlands for years.

Sincerely,

5.1.2e and
On behalf of 5.1.2e
5.1.2e

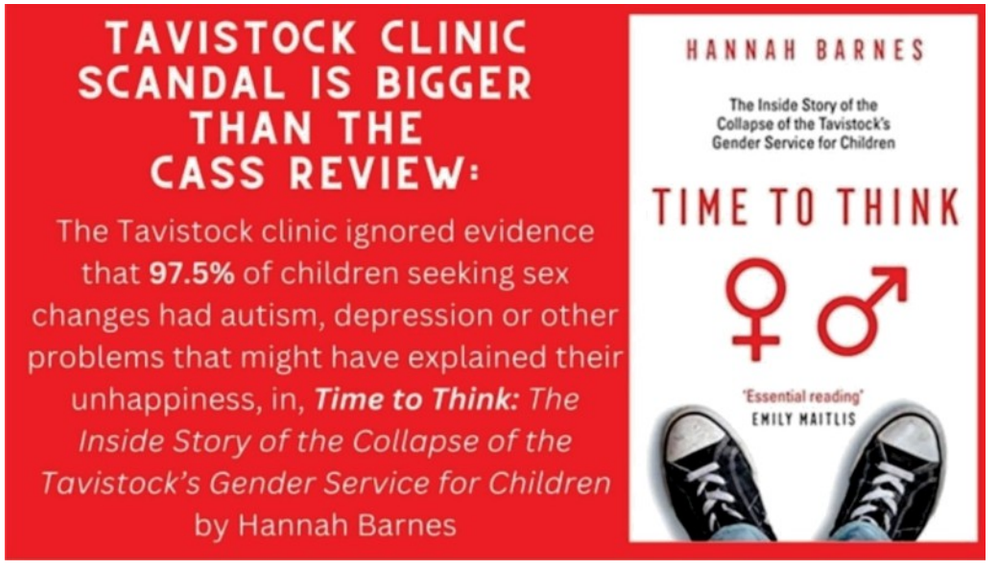
lesbiansunitedusa



64 7

lesbiansunitedusa Lesbians United's review of the evidence on puberty suppression is out NOW as a free PDF. "Puberty Suppression: Medicine or Malpractice?" cites over 300 sources, and catalogs over 100 side effects of puberty-suppressing drugs. Get it at https://lesbians-united.org/resources.html

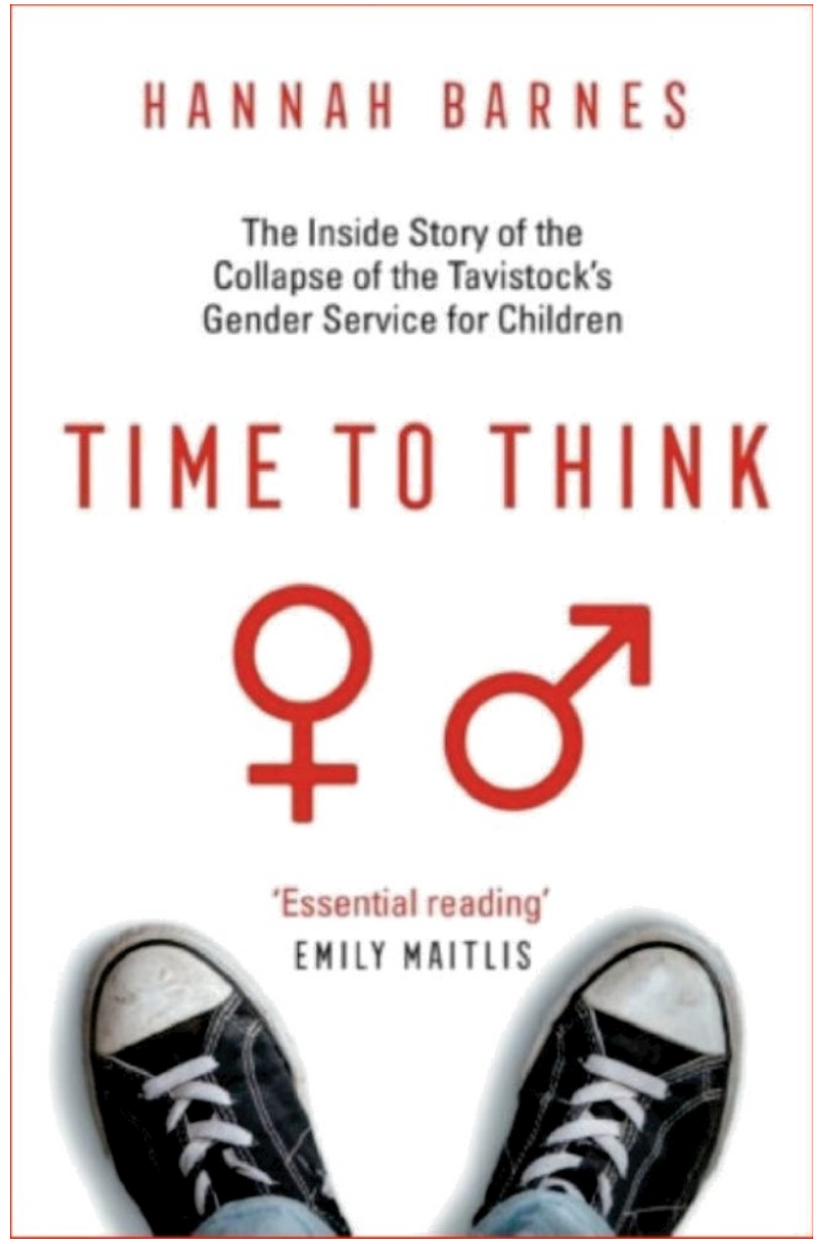
Our report delves into better-designed studies of adults taking GnRH agonists (now marketed as "puberty blockers"), which document side effects ranging from osteoporosis and heart attack to depression and fibromyalgia. This is a vast body of evidence - and extremely important, since recent studies of puberty



- ONLY 2,596 of the children seen at the clinic had no known associated problems.
- 7,096 of the referrals had MORE than 5 associated features or comorbidities, such as abuse, depression, self-harm, suicide attempts, anxiety, eating disorders, ADHD, or bullying
- 35% of referrals had ASD (Autism Spectrum Disorder)—YET fewer than 2% of children in the UK have ASD
- 2,596 of the referrals had spent time in foster care, compared with 0.67% of the general population.
- Children referred were 10 times more likely than the national average to have a registered sex offender as a parent
- 42% of referrals had lost a parent through death or separation
- A clinical psychologist was “horrified” that highly vulnerable children were being wrongly given irreversible drug treatments following referral by the Tavistock, but discussion of the subject was shut down by colleagues.
- Children who might not have identified as trans were treated as “collateral damage” by clinicians who labeled skeptics “transphobic.”

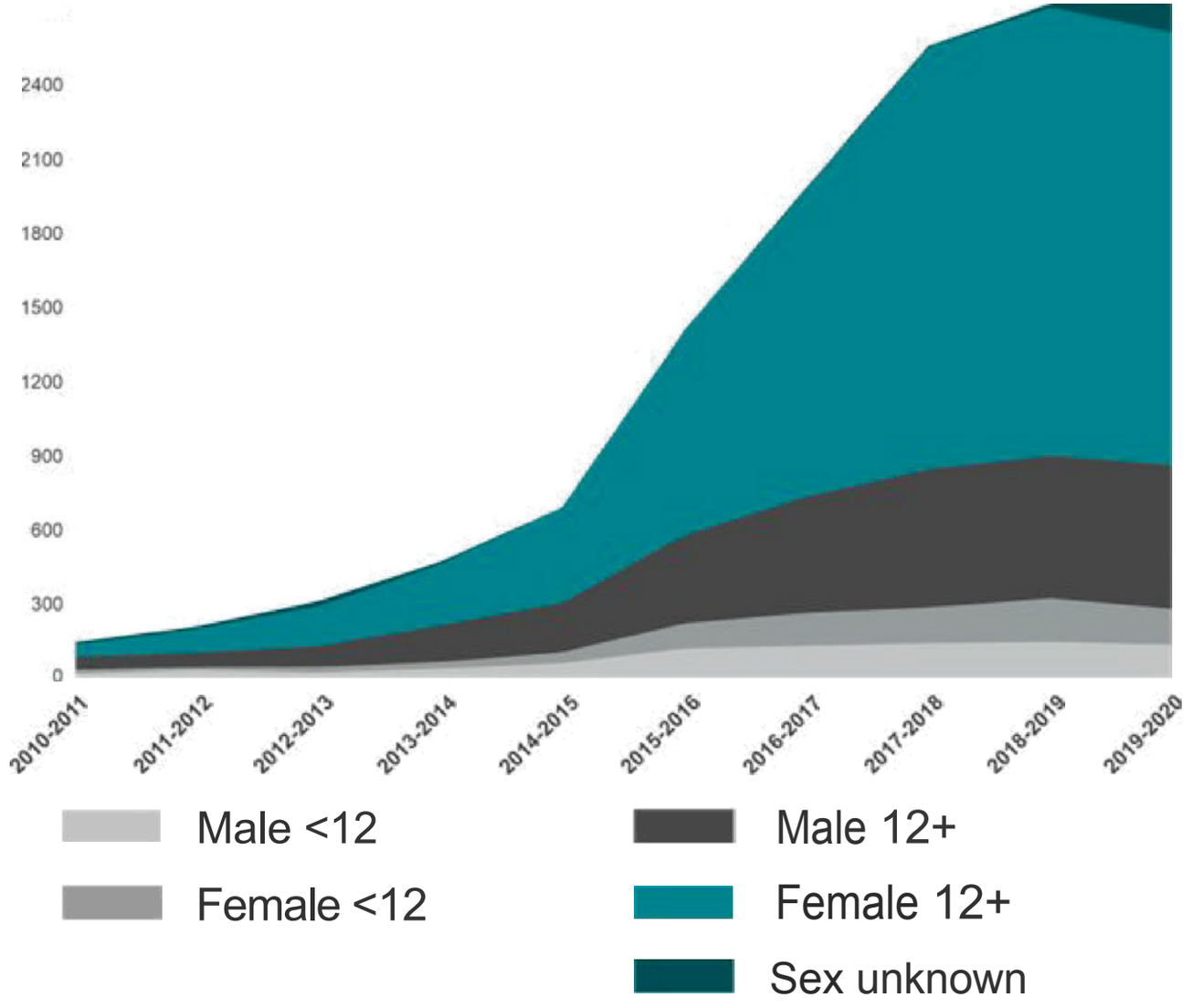
"When GIDS asked older adolescents about who they were attracted to, over 90% of natal females reported that they were same-sex attracted or bisexual."
"For the natal moles, 80.8% reported being same-sex attracted or bisexual."

Gay clinician Mott Bristow "came to feel that GIDS was performing 'conversion therapy' on gay kids."




PUBERTY
IS NOT A
MEDICAL
CONDITION
TFABR

Referrals to GIDS, under 18s (UK)



Position Paper on the *Dutch Protocol*

5.1.2e

To the Health Council Date: May 20, 2025

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1. Introduction

The Health Council has been asked to assess treatment according to the *Dutch Protocol* against the applicable health law framework. The current situation conflicts with that framework in three respects: (i) the protocol itself does not meet the requirements set for medical protocols; (ii) the administration of puberty blockers violates the Medicines Act; and (iii) the regulatory framework governing puberty blockers is inadequate. The following provides further clarification.

2. (i) The *Dutch Protocol* (2018) itself does not meet the requirements set for medical protocols

For further details on this, see "Transgender Care for Children; Legal Concerns Regarding the Dutch Protocol (2018)," *Nederlands Juristenblad*, July 14, 2023 – Issue 25 (**Appendix 1**).

In summary: Normally, medical protocols serve as a guide for defining the standard of medical practice. For a protocol to indeed serve as a guide, it must (i) be evidence-based, (ii) have limited medical-ethical implications, and (iii) have been developed through an adequate process. The *Dutch Protocol* (2018) does not meet any of these conditions.

3. Puberty suppression in children violates the Medicines Act

For further details, see "Administration of Puberty Blockers to Minors with Gender Dysphoria and the Medicines Act," *Journal of Health Law* 2024 (48) 6 **(Appendix 2)**.

In summary: It appears that a practice has developed in the field of puberty blockers for gender dysphoria that does not withstand legal scrutiny. The documented assessment of expected benefits and risks, as required by the Medicines Act and the position statement "Safe Off-Label Prescribing of Medicines to Children," is lacking. In the Cass report, however, that assessment was conducted. The risks appear to outweigh the expected benefits. The ESCAP statement and developments in neighboring countries are equally cause for concern.

4. The regulatory environment regarding puberty blockers is inadequate

This assertion is explained in greater detail in a forthcoming publication—which will be sent to you. The gist of that publication is that the regulatory framework has six structural shortcomings:

1. **Scientific exceptionalism**: there is a deviation from standard practices in evaluation and accountability. Initially, it was argued that puberty suppression improves well-being. The evidence for this was never provided. Amsterdam UMC has since abandoned "improved well-being" or "effectiveness" as an outcome measure. What the outcome measure should be remains to be determined. This lack of clarity is unprecedented, given the risks associated with puberty suppression.
2. **Lack of open debate**: public conferences on the topic are not permitted but must take place under the Chatham House Rule. A culture of secrecy prevails; Amsterdam UMC does not provide even the most basic data for research to third parties, and there is no research protocol to serve as a basis for collective, evolving understanding.
3. **Exclusion of third parties and outsiders**: while the involvement of outsiders is crucial to preventing tunnel vision in gender care, participation by such third parties in the debate is highly unattractive, not least because of reputational risks.
4. **Intertwining of practice and science**: Because trans healthcare and the research into it are carried out almost entirely by the same individuals, there is a undermining conflict of interest. There is also a high risk of *confirmation bias*. The lack of a clear outcome measure further increases that risk.
5. **Unbalanced patient representation**: When shaping healthcare policy, the difficult challenge is to find adequate representation of the population, which largely consists of girls at the onset of puberty. In effect, trans advocacy groups currently hold a monopoly on public input. This constitutes a one-sided—and therefore inaccurate—representation of the population.
6. ***Regulatory capture***: Regulation is heavily influenced by the individuals and institutions to which the regulation applies. The Minister relies on information from Amsterdam UMC when responding to parliamentary questions. Half of the Health Council consists of individuals who are or have been closely involved in prescribing puberty blockers. A negative assessment of the *Dutch Protocol* by the Health Council would put these individuals and/or the institutions for which they work in a difficult position, both legally and in terms of reputation.

5. Conclusion

The current situation conflicts with the public health legal framework in three respects. Attention must now be focused on designing a sound decision-making framework that addresses the six points mentioned in paragraph 4. Only then can decision-making take place in a legally sound manner.

Health Council
Health Council of the Netherlands

Date:	May 6, 2025	Your ref:	-	Our ref:	4109324/HV/idv/101
Phone:	+31 70 340 75 20	Email:	5.1.2e @gr.nl	Encl:	-

Subject: Invitation to speak at the Health Council Committee meeting – May 16, 2025

Dear Prof. 5.1.2e

As an independent scientific advisory body, the Health Council of the Netherlands is tasked with advising the government and parliament on matters of public health and health care. The Health Council was recently asked by the Minister of Health to provide advice on transgender care for children and adolescents in the Netherlands. The request concerns the following aspects:

- physical and mental health outcomes following treatment with puberty blockers and/or gender-affirming hormone therapy
- discontinuation of treatment or feelings of regret related to treatment
- whether this treatment aligns with the Dutch health law framework (including the decision-making capacity of young people regarding choices for this treatment).

The Health Council has also been asked to compare results from the Netherlands with those of other European countries that may or may not use a different standard of care.
The Health Council has established a temporary committee of clinical and scientific experts from various disciplines to advise on this issue. Here you can find an overview of the committee members.

Since part of this advice focuses on a comparison with other European countries, the Committee wishes to consult experts in the field of transgender care for children and adolescents from other countries. The Committee is particularly interested in those European countries where the standards of care for transgender children and adolescents have recently been revised. In that context, we would kindly ask if you are available to speak at our next Committee meeting on Friday afternoon, May 16, 2025, from 1:45 p.m. to 3:15 p.m. CEST. The Committee meets in person (in Utrecht, the Netherlands) but would like to invite you to participate online.
During this meeting, the Committee would like to ask you to share your views on the following questions:

- Could you elaborate on how transgender care for children and adolescents was previously organized in your country and what has changed recently?
- What have been the underlying reasons for revising transgender care for children and adolescents in your country?
- Are there any other matters you wish to convey to the Committee regarding (specific aspects of) the request for advice?

In total, six experts are invited to speak at this meeting (see Attachment 2). Fifteen minutes have been set aside in the agenda for each expert. During the first 10 minutes, the Committee would like to ask you to reflect on the questions mentioned above. The remaining 5 minutes are reserved for the Committee to ask additional questions. Unfortunately, due to a tight schedule that afternoon, speaking time is limited. Therefore, in addition to your presentation, you may submit a written contribution of up to 1 A4 page if you wish to elaborate on your reflections regarding the aforementioned questions. You can submit your written contribution via email (5.1.2e @gr.nl) by May 14, 2025.

Visiting Address
Bezuidenhoutseweg 30
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e. info@gr.nl
t. +31 70 340 75 20
www.healthcouncil.nl

Would you be interested in participating in this meeting? We kindly ask you to let us know if you plan to attend by May 9, 2025, via 5.1.2e @gr.nl. Shortly after this date, we will share the reserved time slots for each participant. Please let us know if you have a time preference between 1:45 p.m. and 3:15 p.m. CEST.

Please do not hesitate to contact us if you have any questions. Best

regards,

5.1.2e

Members of the scientific staff

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Reflections on Parental Insight and **Comments on the Use of Diagnostic** Codes for Insurers

5.1.2e
June 1, 2025

Introduction

My name is 5.1.2e and I'm here to share a story that has touched not only our family but also many other families worldwide. First, a little about my background. I'm an artist and professor at universities and art academies in Europe, specializing in a field called transgressive art.

Through that discipline, I am very familiar with explicit expressions related to sex, drugs, and acts of resistance against society, as well as the tendency toward self-harm within fringe youth cultures. The current trans movement has all the hallmarks of such a rebellious counterculture, where intense gothic fashion, violent manga, anime, and gaming, designer drugs, and explicit gender-related identity behavior converge. Because of my expertise, I'm philosophically on a very different track of thought than gender specialists.



And I have no doubt whatsoever that this form of care is also very well organized at Radboud. I express my admiration even more because we live in a rapidly aging society where healthcare is a scarce resource, and yet the quality remains very high. I am not a conspiracy theorist who is suspicious of our healthcare system as a whole. But how different is my experience with gender-affirming care...

The Responsibility of Healthcare: Family Disruption in Gender-Affirming Treatment

5rwo‹dt •enbvltengewoong‹ote whsel g«t‹o?èen.q› acceptance by the social environment.

In 1992, a heated debate unfolded in the daily newspaper *Trouw* between ethicist Professor **Gerrit Manenschijn** and endocrinologist **Louis Gooren,** founder of the Dutch gender clinic. In one of his articles, Manenschijn wrote a striking sentence:

In other words: **33 years ago, professionals in the field already recognized** that a medical transition can have far-reaching social consequences—particularly within the family. This fundamental issue is also clearly highlighted in Kuiper's 1991 book. Yet this awareness is not reflected in current care protocols, neither in the Netherlands nor internationally. Instead, the focus is exclusively on "accepting" the transgender person's gender identity—as if family breakdowns were merely a matter of attitude and understanding.

This raises a fundamental question:
Who bears responsibility for the social harm caused by medical intervention?

That is not a medical question. It is a public, ethical, and political issue. The balance between individual freedom and collective impact must be determined through democratic debate. And healthcare models must adapt to the outcome of that public process—not the other way around. Society cannot simply comply unquestioningly with the wishes of the medical system. That is the world turned upside down.

I suggested undergoing family therapy before starting gender-affirming treatment. This request was approved by the clinical psychologist Derwig. But the therapist then refused to take on the case, claiming I would be “too difficult.” However, I never spoke to that man. And I never heard anything from the gender clinic again after that.
Gender-affirming care is care that disrupts families.
Should this injustice be resolved through legal channels, or will the clinics adjust their policies on their own?

Peer Pressure and Gaslighting

There’s no denying that I have a distinctly progressive profile. My work and background as an artist make that clear—yet I’m certainly no exception among other parents when it comes to political views. Because specialists often don’t meet the parents until the final stages of the process, their first impression can easily be that the parents are conservative. But in reality, these parents are simply at their wits’ end, emotionally exhausted, and frustrated after years of struggle.
Criticism of medical transition is not far-right, conservative, or narrow-minded. The level of framing and stigma is so extreme that it has become nearly impossible to speak out publicly about it without serious consequences for friendships, family ties, or—as in my case
— your career. As an artist and teacher, I would immediately lose all my professional credibility. You’re expected to be pro-trans, even if you have serious reservations about the whole idea of something like a “gender soul”—a metaphysical concept for which there is absolutely no evidence.

Due to the enormous social pressure, the child gains **a disproportionate amount of power within the family.** Parents have only very limited options left to correct inappropriate behavior or resist the psychological coercion imposed through gaslighting
— through pronouns, name changes, confusing gender jargon, and even threats of suicide. The peace of the household is severely disrupted. The extent to which this occurs can hardly be overstated.

It is therefore not surprising that most parents eventually give in to this pressure and, in desperation—out of fear of losing their child—agree to the treatment plan. They have become **automatons**. Victims of what the renowned mass psychologist **Joost Meerloo** called **“menticide”—**
— psychological death caused by ideological coercion.[2] Brainwashing.

Parents who give their consent despite deep doubts often do not realize the implications until much later. A striking example of this dynamic came to light during Elon Musk’s interview with Jordan Peterson in July 2024.[3] In that interview, Musk states that he feels betrayed. To be clear: I have strong reservations about the man, and this is not about his political

profile, but if even Elon Musk—the world's most powerful businessman—could be swept up in his child's transition, who is still immune to this dynamic?

Ethical Objections to Sidelining the Parental Perspective

The official guidelines for transgender care offer strikingly little information about family dynamics. If there is a social divide, relationship therapy should take place first. Disrupting the family through a care process that involves significant interpersonal tensions raises serious ethical questions about patient care and the well-being of the family.

In a society shaped by such immense forces, my wife and I have struggled for years within our own family with our son's desire to transition. What began with compassionate empathy developed—through open questions and sincere conversations
— — into a veritable Cold War, in which our son eventually became completely isolated within the family.

As we tried to navigate this difficult period, I began to delve deeply into the subject matter. Dutch gender teams claim to strive for family harmony. Because the medical record must give the impression that a broad perspective is being taken into account, practitioners actively encourage conversations with parents, partners, and others directly involved.
Anyone familiar with gender-critical literature—such as the books by **Abigail Shrier**[4]and **Hannah Barnes**[5]and the testimonies of **whistleblower Jamie Reed**[6]—knows that the reality is much grimmer. I noticed a disturbing pattern: Parents are formally invited to share their views. The healthcare providers nod kindly, take notes, and offer reassuring words that they understand. Many parents disagree with their child's self-diagnosis; some go along with it, but others remain critical.

Although the concerns of critical parents seem to be taken seriously at first glance, they are brushed aside in follow-up conversations. The parents' impressions are noted but have no influence on the diagnosis. In fact, **their objections are used to make the assessment appear more thorough on paper**—in order to meet the health insurer's requirements.

My concern grew as I began to recognize this pattern—and escalated when I consulted the **DSM-5-TR** to understand exactly what the criteria are for a positive diagnosis. What I found was shocking:
"Do you like to wear a dress?
Yes. Do you feel like a
woman? Yes." Then you have
gender dysphoria.[7]
It's literally that simple. Anyone who goes through the intake interview receives a positive diagnosis.

Because I took a very proactive approach, questions arose about the diagnostic process itself, and whether there might be fraud on the part of gender clinics—specifically in the way they report diagnostic codes to insurance companies.
I'll explain how the diagnostic process works and where the weaknesses lie.

Our Case Study: Intervention with a Counter-Investigation

Our son received an invitation from the Radboud gender clinic. To our great surprise, our son successfully passed the intake.



I suspected we were dealing with a gender clinic that did not follow a proper diagnostic process—and I was right. This not only led to a misdiagnosis of our son but also caused deep psychological and emotional harm within our family.

What makes this case even more distressing is that it is not an isolated incident. Worldwide, more and more families are reporting similar experiences through Facebook groups and organizations such as Genspect and Therapy First. They feel that something isn't right—but how do you prove it?

In practice, the patient receives a questionnaire from the clinic. In addition, they are asked to write a letter of motivation—which can easily be copied from the internet. When parents are later invited to share their concerns, both the questionnaire and the letter of motivation already point toward a positive diagnosis. **These two elements reinforce each other and effectively override the parents' perspective.**

How do you defend yourself against that? I devised an intervention method to demonstrate the lack of transparency that families face at these clinics. I copied the DSM-5-TR criteria and turned them into a questionnaire that I could present to my extended family and circle of friends
— —people who have known my son since birth:
"Did you ever see my son playing with dolls as a child?
Has he ever worn a dress?
Do you perceive him as feminine now, in terms of appearance and behavior?"
Questions like that. When the results of such a survey are unanimous, it lends objectivity to the parents' perspective.
It's important to note here that the DSM criteria involve a combination of feeling and expression. If no one has ever observed unusual behavior, then there has been no gender expression—and thus, according to the DSM-5-TR criteria, no gender dysphoria.

The core of the problem in clinical assessment is that gender identity is an internal experience that cannot be physically measured. Care decisions must be based on objective data and not solely on subjective experience.
Healthcare providers often dismiss parents' observations by arguing that the child did not feel safe expressing themselves at home, or that the parents have a blind spot. Although this may be true in some cases (for example, in strictly religious or conservative families), it becomes implausible if no one from the broader family or social circle has ever noticed anything. A cousin, childhood friend, neighbor, teacher, aunt, or grandparent—someone must have noticed something over the years. If no one has noticed anything, the story simply doesn't add up.

In my case, the outcome was crystal clear, because my son is 100% goth: dressed in black, with eyeliner, black nail polish, and heavy chains around his neck. He looks like a punk from an emo band and is not at all feminine in his behavior or expression. He resembles Kurt Cobain with unkempt black hair.

You have received a copy of my scientifically designed questionnaire, which we as parents used to objectively assess whether our child exhibited signs of gender dysphoria. Eight immediate family members completed the survey. **None of them recognized even the slightest indication of**

gender dysphoria or transgender identity—neither in the past nor in the present. None of them had ever observed anything unusual in his behavior. **My family doctor had a slip of the tongue, and he, too, indicated that he did not recognize anything indicative of a transgender identity in our son's behavior or emotional expressions.**

This information was submitted to the gender clinic. Clinical psychologist Derwig, who made the diagnosis, confirmed that the survey was very well structured. I recorded his statement on my phone. With that statement, he acknowledged the quality of the survey. He is therefore obligated to include this information in the diagnosis as a fundamental factor.
The survey results were then completely disregarded. The 25 additional questions on pages 22–24 of the survey, directed at the clinic, remained unanswered. Months later, we learned from our son that the clinic had ultimately issued a positive diagnosis—a diagnosis that was at odds with the findings of the family assessment.
I asked my son, "How is that possible? On what basis did he ignore the survey results?"
Mr. Derwig then told my son, "We can't really make a diagnosis because we don't have any measuring instruments. That's why we can only rely on what the patient himself says."
This was a huge "wow…" moment for me.
So the clinic openly acknowledges that it does not use an objective diagnostic method, yet at the same time ignores a diagnostic tool (our family questionnaire) that it itself has recognized as valid. And even though they claim they cannot make a diagnosis, they still consider it justified to use a diagnostic code to bill the insurance company for treatment costs.

This raises serious questions about the medical and ethical integrity of their approach.
If you cannot diagnose because no tools exist, how can you justify the use of a diagnostic code?
That seems legally highly questionable—especially when there is strong contrary evidence from eight family members and the family doctor who contradict the self-report.

And "no tools available"? They themselves had used a survey and a cover letter. Do those suddenly no longer count as tools? My counter-survey exposed this inconsistency: the moment I myself introduced a tool, there were suddenly "no tools" left. In reality, their tools are therefore pseudo-tools—**a smokescreen designed to make insurers believe that a legitimate diagnostic process has taken place.**
In my view, setting up this sham is fraud. It facilitates medical consumerism in its most extreme form. A structural failure of medical responsibility.

A Critical Question for the Clinics

If we take a step back, something even more shocking comes to light:
If the widely shared, identical opinion of eight family members and a family doctor does not lead to a negative diagnosis, when has parental input ever led to a negative diagnosis? There are two possible answers: Such parents exist, but is it plausible that their input carries more weight than ours? Most likely not—which points to arbitrariness in the diagnostic process. But a more realistic explanation is this: **Parents are always ignored when they offer critical observations.** Why, then, do clinics even invite parents in the first place?

Because of this painful realization, I have asked my health insurance provider to actively pose the following critical question to the gender clinics with which they collaborate:

“Can you show us a patient record in which parental input overruled the patient’s self-report and led to a negative diagnosis?”

I suspect that no such case exists.

If that is correct, it would mean that gender clinics systematically use diagnostic codes without objectively and critically weighing all available information—and that they have misled many parents by giving them false hope through the illusion that they are being heard.

That is a massive deception and, in my view, a criminal offense.

Investigation into Unfounded Diagnosis

An adult has the right to bodily autonomy, which means that he or she may decide for themselves about their own body and the associated medical treatments. However, this right does not imply that a medical diagnosis may be based solely on personal beliefs or preferences. **A specialist must base their assessment as much as possible on objective medical facts, a broad perspective—including impressions from direct interaction—and clearly formulated diagnostic criteria.** When a diagnosis is not based on factual grounds and strict methodology but is influenced by non-medical considerations, this can lead to incorrect decisions and the unjustified allocation of care.

Physical autonomy means that a family may not force a diagnosis—but it also does not mean that a diagnosis is detached from the broader medical and social context. Therefore, the following questions arise:

- Why did the clinical psychologist issue a positive diagnosis that completely contradicts the observations of both the family and the primary care physician—particularly regarding the unrecognized gender expression?
- On what objective grounds is he convinced that the entire family has an incorrect view of the situation?
- And are those facts truly more convincing than the general practitioner’s impressions and the findings of a thorough family assessment—an assessment that is an essential part of the differential diagnostic process?

The Limits of Self-Report as Justification for Invasive Medical Care

A frequently heard argument in defense of current diagnostic practices regarding gender dysphoria is that psychiatric diagnoses are, by definition, based on the patient’s self-report. Although this is factually correct, this comparison is misleading in practice.

When someone reports compulsively washing their hands a hundred times a day, that self-report can indeed lead to a diagnosis of obsessive-compulsive disorder. The subsequent treatment, however, consists of psychotherapy or medication—not amputation of the hands. The medical response remains proportionate and is aimed at alleviating suffering without causing irreversible physical harm.

Gender care, however, takes a fundamentally different approach. Here, subjective experiences — —such as the feeling of “being in the wrong body”—can lead to medical interventions that are permanent, drastic, and irreversible: hormone therapy, mastectomy, castration, and genital surgery.

To justify such drastic somatic interventions, much more is needed than mere subjective self-reports. In line with the medical principle **of *in dubio abstine*** (“when in doubt, do not act”) and the ethical imperative **“First, do no harm**,” one would expect irreversible medical procedures to be performed exclusively in cases of extreme suffering, long-term stability of the

desire for treatment, and a clear medical indication. That level of evidence is lacking.

As demonstrated in my case, diagnoses are made solely on the basis of self-reporting
— followed by a course of treatment that causes serious physical harm to a healthy body. This not only exceeds the bounds of medical proportionality but also crosses the ethical line between care and harm.

The question then arises: **Is this still legitimate healthcare—or are we dealing with an ideologically driven system that no longer meets the standards of medical reasonableness and ethical responsibility?**

Addendum

I wrote this text back in April, a few weeks before the publication of the article *"Attention Insurers: False Diagnostics in Gender Healthcare Exposed"* on the Genspect website.[8] The text I am now presenting to you approaches the subject from the perspective of my personal story. It was not feasible to fully integrate the broader analytical perspective from the Genspect article. I recommend reading the article as a supplementary resource—it addresses the same core issues but takes the position that **the lack of a proper differential diagnosis essentially amounts to medical negligence.**

Lack of transparency and unjustified claims: how are these monitored?

A health insurer does not have full insight into the diagnostic processes within a clinic. Insurers only receive claims for cases in which a positive diagnosis has been made, since negative diagnoses do not qualify for reimbursement. This means that when a clinic systematically issues positive diagnoses, **this remains invisible to insurers**, and a potential pattern of unfounded diagnostics goes unnoticed.

If a clinic has acted in a non-transparent manner, made a false diagnosis, or used an unjustified diagnostic code, this may be considered deception and fraud. In such cases**,** the health insurer has **the right to recover reimbursements already paid, because the claim was not based on adequate medical grounds.** This follows from applicable regulations and contractual agreements between insurers and healthcare providers.
I set out to find other concerned families and have already identified ten families who were all ignored by the clinic. This supports the impression that parents are never listened to during the diagnostic process. I have consulted with a number of insurers, and they share my view that the actions of Mr. Derwig and the gender clinic do indeed raise questions. However, they are bound by the legislation established by the NZA and were unable to assist me. They advised me to contact the NZA. I am currently in the process of doing so, but I wanted to bring this issue to your attention first to prevent it from escalating.

Given the potential scope of the problem and its impact on a very broad group of families **(possibly hundreds, or even thousands)**, this could be a systemic legal issue with far-reaching consequences. This could lead to large-scale recovery proceedings by multiple insurers. If these suspicions are confirmed, this could develop into **one of the biggest medical and insurance scandals of our time**.

Clinical psychologist Derwig: “Transition doesn’t make you happy”

The problem isn’t limited to ignoring the family’s observations. During our conversation, clinical psychologist Derwig made a number of very remarkable statements. The most striking one: ***“Transition doesn’t make you happy.”*** He repeated this statement several times, and I recorded it on my phone.
If a healthcare provider within the clinic itself admits that a medical transition does not improve well-being, the question arises: **why are we still doing it—and is this even responsible care?** What justification, then, remains for this treatment?[9]

Non-binary, Nullification, Eunuch

The situation surrounding my son is even more peculiar than I have described so far. I’d like to delve a little deeper into his wishes.
My son hates **“the patriarchy”**—whatever that may mean. He is extremely left-wing. The logical leap that follows is this: patriarchy is caused by oppressive men. Masculinity is caused by testosterone. So he wants to be castrated. Because that would stop testosterone production. **But he does want to keep his penis and doesn’t want vaginoplasty...**
How this relates to gender dysphoria is a mystery to me. And how a diagnostic code can be applied to this is also unclear. Because what, then, is the definition of “the opposite sex”? The DSM-5-TR operates on a binary system in its criteria and does not recognize non-binary categories. How, then, can a diagnostic code be assigned based on a non-binary identity?

What my son wants is also known as “nullo” or “nullification.” Or “eunuchism.” Because that is essentially what we’re dealing with here.
What almost no one knows is that the Dutch Protocol 2024 recognizes *“*eunuch*”* as a gender.[10]
The often-cited sadomasochistic scandal regarding “eunuch” as a gender in WPATH’s SoC8[11]was therefore not a “slip of the tongue” based on a leaked draft, but intentional. The Dutch publication proves this.[12]
The eunuch scandal is one of many scandals surrounding WPATH. Prior to the Amicus brief, there was already the publication of ***The WPATH Files*** by Mia Hughes and **the Rachel Levine scandal**, in which **Annelou de Vries** of the Amsterdam clinic was closely involved, as she is the lead author of the chapter on which Levine exerted political pressure and forced changes. I explicitly pointed out the eunuch issue to Mr. Derwig, as well as the other problems surrounding WPATH, and asked him for an explanation as to why he (and other Radboud specialists) were still members of WPATH. I never received a response, and he remains a member to this day.[13]

Eunuch castration raises serious medical-ethical questions, because it does not create a female body, but rather a medical condition that deviates from accepted principles in medicine. Plastic surgery is not intended to create fantasy creatures, and medical procedures must always have a clear ethical justification: namely, that they are performed for aesthetic reasons, but with the primary condition that the body is not mutilated in an extreme manner.

Furthermore, this desire for castration is at odds with ethical and legal boundaries surrounding body modification.

Gender surgery violates fundamental ethical values. In the Netherlands, the practice of apotemnophilia (the removal of healthy limbs) and female genital mutilation (FGM) are prohibited. It is unclear why gender care believes it should be exempt from these prohibitions.
This appears to be legally and medically untenable. **Is this a case of negligent care?**

Informed Consent and the Concorde Effect

After I received the shocking news that he wanted to be castrated—even though he wanted to keep his penis—I had to explain to him that such a procedure almost always leads to complete loss of erectile function. He didn't believe me and responded casually: "Then I'll just take Viagra." I had to explain that when you're at zero, two zeros is still zero. Apparently, that got him thinking. In later conversations with my wife, he indicated that for now he only wanted hormones. It didn't stop there; I found a strip of estradiol. It's unclear whether this was prescribed by Radboud or if he purchased it illegally. During our conversation, Mr. Derwig indicated that the family rift was a problem for him in starting the medicalization process. If he has gone ahead and done so anyway, this is a serious crime that calls for far-reaching consequences. He gave the impression that we were safe with him and that no transition could take place as long as the rift remained unresolved. After all, medicalization would only widen the family rift. And there is an immediate health risk that causes me serious concern. For these reasons, I am requesting a thorough investigation and would like to know exactly what took place and who was responsible for it. Was the medication purchased illegally, or did Radboud prescribe it?

My son's exact wishes remain unclear. Just hormones, or physical castration as well? Any discussion of this has now become taboo. That taboo is dangerous, because it involves a desire for self-harm by proxy. A form of self-mutilation carried out by the hospital. A clear confirmation that he is abandoning the idea of castration would be an enormous relief to me—but even then, the concerns would not have disappeared. I would like to draw attention to an underreported pattern, which, in my opinion, constitutes a strong argument in the context of lawsuits surrounding detransition and liability issues.

Many boys initially say they only want hormone therapy and explicitly reject surgical procedures. The protocol stipulates that a treatment plan must be drawn up before the medical transition begins. However, what is rarely discussed—and is often underestimated or unknown to primary care physicians and insurers—is that estrogen is only effective in biological males when their natural testosterone is actively suppressed with antiandrogens.

This antiandrogen medication has far-reaching consequences, including:

- Penile shrinkage
- Significant shrinkage of the testicles (up to two-thirds of their original size)
- Reduced sexual desire
- Problems with erections and orgasms
- And ultimately, in the long term: total impotence and sexual dysfunction—effectively a form of chemical castration

The side effects of antiandrogens are severe and often difficult to tolerate. One "solution" to this is surgical castration, because then you only need to take estrogen. **However, this procedure was not part of the original treatment plan.** Nevertheless, patients are often ultimately forced to undergo it because the antiandrogens are too severe to continue taking. This is a **path-dependent compulsion**. The tragic case of Richie Herron illustrates this well-recognized problem.[14]

A similar dynamic occurs in women who use testosterone long-term. There, too, serious medical complications arise over time, such as vaginal atrophy—a condition that causes extreme pain and can ultimately lead to mandatory surgical procedures that were never planned or discussed beforehand.

In both cases, there is a purely iatrogenic **"Concorde effect**": the patient continues the transition and is driven by the complications to make extreme choices, facing increasingly severe consequences that were never explicitly chosen or understood at the outset. This complexity is particularly difficult to grasp for young people, who often begin their transition with idealistic, wishful thinking. **True informed consent is virtually unattainable in such cases.**

This alarming observation is also confirmed in the WPATH Files, as documented by Mia Hughes. Internal communications revealed that professionals in transgender care are aware that patients are not truly capable of giving informed consent—and yet they provide invasive, often irreversible care. In such cases, there is culpable conduct.

In gender care, the term "gender journey" is used, which obscures this sunk-cost effect. **Through misleading language, unethical, iatrogenic care is packaged as an individual's free choice.**

For insurers, it is difficult to discern from the records that the change in preference was iatrogenically caused, and too complex to recognize that it involves culpable care.
This raises crucial questions:
Should the insurer reimburse these additional, often costly treatments? Or does the financial responsibility actually lie with the healthcare provider, who failed to act realistically, comprehensively, and ethically?

Questions for the specialists at the gender clinic

As mentioned, I am currently preparing a dossier on behalf of myself and ten other families that I will submit to the NZA.

To prevent the situation from escalating, I believe it is urgent that Radboud itself launch an investigation immediately. The NZA will appreciate this, and hopefully, this will limit the damage.

To assist you, I have compiled a list of investigative questions that you can use.
Based on the answers to these questions, you can assess whether my concerns are justified or whether there is no cause for alarm. I have no doubt about your professionalism and judgment in this matter.

1 – Is gender-affirming care family-disruptive care? If the clinic believes it is not, how does the clinic respond in cases where a family rift has already occurred? Is there an active focus on family therapy prior to the transition, or is moving out of the home promoted as a "solution," effectively encouraging family breakdown through this avoidance?

2 - Does the clinic acknowledge and recognize the criticism that gaslighting and brainwashing may have occurred within the patient's immediate social circle, both before and during treatment? If the clinic believes this is not the case, on what is that impression based? Can the clinic prove that no gaslighting or brainwashing

? Is the immediate social environment being investigated in this regard?

3 If you cannot make a diagnosis because no diagnostic tools exist, how can you justify the use of a diagnostic code?

The most important question:
4 Can you show us a patient record in which parental input overruled the patient's self-report and led to a negative diagnosis?

5 Why did clinical psychologist Derwig issue a positive diagnosis that completely contradicts the observations of both the family and the primary care physician—particularly regarding the unrecognized gender expression? Did Mr. Derwig consult the extended family to verify whether the parents' account makes sense?
6 On what objective grounds is he convinced that the entire family has an incorrect view of the situation?

7 Are those facts truly more convincing than the general practitioner's impressions and the results of a thorough family assessment—an assessment that is an essential part of the differential diagnostic process?

8 The case described above shows that self-reporting has overshadowed differential diagnosis. What justifies abandoning the fundamental medical principle of differential diagnosis and relegating it to a "side dish" subordinate to self-reporting?

9 The statement "Transition does not improve your well-being" raises questions about the legitimacy of somatic transition care. Can you explain why this care is necessary if it does not promote the patient's well-being?

10 The ethical issues surrounding non-binary identities, nullification, and eunuchism raise questions. Why is there a deviation from the binary system of the DSM, and is this even tenable? What evidence is there for the existence of the following genders: non-binary, nullo, and eunuch?

11 Do you recognize the problem described regarding the lack of informed consent? How will you prevent harm to the patient that cannot be assessed in advance?

12 Do you recognize the iatrogenic Concorde effect? How do you prevent it? If it occurs, will your department be liable for the costs of this damage? As a specialist, you bear ultimate responsibility. Will you personally bear the consequences if this goes wrong?

In addition, the Genspect survey on pages 22–24 contains 25 supplementary questions. If the above questions reveal no evidence of medical malpractice, the clinic must also provide adequate answers to these questions. These 25 questions will give you a good understanding of gender-critical thinking. An increasing number of parents are becoming more aware due to constant media attention and are becoming familiar with these issues. If these questions are not answered, it will lead to legal issues.

Sources

1 **Medical ethics is not a technique for wearing a slip**—Prof. Dr. G. Manenschijn, Dec. 3, 1992, Trouw newspaper: *"Gender transition places an extraordinary burden on acceptance by one's social environment." See scan.*

2 **The Rape of the Mind: The Psychology of Thought Control, Menticide, and Brainwashing**—Joost A. M. Meerloo, 1961. ISBN-13: 978-1614277873

3 **Elon Musk interviewed by Jordan Peterson** (July 2024) https://www.youtube.com/watch?v=Q20Nbq3EJsc

4 **Irreversible Damage** - Abigail Shrier ISBN-13 978-1800750364 (2021).

5 ***Time to Think***—Hannah Barnes, ISBN-13 978-1800751118 (2023).

6 Allie Beth Stuckey - **Former Gender Clinic Employee Blows the Whistle on Medical Abuse, Guest: Jamie Reed**, Ep. 1109, December 5, 2024, around 17 minutes. https://www.youtube.com/watch?v=99CIw4jFX8

7 **DSM-V-TR online:** https://archive.org/details/dsm-5-tr/page/n1/mode/2up

8 **Attention Insurers: False Diagnostics in Gender Healthcare Exposed** - Hermes Postma, April 30, 2025. https://genspect.substack.com/p/attention-insurers-false-diagnos-tics

9 Derwig's comment is not an isolated incident. Annelou de Vries of the VU UMC Gender Clinic stated: *"What is very clear is that puberty blockers work—they halt sexual development. Estrogen works—feminization begins. Testosterone works, too. If we take that as a measure of effectiveness, these are extremely effective treatments. And that's why people come here."* (Source: **Interview with Annelou de Vries in NRC**, January 30, 2025 — https://www.nrc.nl/nieuws/2025/01/30/we-kunnen-veel-opener-vragen-hoe-voel-je-je-over-je-lichaam-a4881300)

10 **Evaluation of the Quality Standard for Transgender Care – Somatic**, pages 21, 25, 27. February 2024. https://demedischspecialist.nl/sites/default/files/2024-04/Evaluatie%20van%20de%20kwaliteitsstandaard%20Transgenderzorg%20%282024%29%20%281%29.pdf

English version herehttps://www.boomdocent.nl/tijdschrift/FenR/FENR-D-24-00001

11 Amicus brief by Alabama Attorney General Steve Marshall, pages 34–36: https://www.alabamaag.gov/wp-content/uploads/2024/10/2024.10.15-Ala.-Amicus-Br.-iso-TN-FI-NAL.pdf

Translation of pages 34–36:

"WPATH Recommends Castration as 'Medically Necessary' for 'Eunuchs.'"

As if to further emphasize just how unscientific the SOC-8 project was, WPATH included an entire chapter on "eunuchs"—"individuals assigned male at birth" who "wish to eliminate male physical characteristics, male genitalia, or genital functions." Because eunuchs "desire a body that is compatible with their eunuch identity," WPATH "recommends castration to better align their bodies with their gender identity."

That is no exaggeration. When Dr. Coleman was asked in his testimony whether "in the case of a physically healthy man with no recognized mental health conditions, who presents as a eunuch and requests castration, but for whom there is no indication that he is actually at high risk of self-castration—is it still WPATH's official position that such castration could be a medically necessary procedure?" Dr. Coleman confirmed: "That is correct."

Dr. Coleman also acknowledged that no diagnostic manual recognizes "eunuch" as a medical or psychiatric diagnosis. And other authors of SOC-8 criticized the chapter as "highly speculative and based on assumptions, while a solid body of evidence is largely lacking." Dr. Bowers even admitted that not every board member had read the chapter before it was approved for publication. It doesn't matter: the guideline that the United States requires states to adopt officially recommends castration for men and boys who identify as "eunuchs."

And how did WPATH come to the conclusion that castration is "medically necessary gender-affirming care"? From the internet—more specifically, a "large online peer-support community" called the "Eunuch Archive." According to SOC-8 itself, this "Archive" contains "the greatest wealth of information about contemporary eunuch-identified people."

The directive does not mention that part of that "wealth" comes from the site's fiction archive, which contains thousands of stories that "focus on the eroticization of **child castration" and "describe sadistic sexual abuse of children**." This "fictional pornography" includes "themes such as **Nazi doctors castrating children, baby boys being fed milk laced with estrogen so they can be abused through violent sex trafficking during adolescence, and pedophilic fantasies about children who have been castrated to halt their puberty."** Despite all this, the medical advocacy groups supporting the petitioner still claim that the WPATH guideline "followed the same type of procedures … as other guidelines issued by amici and other medical organizations."

"*Let's hope not.*"

12 Evaluation of the Quality Standard for Transgender Care—Somatic, Feb. 2024. Care for eunuchs is mentioned on pages 21, 25, and 27. https://demedischspecialist.nl/sites/default/files/2024-04/Evaluation%20of%20the%20Quality%20Standard%20for%20Transgender%20Care%20%282024%29%20%281%29.pdf

13 WPATH Membership search results. See the printed appendix of screenshots from June 1, 2025, and August 29, 2024. https://app.wpath.org/provider/search?provider directory search form%5Baddress%5D%5Bcountry%5D=NL&provider directory search form%5Baddress%5D%5Bstate%5D=&provider directory search form%5Baddress%5D%5B-city%5D=&provider directory search form%5BfirstName%5D=&provider directory search form%5BlastName%5D=&provider directory search form%5Bspecialty%5D=

14 Andrew Gold, *Heretics*. 76 **Ideological Doctors Pushed Me Into Gender Surgery** - Ritchie Herron, July 24, 2024. https://www.youtube.com/watch?v=tk7NX7iPr9k

Trouw, March 12, 1992

Medical ethics is not panty-wearing techie

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An aïfed/sczezïes must be an efnd Jromerr, even though others W zrwzs• se€zudïïefC Á ae'Jk to z ĝeneo <r/e demoefre/zobbnn peno• men uitvoerig op mijn beide artikelen in te gaan, een antwoord verplicht te zijn.

Er waren veel reacties. Afwijzende en veroordelende, zoals die van de hoogleraren Gooren en Broekman, dominee Doolaard (alle drie verbonden aan de medische faculteit of the academic hospital of the VU) en de journaliste Nicole van der Toorn, Hzxsb§dragen zFjn elfefwaal was published in mourning. Furthermore kreeg ik nog een afkeurende brief. Instemmende reacties bereikten mij vooral telefonisch en mondeling, ook uit kringen van transseksuelen, uit hun directe omgeving, uit de kring van hoogleraren aan de VU en van medici.

De zaak zelve. Het indrukwekkendst waren de verhalen van twee mensen die een geslachtsverande-

ring vari ftsazt to vroqw twbbgg matter: Nlcols van der Toorn and woman who had been treated (so to speak) team has now made it clear to me that a significant impact on) the fact that she has not yet back to be able to Gm da aaakwaarorn clear that a hot bath etg•nfijlca the r«akon@n dexe vefhalsn"meeÉ McitaW...Hct Ilj‹5eti @qn valdoeude, Everything is there lzsge• zsgd.zcstasn n•ast el$ta '¥b €we6autfientlèÏxe isgen die je niet tegen elkaar kunt wegstrepen. Voor beide vrouwen ge-

Bewoordingen

Uit de vele reacties trek ik vijf conclusies.

1. De communicatie is erg moeilijk. Om voor niet-ingewijden duidelijk te maken wat er feitelijk gebeurt bij een geslachtsaanpassing koos ik al te harde bewoordingen, maar vind maar eens woorden die acceptabel

nłżit lerr xl that have a gcslachtś«eranderB+g has cfrutetgaan schreef mij of ik liever helemaal niet over deze problematiek wilde schrijven, want het ter sprake brengen ervan deed al pijn. Dat gaat wel erg ver. Als een publiek debat niet kan, is er dan wel enig probleem opgelost?

z. Both ńWzouw Vazi and Tom'n

... also from the perspective of a.a. Kuipw{in 7rotnv of Ze fetvusf}, who considers "deDancsatmzafbatfe" as a candidate for the Lt>andsIIng mblet• dend is, en wel omdat zij suggereert dat de transseksuelen na de behandeling verlost zouden zijn van hun transseksuele achtergrond, wat niet het geval is. Trouwens, als men de cijfers van dr. Kuipers proefschrift ziet, dient de opmerking dat dit proefschrift aantoont dat de behandeling zinvol is ge-

West. Relative to

3. Er is geen weg terug. Gooren gives this window 'rl@ to My question was: 'What do you have to to say to them?" 7 The answer remained:

mens in haar/ zijn eigen hoedanigden en daarbij mag de seksuele identiteit geen enkele rol spelen,

but this is the essence of the followed by In any case, a the treating (which has accepted by

From the story by Bro•fozt¥ri, it's gr}}plkdaLhg this is the bteern vlndc as -toanlgthe view seästzsïe wgs• nenot tUUc lmegendeel: dat lijden wordt veroorzaakt door de samenleving die professor Manenschijn en wij allemaal tot stand brengen en in stand houden." (Aan deze opvatting verbindt Broekman tot twee keer toe de concbale that rriensen ale I the zgn d vetant'¥6oordeB}k zgn forJset

Er is hier echter sprake van twee types of łgdAn, which are a whole lot worden gegooid. Er is het lijden aan de aandoening en het lijden dat de sociale omgeving je aandoet. Broekman laat het eerste lijden opgaan in het tweede. De getuigenissen van de beide MV's weten echlang. Als men als team daarop nauwelijks invloed kan uitoefenen,

5. Broekman zegt dat medische ethiek te maken heeft met de kwetsbaarheid van elke mens. Akkoord, maar met nog veel meer. Ook met het handelen van medici, met de verdeling van schaarse middelen in de gezondheidszorg en dus met prioriteiten, en met een kri-

de taak elke nieuwe ontwikkeling in medische techniek maatschappelijk aanvaardbaar te helpen maken.

I'll say that I'm sorry. I'm very sorry for what the Prophet

sor Broekman zich in die rol goed thuisvoelt. Ik citeer: „Er is dus geen sprake van een 'lichaamsaanpassing aan de ik-beleving', maar *de lichaamsaanpassing wordt verlangd*

zegt dat de medische techniek tot niets anders in staat is dan een aanpassing van de uiterlijke gedaante. Daaruit trekt hij niet de conclusie dat de medische techniek terughoudend dient te zijn, maar dat de ethicus moet meehelpen de persoon in kwestie de identiteit te verlenen die de *samenleving* van haar-/hem verlangt.

Het sociale aspect is voor hem kennelijk belangrijker dan het medische. Dat stemt aardig overeen met de analyse van de Oxford-hoogleraar Oliver O'Donovan dat het aangeboden goed van de transseksuele geslachtsaanpassing niet een *medisch goed is, maar een sociaal* goed. Het lijkt mij duidelijk dat voor Broekman het probleem in de samenleving ligt, niet in de medische wereld en de medische techniek. Op de ontwikkeling van de medische techniek als zodanig wordt immers geen enkele kritiek uitgeoefend.

Ik kan mij niet goed voorstellen dat Broekman de rol van de medische ethiek ziet als slippendraagster van de medische techniek, maar zijn beschouwingen suggereren dat wel. Om als slippendraagster te dienen is het voldoende respect te heb ritiek te kunnen oefenen is een scherp analytisch vermogen nodig, alsmede de moed om tegen reputaties en heersende opvattingen in te gaan.

De auteur is hoogleraar ethiek aan de Theologische Universiteit van de Gereformeerde Kerken in Kampen.

de

Is da a łem. Five would

Example of a gothic boy—not my son, but he dresses like that. Not girly.



Search result for WPATH membership June 1, 2025

41 RESULTS:

member name	Specialty	City	State	Profile
Cameron Boisen, Ph.D.	Behavioral Health, Counseling, LGBT Therapy, Psychology, Other	Amsterdam	North Holland	HSE PROFILE
Jofian3cone, BA	Counseling, Education, Other Social Sciences (Anthropology/Education/Political al Sciences/Sociology/etc., Religious Studies/Research, Social Work	Natur	Zeeland	VJF\ PROFILE
John Capozuca, PhD	Psychology	Amsterdam	North Holland	VIEWPROHLE
Siemens de \recze	Graduate Student	Assen	Drenthe	VIEW PROFILE
An Nelou L.C. de Vries, MD, PhD	Pediatrics: Psychiatry	Amsterdam	Holland	VJEW PROFILE
Joost Derwig, MA	Behavioral Health, Psychobogy	Nijmegen	gelderland	VIEW PROFILE
Koen Dreijerink	Endocrinology	Amsterdam	North Holland	VIM PROFILE
Lieke Galas, MD	Endocrinology, Graduate Student	Nijmegen	Gelderland	VIFW PROFILE
Noor Gieles, ND	Endocrinology, Graduate Student, Sexology/Sex Therapy/Sex Research	The Hague	South Holland	VJFW PROFILE
Luk Gijs	Psychology, Sexology, and Sex Therapy/Sex Research	's-'s-Hertogenbosch	North Brabant	VIEW PROFILE
Noortje Hartog Jager, NS	Behavioral Health, Counseling, LGBT Therapy	Groningen	Groningen	VIEW PROFILE
KimHo‹snlj*4D	Counseling, LGBT Therapy, Pediatrics, Pediatrics: Psychology, Professional Counselor, Psychology	Haarlem	North Holland	VIEW PROFILE
RudoJph Hou ben, BIO, Ph0	Resident, Surgery: Facial, Surgery: Plastic, Surgery: Urology	Amsterdam	North Holland	VIEW PROFILE
LJ Kalverdijk, MD	Pediatrics: Psychiatry, Psychiatry	Üf0DiP#6O	Groningen	ViM PROFILE
Boris Kanen, kl0	Endocrinology, Internal Medicine/Family Practice/Primary Care	Amsterdam	North-Holland	VIEW PROFILE
Alex Kolman, P D	Pediatrics: Psychiatry, Psychiatry	Santpoort Zuid	NLI	VGM PROFILE VIEW
Baude\vijntje Kreukels, PhD	Psychology	Amsterdam	North Holland	PPOFILE
Peter Leisink, CO, Ph.D.	Endocrinology, Internal Medicine/Family Practice/Primary Care, Sexology/Sex Therapy/Sex Research	Utrecht	Utrecht	VIEW 99PROFILE
Wilma Yathurin	Education, Graduate Student, LGBTQ Therapy, Marriage and Family Therapy, Psychology, Sexology/Sex Therapy/Sex Research	Almere	Flevoland	VIEW PROFILE
nm jhus », to	Surgery: Facial, Surgery: Plastic	Nijmegen	Gelderland	VIEW PROFILE
This is Oosthuek, MA	Graduate student	Rotterdam	South Holland	VIEW PROFILE
M'ujde Ozer, MD	Sexology/Sex Therapy/Sex Research, Surgery: Plastic, Other	Naarden,	North Holland	VIEW PROFILE
Nina Pot	Graduate Student	Amsterdam,	Noord-Hofland	YIE's PROFILE
Fredefiqne Retsema, APEN, ARNP, BA, b5, CFTP	Counseling, Education, Psychology, Other	Almefe	FL	VIEW PROFILE
Joep Roepen, MA	Professional Counselor, Psychiatry, Psychology	EINDHOVEN	North Brabant	VIEW PROFILE

November 9	Specialty	City	State of	Profile
Skye Stanwich, BA, US	**Graduate Student**	**Utrecht**	Utrecht	'YJEW PROFILE
Thomas 0. Steensma, PhD	Psychology	Amsterdam	**North Holland**	VIEW PROFILE
Maaike Terheggen, MA	LGBTQ Therapy, Psychology	Fllimmen	Groningen	VI MW PRO F-IU
Jasmijn Tissingh, AMP	**Endocrinology, Nurse Practitioner, Nursing, Pediatrics, Physician Assistant**	**Zaandam**	**North Holla nd**	VIEW PROFILE
Christa van Bunderen, MD, PhD	Endocrinology	Nijmegen		\VIEW PROFILE
Emmy van den Boogaard, TO, PhD	**Gynecology, Surgery: Gynecology**	Baarn	Utrecht	V|EW PROFILE
Anna van der Xliesen, ID, PhO	Psychiatry	Amsterdam	**North Holland**	VIEW PROFILE
Mason van Heesea'ijk, MW	Endocrinology, Psychology	Amsterdam	**North Holland**	VIEW PROFILE
Naomi Van Hout, NO	Surgery: Plastic Surgery	**Amsterdam**	**North Holland**	VIEW PROFILE
Norah Van Me|o, MD, P-0	Endocrinology, Gynecology, Surgery: Gynecology	Amsterdam	tJ 0 O F$- holiard	VI MW PRO F-IU
Wouter van Vu§t, M.D.	**Graduate Student, Gynecology, Sexology/Sex Therapy/Sex Research, Surgery: Gynecology**	**Amsterdam**	**North** Holland	VIEW PROFILE
Renate VanGenugten, MD, PhD	Endocrinology	iféillg Landstkhtln$	Gelderland	V|EW PROFILE
Camiel Welling, M.D.	**Public Health, Sexology/Sex Therapy/Sex Research**	Amsterdam	North Holland	VIEW PROFILE
Oanny Young Afat, M.D., Ph.D.	**Surgery: Plastic Surgery**	Amsterdam	North-Holnd	VIEW PROFILE
Bas Zegers, MO, PhD	LGBT§ Therapy, Pediatrics, Pediatrics: Psychiatry, Pediatrics: Psychology	Venlo	Limburg	\IE¥ PROFILE
Odo|Zemko, FNP, f3SN	**Endocrinology, Nurse Practitioner**	Debt	**South Holland**	V|VIEW PROFILE

An older check from August 29, 2024 also showed the following names:

¥\ei$fCt¥ghgnn• yBo der Grinten, MD, PhD	Endocrinology, Pediatrics. Other	Nijmegen	Gelderland	VIEW PROFILE
Fleur Lahaije, MD	Endocrinology, Pediatrics, Other	nijmegen	Netherlands	VIEW PROFILE

The WPATH search directory is unreliable. It is unclear whether Hedi Claahsen-van der Grinten and Fleur Lahaije are currently still members.

Date: Monday, November 10, 2025

To:
5.1.2e
Health Council

Subject: Response to your letter of October 29 – committee composition and weighting of literature

Dear 5.1.2e **,**

Thank you very much for your clear response of October 29, in which you explained three main points:

1. The composition of the committee,

2. The basis in scientific research reports,

3. The consideration of parents' perspectives.

I appreciate the careful structure of your response, but I am seriously concerned about three structural shortcomings that, in my view, could affect the independence and completeness of the final recommendation.

1. Incomplete multidisciplinary composition

In my view, the committee lacks several crucial areas of expertise.
First of all, there is a lack of a **philosopher specializing in mind-body issues**. Concepts such as *gender identity* are fundamentally conceptual and deserve deeper epistemological consideration. Without this perspective, there is a risk of a one-sided approach that is not in line with the principles of evidence-based medicine.

I am in contact with several prominent Dutch philosophers and, if desired, can put the Health Council in touch with suitable experts who can provide valuable insight on this matter.

In addition, there is a lack of a **specialist in counterculture and youth subcultures**. The current phenomenon surrounding gender identity among young people shows clear parallels with online and subcultural dynamics, including radical identity formation, group loyalty, and self-expression.
An expert in the field of radicalization, countercultures, or collective identity formation is therefore indispensable.

Due to this gap, there is a risk that the committee lacks sufficient insight into the cultural and psychological factors that play a role in young people with gender dysphoria. Drawing on my 25 years of experience as a research artist and instructor at more than 25 European academies, specializing in avant-garde and counterculture, I would be happy to offer a lecture or presentation on this topic.

In addition, I have an extensive international network of independent researchers and experts with whom I am in weekly contact. These include, among others:

- **Zhenia Abbruzzese** (Director of SEGM)
- **Stella O'Malley** (Director of Genspect)
- **Mia Hughes** (author of **The WPATH Files**)
- **Dr. Az Hakeem** (psychiatrist, formerly of the Tavistock Clinic, founder of the world's only "regret clinic")
- **Michael Biggs** (sociologist, known for his analysis of the De Vries studies)
- **Dr. Lisa Littman** (founder of the ROGD hypothesis)
- **Erin Friday** (attorney, Director of *Our Duty*, involved in lawsuits against clinics in the U.S.)
- **Jamie Reed** (whistleblower, former employee of an American gender clinic)
- **Helen Joyce** (philosopher, specializing in the relationship between gender and women's rights)
- **Hannah Barnes** (journalist who exposed the Tavistock scandal).

My advice is to consult with some of these experts; I can provide you with their contact information upon request.

2. Incomplete consideration of relevant literature

I appreciate that the committee recognizes the importance of the *Cass Review* and the *HHS report*. These are indeed the most comprehensive systematic evaluations to date.
However, the lack of references to the **WPATH Files**, the **FTC conference proceedings**, and **Marshall's Amicus Brief** raises questions. Although these publications are not traditional scientific studies, they provide relevant context regarding structural shortcomings within international gender care, in which Dutch practice plays a leading role.

Furthermore, the list of critical books recommended in the *Genspect Survey* does not appear to have been included. This increases the risk of tunnel vision.
In addition, I have found serious inconsistencies in older Dutch literature (Gooren, Cohen-Kettenis, Kuiper, De Cuypere) that may indicate structural research and diagnostic errors. These findings could lead to legal issues.

Current events underscore the urgency of this matter. In Belgium, a **lawsuit** was **announced** in November 2025 **following the death of a young person** who passed away shortly after beginning hormone therapy. This case involves similar issues surrounding diagnosis, informed consent, and medical supervision, and demonstrates that these matters are not hypothetical. Parents in the Netherlands are also reporting similar experiences.

For this reason, I am hereby formally registering as **a whistleblower**, with a request to discuss this matter. I am willing to share and explain my findings in a presentation to the committee.

3. Limited Representation of Parental Perspectives

Although you indicate that the Health Council has held discussions with both positive and negative "experts by experience," it is my observation that **not a single critical parent** has actually been heard.
Organizations such as 5.1.2e represent an affirmative perspective, but there is no dissenting voice from parents who have serious concerns about the way in which diagnosis and treatment are carried out.

5.1.2e was invited—a relevant but not parent-focused group.
In addition, 5.1.2e ; however, he declined to participate because he wanted to speak from his professional background as a lawyer, rather than as an individual parent.
As a result, no critical parental voices have in fact been heard directly.
It would be valuable if the committee were to hear not only from 5.1.2e but also from the group of critical parents. I offer to introduce three parents who can share their experiences in an honest and factual manner. Their testimonies illustrate structural problems that appear to occur in several Dutch clinics.

Summary Request

I kindly but urgently request that you:

1. Me opportunity to give a **lecture to to on counterculture and identity formation among young people**;

2. To appoint a **philosopher** (or have me nominate one) who can offer his perspective on the phenomenon *of gender identity*;

3. **To consult with some of the international experts mentioned above**;

4. A meeting to plan in which I can **research findings regarding suspected scientific** fraud;

5. Invite **three parents** who can share their experiences with the committee.

I trust that the Health Council recognizes the importance of hearing both sides of the story, especially given the social sensitivity and potential legal implications of the issues under discussion.
A careful and open discussion with me and a few of the parents involved could contribute to a more balanced and better-informed advisory process.
I look forward to your response.

Sincerely,
5.1.2e

Concerned Parent
Specialist in radical counterculture
Independent researcher—history of Dutch gender care and diagnostics

5.1.2e *@gmail.com*

The Dangers of "Gender-Affirming Care" for Minors

July 9, 2025

Jon Schweppe:

Good morning, everyone. Let's go ahead and take our seats if we can. Folks, we'll start our program in a minute once everyone is seated. Good morning and welcome to the Federal Trade Commission's workshop on the dangers of so-called gender-affirming care for minors. My name is Jon Schweppe. I'm a senior policy advisor in the chairman's office. We have an incredible program for you today featuring 33 guest speakers, plus Chairman Ferguson and Commissioners Holyoak and Meador. Our approach to this workshop is simple: we want to hear from a wide variety of people across the political spectrum on this issue. Our speakers today include medical professionals, ethicists, physicians, whistleblowers, parents, and survivors. We have Republicans, Democrats, conservatives, progressives, and even feminists who are concerned about a profit-driven industry pushing to medicalize—and in some cases, sterilize—gender-dysphoric minors at increasingly younger ages. Before we begin today's substantive program, I need to go over some administrative details.

Please silence any cell phones or other electronic devices. If you must use them during the workshop, please be respectful of the speakers and your fellow audience members. Please be aware that if you leave the Constitution Center Building for any reason during the workshop, you'll have to go through security screening again. Please keep this in mind and plan ahead, especially if you're participating on a panel, so we can do our best to stay on schedule. Most of you received a lanyard with a plastic FTC event security badge. We reuse these for multiple events, so when you leave for the day, please return your badge to security; we'll also have staff collecting them after the event. If an emergency occurs that requires you to leave the Constitution Center but remain in the building, follow the instructions provided over the building's PA system. If we are required to evacuate the building, an alarm will sound; we'll exit in an orderly manner through the main Seventh Street exit, and we'll provide further instructions once outside.

If you notice any suspicious activity—see something, say something—please alert FTC staff and building security. Restrooms are located in the hallway just outside the auditorium. Coffee will be provided throughout the day, and lunch will be served at approximately 12:30 PM outside the ballrooms.
Please do not bring food or drinks into the auditorium. Only water is allowed. Please be respectful of the speakers and panelists, and refrain from interrupting the program. Anyone disrupting the event will be removed by security. Please be advised that this event may be photographed, webcast, or recorded. By participating in this event, you agree that your image and anything you say or submit may be posted indefinitely on ftc.gov or on one of the Commission's publicly available social media sites. All

right. So let's get started with the program. Please welcome to the stage the Chairman of the Federal Trade Commission, Andrew Ferguson.

Andrew Ferguson:

Good morning. Welcome to the Federal Trade Commission. Thank you all for being here, and thank you, Jon, for that introduction. Just over a year ago, the New York Times reported that the Biden administration had pressured the World Professional Association for Transgender Health (WPATH) to remove age minimum requirements for cross-sex hormones and other sex reassignment surgeries from their forthcoming guidelines on the care of transgender youth. Why did the Biden administration object to age minimum requirements? According to emails provided to the New York Times and the state of Alabama in its lawsuit against the Biden administration, the Biden administration's health agencies worried that including minimum age requirements in the guidelines would "result in devastating legislation for trans care." The Biden administration's concern was not that age minimum requirements were unscientific, unreasonable, or unhelpful to doctors, therapists, parents, and children experiencing gender dysphoria. Science was beside the point.

Instead, their concern was political. They worried that age minimum requirements gave too much ammunition to critics of gender-affirming care. The Biden administration didn't care about the parents and children who might have relied on those requirements when deciding whether to consent to expensive hormone treatments and sex reassignment surgeries. They didn't care about the parents and children who might have been spared a lifetime of pain and regret if their doctors, therapists, and surgeons had followed those requirements. They cared about politics; they didn't care about people. Today, by contrast, is not about politics. It's about the parents and children the Biden administration chose to ignore. It's about our nation's children, who are most in need of our love, protection, and support. It's about their parents, whose selfless and fruitful love is the foundation of our nation and of every nation. It's about caring for the most vulnerable among us and protecting them from manipulation, deception, and abuse.

It is about healing the wounds that proponents of gender-affirming care may have inflicted on our nation's children and parents, and preventing the potential for future harm. Today is about people, not politics. So I want to focus on some of the courageous young people we have with us today. While each person's story is unique—and you will hear from them—they do share some common traits, and I want to highlight those traits because they point to recurring patterns of potential deception in gender-affirming care. As chairman of the Federal Trade Commission, Congress has entrusted me with protecting citizens from deceptive acts and practices. And one of the reasons we are here today is to examine whether some of the practices in gender-affirming care are deceptive and require greater scrutiny by the FTC. Let's start with Prisha Mosley. You'll hear from Prisha herself that, at age 14, she was a victim of sexual assault.

By the age of 16, she was suffering from depression, obsessive-compulsive disorder, and anorexia. After a concerning episode of self-harm, a pediatrician was recommended to help Prisha address her eating disorder. After a brief consultation, the pediatrician concluded that Prisha was actually a boy and recommended a therapist specializing in transgender care. Prisha recalls that the therapist assured her that she could cure her depression, obsessive-compulsive disorder, and anorexia by making her body more masculine through testosterone injections. Just a few months later, Prisha obtained a letter from a mental health counselor stating that the surgical removal of her breasts was a clinical necessity. One month later, Prisha's breasts were removed. What had begun two years earlier as a referral to a pediatrician for treatment of anorexia ended on a surgeon's table with the removal of her breasts. Claire Abernathy will describe her similar experience. After experiencing a traumatic sexual assault, she began identifying as a boy when she was just 11 years old.

A year later, she met with a therapist who specialized in transgender care. Claire explains that this therapist recommended she affirm her male identity through hormone therapy and gender-affirming surgeries. Although Claire's mother was skeptical of this diagnosis, she was told that affirming Claire's identity as a boy was necessary to prevent her from committing suicide. The message for Claire's mother was clear. The only way to help Claire heal, the therapist explained, was to take the chemical and surgical steps necessary to make Claire's body more masculine. And so, in the summer following her eighth-grade graduation, Claire underwent a mastectomy. Soren Aldaco also identified as a boy when she was just 11 years old, although she did so at the urging of an older girl she met online. Four years later, Soren suffered a severe mental health breakdown that required hospitalization. There she met a psychiatrist, whom Soren recalls telling her that transitioning to become a boy was a medically legitimate form of treatment for mental health challenges.

After a brief appointment, Soren was prescribed testosterone. After a year of testosterone, social isolation brought on by government-mandated COVID lockdowns, and a difficult breakup, Soren decided she wanted to have her breasts removed. Although Soren's therapist knew Soren had expressed reservations about this, she still wrote a letter recommending the surgical removal of her breasts. $25,000 later, Soren's breasts were removed. These are not stories of liberation but of desperation. After years of intense mental health struggles, these girls and their parents were searching for any path that might lead them to genuine healing, and they encountered physicians, therapists, and surgeons who claimed to offer them one. Their pitch was simple. The children's problems were not due to the trauma of sexual assault, depression, or anorexia. Instead, the real problem was that they were boys trapped in girls' bodies. Taking the chemical and surgical steps necessary to look more like a boy would relieve their symptoms, but they were not cured.

In fact, their mental health continued to deteriorate throughout their treatment. By the time they realized that their medical transition had not resolved their mental health issues, permanent and irreversible changes had already been made to their bodies. They say they were never informed that testosterone injections would cause permanent changes to their voices, their faces, their hormone levels, and their fertility. Far from making them whole, this gender-affirming care left them, in Prisha's words, "broken, with extreme physical injuries and missing body parts." Unfortunately, these stories are common. The path to puberty blockers, hormone injections, and sex reassignment surgery often begins with a young person struggling with various mental health issues who has recently experienced a personal crisis. At a loss as to how to help their child, helpless parents seek the advice of medical specialists who believe they will provide objective, evidence-based guidance. After a brief meeting with the child, the specialist may declare that his or her problems can be solved by undergoing a medical transition. Parents may be told they should affirm their children's identity lest they put their child at a greater risk of suicide.

Parents are thus faced with a terrifying choice: either consent to gender-affirming care or risk their child's death. As one of the most prominent advocates of these therapies exclaimed more than a decade ago, "We often ask parents, 'Would you rather have a dead son than a living daughter?'" Faced with this terrifying choice, parents are sometimes told that puberty blockers will give their child time to think and make an informed decision about transitioning. What parents are often not told, however, is that puberty blockers do not delay puberty—they suppress it entirely—and that most children on puberty blockers go on to receive sex hormone injections.

In such cases, puberty blockers do not give a child or his parents time to think. They are a gateway to a lifetime of expensive hormone injections and sex reassignment surgeries. The stories we will hear today paint a troubling picture. Lured by the promise of a fail-safe cure for their mental health problems and kept in the dark about the permanent and irreversible effects of medical transition, these young

people and their parents say they were coaxed into opening their minds, their hearts, and their wallets to the miraculous healing powers of puberty blockers, hormone injections, and sex reassignment surgeries.

There is only one problem. It isn't true. And that isn't just my opinion. That is a quote from *The Atlantic*, written by the same reporter who previously accused the Trump administration of waging a nasty campaign on this issue. Europeans have a few decades of empirical experience to offer us on this matter. A 2024 report on gender identity services commissioned by the UK's National Health Service—referred to as the CAS report after its author—found no evidence to support the claim that puberty blockers improved a child's body image or gender dysphoria, no evidence to support the claim that gender-affirming treatment or sex hormone injections reduced a child's risk of suicide, and no evidence to support the claim that social transition in children led to positive mental health outcomes. Most importantly, the report did not find sufficient evidence to support the claim that gender-affirming care, puberty blockers, or sex hormone injections had a positive effect on patients' psychological well-being.

The report criticized many of the most widely used clinical guidelines for recommending medical transition despite insufficient evidence regarding the risks and benefits of medical treatment in adolescents, particularly in relation to long-term outcomes. More specifically, the CAS report notes that the most influential clinical guideline published by WPATH overstates the strength of the evidence in recommending medical transition for adolescents. The shocking disconnect between the science behind these treatments and the claims made about them is by no means limited to Europe. Just last year, the New York Times ran a lengthy exposé about how one of the leading advocates of these treatments refused to publish the results of a nearly ten-year study suggesting that "puberty blockers do not lead to mental health improvements in children diagnosed with dysphoria." She refused to publish the results of her study because she worried they might provide support to state governments that were regulating this care.

You heard me right. She refused to publish the results of her scientific study because of her political views. This contradiction played out before the Supreme Court of the United States just a few months ago. During oral arguments in United States v. Skrmetti, the Biden administration's solicitor general criticized Tennessee's regulation of gender-affirming care for children because it failed to "take into account the significant health benefits that can come from providing gender-affirming care, including reduced suicidal ideation and suicide attempts." But just a few minutes later, the lawyer representing the private plaintiffs challenging the law made a shocking admission in response to Justice Samuel Alito's question about the CAS report. "There is no evidence in the studies that this treatment reduces completed suicide." This had been the entire premise behind the push for gender-affirming care—a choice between hormones and sex reassignment surgery or suicide—but there is no evidence to support that premise.

Indeed, the state of Alabama's brief filed in the same case revealed in gruesome detail the lengths to which the Biden administration went to deny this reality for fear of political consequences. Now, why does all of this matter to the Federal Trade Commission? As chairman, I am not tasked with passing moral judgment on anyone's ideology, lifestyle, or medical choices. I am tasked, however, with protecting my fellow citizens from unfair or deceptive trade practices. And experience has taught us that the more vulnerable the population, the more likely they are to be targeted with deception. For example, people suffering from chronic or terminal illnesses are more likely to be deceived by healthcare scams. Taking advantage of their desperation, modern snake oil salesmen promise them the moon—an affordable and scientifically proven cure that will succeed where all conventional medical treatments have failed. Of course, the cure is not scientifically proven to be effective. The salesman simply presents it as if it were.

The FTC's statutory mandate is to protect vulnerable people from deceptive claims about health and cures. Now, I have heard it argued that the commission ought not to address today's topic at all because

the commission does not regulate the practice of medicine and because the topic is politically controversial. Both arguments are categorically wrong, and I reject them. First, the FTC is the federal government's guardian against false and deceptive health claims. We have brought dozens of enforcement actions against false and misleading health claims—ranging from shyster snake oil salesmen to powerful pharmaceutical companies. We have won cases against individuals selling everyday herbs and spices as cures for cancer, organizations exaggerating the effectiveness of their products in preventing COVID-19, and medical centers making unsubstantiated claims about their efficacy in treating chronic diseases. Time and time again, we have enforced the FTC Act against businesses and individuals who have made claims about their health products and services that were not backed by scientific evidence.

Just last year, we won a judgment against a company that "tricked people who needed real help into buying expensive and unproven stem cell therapy." This was deceptive medical care targeting vulnerable people, the elderly, and the disabled. We won another judgment against the makers of a popular supplement, who made claims about the supplement's effects on mental health "without competent and reliable scientific evidence." This is taken directly from the district court's judgment in that case. The Biden Administration's chief consumer protection enforcer publicly warned after the victory that "companies should take note and remember that health claims need to be backed up by reliable scientific evidence." I agree. The Biden administration's FTC also issued 40 pages of guidance on what the FTC Act requires of businesses making health claims, noting that the FTC Act applies to all claims about medical products and cures, and that claims consumers cannot easily assess on their own must meet an incredibly high standard of scientific substantiation. The issue we are addressing today is no different from the health claims we have addressed for many decades. Second, I acknowledge that many people feel passionately about this issue, but if a medical claim is false or misleading, it is the Commission's sworn duty to protect American citizens from that claim—just as it would for any other false or misleading claim. Refusing to investigate these health claims and the potential harm to parents and children, merely because one political party supports those claims as a matter of ideology, would be the politicized choice. And that is why we are here today—to ensure that parents and children seeking professional help during a time of intense distress do not make potentially life-altering choices under the guise of deception, misinformed about the risks and benefits of gender-affirming care. We are not here to pass judgment on anyone. We are here to ensure that those who make claims about gender-affirming care are held to the same standard we apply to everyone else who engages in commerce.

We are here to ensure that everyone can make an informed choice about their own path to healing without fear of being deceived by those who stand to profit from certain medical interventions.
Given our shared goal today, I would like to briefly outline the FTC's perspective on what constitutes a deceptive trade act or practice. For an act or practice to be deceptive, it must satisfy three elements.
First, the act or practice must be likely to mislead the consumer. This can occur either by commission—for example, making a false or misleading claim—or by omission—for example, failing to disclose certain information that would prevent a claim from being misleading to a reasonable consumer. Second, the act or practice must be likely to mislead a reasonable consumer acting under similar circumstances. In the case of acts or practices that target specific groups—for example, children or vulnerable parents—the test is whether the act is likely to mislead a reasonable member of that specific population. And third, the act or practice must be material to the consumer's decision to purchase the service.

For example, if a child or his or her parents would not have chosen puberty blockers had they been aware of the risks associated with those drugs, the omission of this fact by medical practitioners may be considered material. The purpose of today's workshop, then, is clear. The FTC must understand what kinds of claims are being made about these treatments, what kind of science supports them, what the

risks associated with those treatments are, and whether vulnerable populations may have been subject to deception in the administration of these treatments. These are the same kinds of questions we would ask about any health claim, no matter how politically charged. Americans have a right to health claims substantiated by reliable scientific evidence; they have a right to be informed about information that would be material to their decision to accept hormone therapies or sex reassignment surgeries. The FTC's mandate is to protect those rights in this context, just as it does in every other healthcare context.

While not everyone who undergoes gender-affirming care will necessarily experience the same painful loss and regret that Prisha, Claire, and Soren have experienced, every young boy and girl, and every concerned parent and guardian, has the right to be informed of all material information regarding the risks of these procedures. I promise that our agency will do everything in its power to achieve that goal. Finally, a brief note on what comes next. Following the conclusion of today's workshop, the Commission will issue a public request for information on the various topics we are discussing today. We will issue it sometime next week after we have had time to digest everything we learned today and can tailor our request for information based on what we learn. The public will have 60 days to respond to that request, and I encourage every single person here to submit a response. We will also provide a mechanism for individual members of the public to submit information they wish the commission to keep confidential. Thank you very much for your attention, and I look forward to today's discussions. Next, we have a panel of parents and survivors of these treatments, which I will moderate for about half an hour. While they're coming up here, I'll briefly introduce them, but the real goal of this panel is to let them share their stories with you and the American people. I want to say a quick word of thanks to Jon Schweppe, a policy advisor in my office, who organized today's workshop. Jon has worked on these issues—sometimes quietly and in the face of significant criticism. Even before we brought him onto the commission, he has been a tireless advocate for people who have suffered in this industry. And we could not have organized today's event without Jon. So Jon, thank you.

So I'm going to briefly introduce the panel before we begin. We are joined by Simon Amaya Price and his father Gareth, Claire Abernathy—whom I mentioned in my speech—Elvira Syed, and Kayla Lovdahl. Okay, so I don't think anyone here wants to hear from me anymore, so what I'd like to do is go around the panel, and we'll start with you, Simon. Tell us your story about your experience with gender-affirming care.
And once we've heard from each of you about your experiences—both as patients and as parents—I'll ask what you wish you'd been told early on in the process, before treatment began. But why don't we start, Simon, with you and your story?

Simon Amaya Price:

Yeah. First of all, I want to thank you for that amazing presentation. I think it was very balanced, very apolitical, and really great, so thank you for inviting us. Thank you to everyone here in the room, and thank you to everyone at home who's watching—whether live or later. So, as mentioned, my name is Simon Amaya Price. I wrote something beforehand, but I didn't like it, so I wrote another version, but I didn't like that one either—so I'm just going to speak from the heart here. When I was 14 years old, I was going through a really tough time. I was at a new high school, and I'd been ostracized by a group of friends. Shortly after that, I was sexually assaulted by an older boy at my high school. After that, I sought out a therapist at Boston Children's Hospital's Waltham location—based on what I'd been through at school, my conversations with my therapist, and my obsessive Googling, just like any kid in my situation would do.

I concluded that I was transgender—that I was really a girl on the inside. I told my therapist this, and she immediately affirmed me. She said I was so brave. She told me not only that I was brave, but also that she had instructed my father to count all the knives in the drawer because I was at risk of self-harm. She encouraged me to go behind my parents' backs to attend transgender

support groups. I was referred to the gender clinic by her, my psychopharmacologist, and my pediatrician. Around my 15th birthday, I remember meeting with my pediatrician, sharing with him my transgender identity and my gender dysphoria diagnosis. I told him that my dad was refusing to take me to the gender clinic. The pediatrician then asked my dad in front of me, "Would you rather have a dead son or a living daughter?" This isn't just a line used by activists. This is a line used in healthcare settings by the doctors your children are seeing in communities all across this country.

I'm one of the lucky ones. I only transitioned socially. I only lost a couple of years of my life. I didn't lose any body parts. I thank God every day—whether or not He exists—that I'm whole and that I'm here today. I was lied to by medical professionals. I was supposed to trust the same medical professionals who prescribed me antibiotics when I had strep. I was told that changing my name, my pronouns, socially transitioning, taking cross-sex hormones, and undergoing surgeries would "fix" me. That was all a lie. And I'm here telling you that today. If I were in that situation again, I really wish my doctors had asked me about any history of sexual assault. Maybe if they had talked about the two years of homophobic bullying I endured in seventh and eighth grade, when kids threatened to kill me and called me the F-slur almost every day.

Maybe that would have helped. Instead of telling me I was really a girl on the inside and reinforcing my delusions. I wish they'd told me that I was born in the right body, that I'm perfect just the way I was—because nobody told me that, at least nobody I paid attention to. I wanted to mention that for you, Dad. And I'm lucky—and look, I could have started hormones when I was 16, but then COVID hit, and I was away in Western Massachusetts for college. And my dad worked as a statistician at Raytheon, so he's an expert in evaluating methodology and statistical relevance. He read up on all the science. He's the only reason I'm here in front of you today, in one piece, unharmed. Please give him a round of applause. We can't expect every parent to be a trained statistician, and that's why we're here today. What else do you want to know?

Andrew Ferguson:

That was great, Simon. Thank you.

Simon Amaya Price:

Thank you.

Andrew Ferguson:

Thank you for speaking from the heart. Gareth, tell us what this is like as a parent.

Gareth Amaya Price:

Well, I'm going to stick to my prepared remarks. Hello, I'm the father of a 21-year-old man. He was born male 21 years ago, and he's been male every day since. Even when he and medical professionals told me he wasn't anymore, they were wrong, and the proof is right next to me. In the spring of 2019, when my son was 14 and in ninth grade, he began seeing a therapist and a psychopharmacologist at Boston Children's Hospital in Waltham because he was in great distress, suffering from anxiety, depression, confusion, and intrusive thoughts. Our son had already told my wife and me that he believed he was really a girl on the inside, after which I embarked on weeks of research into the nature and social manifestations of trans identity in adolescence—all of which confirmed my instinctive belief that it was delusional. Our son did not always have a happy childhood, partly because of the confusion caused by undiagnosed autism, and puberty was traumatic for him.

He would cry if a gas station closed. The changes in his own body upset him profoundly. He was the target of bullying—both physical bullying by boys and social bullying by girls. The boys threatened him and called him homophobic slurs, and the girls shunned him mostly because he didn't act the way they thought a boy was supposed to. The psychiatrist and psychopharmacologist at Boston Children's were supposed to be treating him for anxiety and depression, but when he told them both that he believed he was really a girl in a boy's body, they repeatedly suggested to me that I should take him to Boston Children's Gender Center (GeMS). I deflected these suggestions and encouraged them to refocus on his anxiety and depression.

I already knew then—as is now public knowledge—that GeMS universally assumed children were the "wrong" gender and conducted only a cursory assessment before recommending medical intervention. The psychiatrist was displeased that I did not take my son to GeMS. I felt I had to tread very carefully to prevent her from recommending to child protective services that my son be removed from our family by CPS. She had already suggested he be placed in an inpatient facility. I believed that his trans ideation was caused by his anxiety and depression, not the other way around. And that solidifying this delusion through medical intervention was a terrible idea. I was right, but I had to keep quiet. At the same time that I was instructed to keep a close watch on our son for signs of self-harm, the psychiatrist at Boston Children's was telling him behind my back to sneak away from home and go to a transgender support group. I was counting the knives in the drawers and checking on him every half hour, and she was telling him to lie to me and evade my supervision. That June, at his annual pediatric checkup, my son told his doctor—who had known us for several years—that he was really a girl on the inside. The doctor immediately agreed and offered to refer him to GeMS. I told the doctor I thought that was absurd, since I had known the boy his entire life, and that transgenderism was a phase he would grow out of—a temporary result of his adolescent distress. I knew then that research supported my view, and now, in hindsight, it does as well. The pediatrician told me he sent every child who said they were transgender to GeMS.

When I told the pediatrician I didn't intend to take him to GeMS, he asked me in front of my son whether I would prefer a dead son or a living daughter. That was emotional blackmail and, in my opinion, medical malpractice. I gave the pediatrician a thorough dressing-down for that abuse, and we never saw him again. He quit the practice. I think he should have quit the profession, but he just moved to the next town over and now runs a practice there. I shudder to think how many children he has medicalized by now.

Later that spring, the psychiatrist and psychopharmacologist at Boston Children's Hospital refused to continue treating my son and referred us to a private-pay facility. I can't name that facility because they did a good job treating his anxiety and depression. And treating a child with transgender ideation in any way other than so-called affirmation therapy is illegal in Massachusetts. As I explained to the several medical professionals who tried to convince me to chemically castrate my son, he eventually outgrew the idea that he was really female on the inside and came to terms with his sex. Here he is today—a happy and healthy man.

Chairman Andrew Ferguson:

Claire, tell us your story.

Claire Abernathy:

[inaudible 00:36:13]. Is this on? Hi, friends. First, I want to offer a little disclaimer: I wear my heart on my sleeve, so please don't mind if my voice shakes while I speak. I want to thank the Federal Trade Commission for inviting me to speak today. I'm grateful for the chance to share my story, because I believe that what happened to me and what's still happening to so many others is an urgent matter of consumer protection and fraud. My name is Claire, and I'm a detransitioner. A week after I turned 14, Dr. May Lau at Cook Children's Hospital in Dallas, Texas, put me on testosterone. Six

months later, Dr. Alan Dulin of the American Institute for Plastic Surgery in Plano performed a double mastectomy on me.

I was too young... Sorry. I was too young to get a tattoo. I was too young to drive. I hadn't even learned... Thank you. Thank you, Jamie. I hadn't even learned algebra in high school yet, but I was old enough to choose to have healthy parts of my body surgically removed. I was sold a product—medical transition—by professionals and institutions who told me it would alleviate my distress and save my life. I was told that if I didn't do this, I would likely end up dead.

But here's what they didn't tell me. They didn't tell me that taking cross-sex hormones and undergoing major surgery at age 14 could leave me with pelvic floor dysfunction and urinary incontinence—problems I have to manage now as a young adult. I'm only 20 years old. They didn't tell me that these complications are common enough to be known risks, and yet they were hidden from me at an age when I didn't even understand what these terms meant, let alone the impact they would have on my daily life—and it doesn't stop there.

When I tried to warn others by leaving honest reviews on my surgeon's websites, describing my regret, the complications, and the lack of true informed consent, my reviews were deleted. Think about that. A surgeon permanently altered my healthy body when I was a middle school student and then erased my negative feedback to protect his reputation. If that doesn't sound like fraud, I don't know what does. In any other context, selling a medical product this way—with half-truths and hidden side effects—would be considered fraud. If a pharmaceutical company pushed a drug on children without disclosing the lifelong damage it can cause, they would be sued out of business. If a cosmetic surgeon buried evidence of complications, they would be shut down. But when it comes to gender medicine, it's not just allowed—it's celebrated. And anyone who asks questions is labeled as hateful.

Every week I hear from more young men and women like me—people who were convinced as children or teenagers that the only way to survive was to become lifelong medical patients. We now live with the irreversible consequences, the scars, the side effects, the pain, and the grief, and we watch helplessly as the same professionals and clinics continue to sell the same product to the next generation of vulnerable children while silencing those of us who speak out. Let me be clear: it's not my place to say that no one should ever transition. I'm here to say that when you sell a product—especially one that removes healthy body parts and alters your life forever—the consumer deserves the whole truth. They deserve honest disclosure of all the risks, possible outcomes such as regret, and alternative treatment options.
They deserve the right to share their negative experiences without being censored.

At 14, I trusted the adults who were supposed to protect me. Instead, they sold me a dream that turned out to be a nightmare. That's not healthcare. It's blatant consumer fraud. I want to thank the FTC and those in the audience again for giving people like me a seat at the table. Please hold these providers and pharmaceutical companies to the same standards as any other industry. We need true informed consent. We need oversight, and we need to ensure that no more children are sold a product they cannot return. Thank you for listening.

Chairman Andrew Ferguson:

Thank you for your tremendous courage, Claire. Elvira, let's hear from you.

Elvira Syed:

Good morning, everyone. First, I want to thank the FTC for having me here and giving me this opportunity to share our family's tragic story. My name is Elvira Syed, and I lost my… I'm sorry. I lost my 17-year-old daughter, Ilene, to gender ideology and the system that failed her at every turn. Ilene was exceptional; despite being on the autism spectrum, she spoke four languages, played five instruments, held

two black belts in martial arts, and earned a full tuition scholarship to Rider University. But behind all those accomplishments was a young woman silently battling anxiety, depression, trauma, and self-harm—especially after losing her father to cancer at age 12.

During the pandemic, like many other kids, she spent too much time online, and after cycling through several LGBTQ labels, she finally declared that she was transgender. Before college, she began seeing a therapist who immediately affirmed her identity—no questions asked, no effort to understand her trauma or mental health, no curiosity about why this identity emerged so suddenly. When she arrived on campus, things took a turn for the worse. She cut me off, and at age 17, she was introduced to a transgender pastor from the Metropolitan Community Church in Hartford—someone who barely knew her but filed a complaint against me with the Department of Children and Families. Why? Because I refused to accept my son's identity.

The goal was to remove me so the state could step in and provide Ilene with all the care she supposedly needed. From that moment on, I lost all contact with my daughter. I would like to thank Project Veritas for conducting a thorough investigation and uncovering that the pastor who filed that complaint against me was providing free binders to minors behind their parents' backs. In January 2024, Ilene began therapy at the Pride Center, referred by Rider University. The therapist there, a transgender man, also affirmed her. And I have to wonder: was this therapist affirming Ilene solely because that's what modern guidelines encourage, or was it also because of her own subjective viewpoint—her personal identity? Was this care, or ideology disguised as therapy?

In her own notes, the therapist documented Ilene's history of self-harm, suicidal ideation, and autism spectrum disorder. In one entry, she wrote, "The client stated that most of the time he feels blank when he zones out or can't remember, and other times it's as if he's watching himself through a screen." To me, this is a massive red flag—dissociation, detachment, instability—but no follow-up was conducted. No second opinion, no attempt to contact me, her only living parent. Instead, the therapist reinforced Ilene's belief that I was unsafe to be around and referred her to an endocrinologist.

When I finally saw the endocrinologist's notes after Ilene's death, they mentioned only anxiety and depression—nothing about suicidal thoughts, nothing about trauma, nothing about self-harm. Her visit was marked as a routine checkup. There was no physical exam, no mention of the visible scars on her arms, no signs that her condition had been properly assessed, and absolutely no indication of an endocrine disorder that would justify a prescription for hormones.

And when discussing side effects, the only one mentioned was fertility. On that very first visit, Ilene was prescribed 40 milligrams of testosterone per week and given a referral for a double mastectomy. In that referral letter, the doctor or APRN falsely claimed that Ilene had dreamed of being a boy since she was eight years old. That was never true. My insurance was billed for this against my will. When I saw this pharmacy alert, I was horrified. Testosterone can increase aggression, emotional numbness, and suicidal thoughts, especially in a vulnerable, unstable teenager. But no one stopped to ask if it was safe.

On just her second visit, the APRN increased her dose to 60 milligrams per week, even though her chart noted worsening side effects like acne and bleeding, and her testosterone level at that point was 289. For reference, the normal female range does not exceed 45. In October 2024, my daughter died by suicide. She overdosed on Benadryl; her body lay in her dorm for four days before anyone found her. The school waited another day to call me. During that time, they were celebrating National Coming Out Day. The autopsy revealed new self-inflicted wounds on her thighs. According to the detective's report, her friend said Ilene's depression was getting worse. She was struggling and having difficulty with her transition.

Those entrusted with her care did not treat her depression. They did not explore what lay beneath her identity. They did not even tell me what was going on. They treated her ideology, not her illness. What she got instead was a fast-track prescription and an ideology that told her her pain was proof she needed to keep going down that path. Ilene deserved better. Every child does. And to answer your question, Chairman Ferguson, what would I wish was different? I wish Ilene had met a genuine therapist who would truly care about her, not about imposing an ideology on a vulnerable teenager, because therapy is not about validating an identity. It is life-and-death guidance, and if done poorly, it leads to irreversible, sometimes fatal consequences.

Chairman Andrew Ferguson:

Thank you so much, Elvira. Kayla, let's hear from you.

Kayla Lovdahl:

Hello, and good morning to everyone here. My name is Kayla Lovdahl. I go by Layla Jane online, and I am a survivor of gender-affirming medical treatment—or a detransitioner. I am someone who was put on Lupron and testosterone starting at age 12, and I underwent a bilateral mastectomy just one month after my 13th birthday. I went straight from training bras to binding, and then straight to the operating table at age 13. The reason for this was that I had undiagnosed autism and unaddressed childhood sexual trauma. I was scared of becoming a woman. I was getting unwanted male attention, which made me fearful of being victimized again. I had sensory issues I didn't know how to cope with when I started menstruating and needed bras.

I learned about transgenderism at age 11, and I thought maybe that was the reason I felt so uncomfortable. I brought up the idea with the therapist I'd been seeing, and she immediately affirmed me and diagnosed me with gender dysphoria. Once I told my parents, she began writing referrals for doctors specializing in pediatric transition care. At no point did anyone question why I suddenly wanted to become a boy. They didn't comprehensively screen me for mental health disorders or ask me about any prior trauma.

I saw Susanne Watson at Kaiser Oakland's Pride Clinic, and within 90 minutes she approved my treatment plan to receive testosterone and meet with a surgeon named Winnie Tong. The mastectomy was explained to me at age 12 using euphemisms like "top surgery." I was told I would never be able to breastfeed. I was told I might lose sensation, but to me, at age 12, that just meant numbness. But today I deal with nerve pain, extreme stabbing sensations, electrical zaps, and itchiness. I could scratch my skin until I bleed, but it wouldn't bring any relief, because the skin is numb and doesn't register touch—yet the nerves underneath are erratic.

This September, I'll have been eight years post-op. As you can probably all tell, my voice is permanently deeper due to the testosterone I took from age 12 to 17. I do have a slight Adam's apple. I can't raise my voice for long periods of time. I can't scream if I'm in danger. Mind you, I'm a pretty small person, standing at about 4' 11". I still grow facial hair that I have to deal with. I have muscle atrophy and urinary issues. Testosterone also damaged my liver. I've had fatty liver disease since I was about 14.

The Lupron essentially put my body into menopause. I gained weight. My mental health issues flared up. I experienced intense hot flashes, which made it really difficult to focus on my seventh-grade homework. Today I live with chronic joint pain. I'm only 20. At no point along the way was I offered a way out. I didn't even know what detransitioning was until I was almost 18 and began tapering off the hormones on my own, too scared to go back to the doctors. Even at 18, I called member services and requested that my name and gender marker be changed back and that I receive a new insurance card reflecting that change. Weeks later, I received one in the mail with my male name. I'm here today to speak out against gender-affirming medical practices for minors. We are allowing vulnerable children to be irreversibly harmed by a

medical system that affirms without asking why. We need to protect children from these rushed, experimental interventions. Let kids grow up whole. Thank you.

Chairman Andrew Ferguson:

I don't think anything could be added to what we just heard. And so I'm going to close with just two comments. First, I'm not sure I've ever seen more courage displayed in my life than what I just witnessed in the last 30 minutes. And second, I want you to know that the FTC hears you. We hear all of you. We want to understand what's going on so that if the law is being broken, we can stop it. So thank you for being here today.

Jon Schweppe:

Thank you, Mr. Chairman, and thank you to the parents—Gareth, Elvira—and the survivors—Simon, Claire, and Kayla—for sharing your personal experiences. We'll now move on to a presentation. Thank you, everyone. Dr. Miriam Grossman, MD, is board-certified in child, adolescent, and adult psychiatry. Her current practice focuses on young people who are distressed about their gender and their parents. She is a senior fellow at donoharmmedicine.org and the author of five books, including *You're Teaching My Child What?* and *Lost in Trans Nation*. Dr. Grossman's work exposing the origins and dangers of the sexuality and gender industry has been translated into 11 languages. In fact, Dr. Grossman, of her own accord, brought books here today to share with attendees, and I haven't checked, but I'm pretty sure they're in English. She has testified before Congress and lectured at the British House of Lords and the United Nations. She has been featured in The Daily Wire's documentary *What Is a Woman?*, Fox Nation's *The Miseducation of America*, and many other documentaries and popular podcasts. Her expert psychiatric opinion is sought for witness testimony and court reports. Please welcome Dr. Miriam Grossman to the stage.

Dr. Miriam Grossman:

Good morning. Thank you, Chairman Ferguson, John Schweppe, and Brandon Scholter. Thank you also to Jackie, Simon, Maria, Laura, Prisha, Kayla, Beth, and Forrest for sharing your medical documents with me. And actually, the books that are out there—my *Lost in Trans Nation*—are thanks to Do No Harm. So thank you very much, Do No Harm. Section 5 of the FTC Act states, as you heard, that fraud and deceptive practices involve presenting as facts things that are entirely unproven or demonstrably false, thereby misleading the consumer in a material way. When I examine gender-affirming care and the history that led up to it, I see fraud and deceptive practices everywhere. Going back decades, I see it in the landmark experiment on Bruce Reimer when he was a toddler and John Money instructed his parents to socially and medically transition him. This was to be Dr. Money's proof of a concept he'd come up with in 1966 called "Gender Identity." Dr. Money announced to the world that the experiment was a resounding success. And for years, the world believed it. But in fact, it was a catastrophe from the start. Decades after Dr. Money, consumers were misled again when gender specialists took the results of a single small Dutch study—whose subjects were carefully selected—and led parents to believe that every child distressed about their sex could benefit from that model of care.

And now, families are told there is a consensus among clinicians about the best way to help these children, but there is no consensus. What there is, is the silencing of opposition. There are many more examples that you'll hear about today, but I think it's fair to say that the fraud is widespread and deep-seated. I decided to focus on three topics: deceptive practices in language, in medical records, and in therapists' letters recommending hormones and surgeries. But first, before discussing fraud and deception, I'll remind you of what is true.

Humanity is divided into two biological categories. Male and female are determined at conception. While there are many ways of being male or female, sex does not change and cannot be changed. These are universally acknowledged facts, but gender-affirming care is based on their denial. The premises of gender-affirming care are that every person knows best who they are, regardless of their age, developmental stage, or mental health. All gender identities should be rubber-stamped by parents, doctors, therapists, and teachers. Medical interventions, including the removal of healthy organs, must be available on demand.

Gender-affirming care's denial of biological facts is right in front of us. We don't need to file any FOIA requests to see it. All we need to do is examine the language. Look at how aggressively the proponents of gender-affirming care dictate the language doctors must use. This is from a course taught by Dr. Erica Metz, medical director of transgender health at Kaiser Permanente in San Francisco. In this course, doctors learn that there are acceptable and unacceptable terms. For example, "sex change operation" is not acceptable. Doctors must say "gender-affirming surgery." "Born male" is unacceptable. The proper term is "assigned male at birth." Here's another slide from the same course. "Always use the pronouns the patient asks you to use, regardless of what they look like to you or what their name is." And the red highlight—I didn't do that. That was in the original.

Why is it so critical for Kaiser to control their doctors' speech? Well, they know what George Orwell taught us. Language is a tool. It can be shaped for a specific purpose. It can change the way we think. I'm going to go through some of the vocabulary of gender-affirming care and demonstrate how this language is designed to change the way we think about male and female and to mislead consumers in a material way. So basically, what I'm suggesting today is that all of these terms constitute violations of Section 5.

Gender identity. We're told that whether we realize it or not, we all have an inner sense of being male, female, both, or neither. And that's represented by the brain in this slide, which, by the way, comes from a sex education course. And we're told that this sense is not only detached from material reality but overrides it—which is the body shown there. The brain overrides the body. You can have, for example, a girl's brain in a boy's body, and that boy is actually a type of girl—a trans girl. This belief is the cornerstone of gender-affirming care. It is presented as fact. It is not open to discussion.

Now, science studies the material world—the world that can be directly observed, measured, and verified. The proponents of gender-affirming care declare that a person's inner sense—something that cannot be directly observed, measured, or verified—is more authentic than the material world. Now, what would you call that? Is that a philosophy? Is that a religion? I'm not sure, but I am sure that the idea is entirely unproven and unprovable in the same way that we cannot prove the existence of a soul, even though we might believe in one. There is no objective evidence of being born in the wrong body, and claiming otherwise misleads and takes advantage of patients, and it impacts their medical decisions.

I know from my patients and many others that when young people hear the idea that their feelings are more significant than their bodies—and when they hear this idea endorsed with great certainty by therapists and doctors, echoed by professional organizations and government agencies—they believe it. They believe that this is bona fide science and that they have a medical condition whose only cure is medication and surgery. Here's Dr. Gallagher, our favorite Miami surgeon. Girls see the language on her website—references to female-to-male procedures—and they genuinely believe that Dr. Gallagher can turn them into boys. And here's Johns Hopkins telling boys they can get female genitals. Boys see this and think they can get an actual vagina and be a woman just like any other. But Johns Hopkins and Dr.
Gallagher cannot do these things. Their claims are demonstrably false. They deceive and exploit vulnerable and misinformed consumers and their families.

Preferred pronouns. If you can choose your pronouns, it means that your feelings determine who you are. And it means, once again, that biology is irrelevant. Preferred pronouns are part of social transitioning,

and we know that social transitioning increases the likelihood that gender dysphoria will persist. Nevertheless, the American Academy of Child and Adolescent Psychiatry—which has been co-opted—instructs parents, “Use the name and pronouns your child prefers.” Chicago Children’s Hospital has pronoun stickers for staff, and the pressure is intense. Trust me, I’ve spoken with many people who work in hospitals. The pressure on staff to wear these pronoun stickers is very intense. In my opinion, using opposite-sex pronouns endorses something that can never be. It supports a patient’s false belief and impacts their medical decisions. So that’s fraud right there. “Sex assigned at birth.” The purpose of that phrase is to lead people to think that male and female are random designations, a doctor’s whim. This is utterly false. I don’t have time to discuss intersex. You’ll be hearing about it later. But the term “sex assigned at birth,” which we hear 24/7 everywhere, is designed to change the way we think about male and female—instead of recognizing it as an inherent quality of every one of the billions of cells in our body.

Cisgender and non-binary. The word “cisgender” was coined in 1994 by a graduate student at the University of Minnesota. The student explained, “There did not seem to be a way to describe people who were not transgender without inescapably framing them as ‘normal’ and making transgender identity automatically the ‘other.’” In other words, this student was unhappy with how transgender identity was perceived. And the goal of creating the word “cisgender” was to change that perception. So again, the goal was to change how we think. We are given the impression that “cisgender” is a scientific classification of people, but it is not.

Non-binary. We’re told this is a valid identity for people who are both male and female, neither male nor female, or some other combination of male and female. Kaiser Permanente offers this list of non-binary options. We might think this is silly—and it is—but to vulnerable youth, it means they can have a new identity every day of the month. If identity is based on feelings and you feel different from day to day, then why not? Do you see why so many young people are confused? I once had a 15-year-old patient who identified as non-binary. I asked him to explain what that meant. He thought for a moment, and he gave me, hands down, the best definition of non-binary I have ever heard. Excuse the language. I would never speak this way, but it’s refreshing to hear the truth.

Moving on. “Wrong puberty.” That’s a disturbing one. Puberty is not a disease. You’ll hear more about that from Dr. [inaudible 01:09:01]. Using that phrase is profoundly misleading, as if someone could go through the “wrong” puberty.

Top and bottom surgery. These are dangerous euphemisms. They’re meant to distract you from what they really are: the removal of healthy organs, causing disfigurement and a long list of serious medical problems—as you’ve just heard—and you’ll hear more about that from Dr. Lappert. Justice Thomas called “top and bottom surgery” sanitizing language. And he was right.

Genital reconstruction. Nope. Reconstruction implies that specific genitals were once present. That is demonstrably false. A surgical procedure that creates an artificial vagina is not reconstruction—it’s construction. The same goes for hormone replacement therapy. You’re not replacing anything. It’s not the same as giving estrogen to a postmenopausal woman, and it misleads the public.

And finally, “chestfeed.” Until recently—because their website was scrubbed and this page is no longer there—the CDC endorsed the idea that men can lactate. Well, the female body is designed to lactate. The male body is not. Men do not lactate unless they have a medical disorder or are pumped full of drugs that cause nipple discharge. This is entirely different from the natural process of lactation that occurs in women. The term “chestfeed,” aside from erasing women in a most offensive way and dehumanizing all of us, misleads boys and men.

To summarize: The language of gender-affirming care seeks to deny the primacy of biology in determining male and female. It promotes the notion that feelings override the objective reality of our sexed bodies. Such beliefs can harm patients and are not consistent with 21st-century science.

Now, regarding fraudulent language in medical records. I'm going to tell you about this case that was reported in *The New England Journal of Medicine*. I'm not going to give you all the details. This is a very concise review. And this article in The New England Journal referred to this woman as a man and used "he" and "him" pronouns, so I'm going to do the same, even though I normally wouldn't. Sam, a 32-year-old man, came to the emergency room. He had intermittent lower abdominal pain and high blood pressure. He told the triage nurse that he was a transgender man. His electronic medical record indicated he was male. The nurse noted that Sam was an obese man, and he was comfortable between his bouts of pain. She assessed his condition as non-urgent. Lab tests were ordered, including a pregnancy test. It took several hours for Sam to finally be seen by a physician who took a detailed history, reviewed his lab results, and performed a physical exam. He determined that Sam was in labor and had preeclampsia, which is a life-threatening emergency for both mother and child. No heartbeat could be detected on the ultrasound. Shortly thereafter, Sam delivered a stillborn baby. Although he had clearly neither planned nor expected the pregnancy, he was heartbroken, and the loss of his baby triggered a major depressive episode.

The language used in medical records must be accurate. There was once a standard way to indicate a patient's sex in medical records, but that is no longer the case. And I want to give a shout-out to Dr. Carrie Mendoza for pioneering work on safety in electronic health records and drafting a model policy. With her help, Texas passed legislation requiring not gender identity, not legal sex, but simply sex—male or female—to be recorded in medical records.

So why is it so critical to accurately indicate a patient's sex on medical records? Well, we can see from Sam's story, of course, what happened, but there's much more to it. The X and Y chromosomes have a profound and lifelong impact on every organ system—and, in fact, on every cell. There are significant differences between men and women in terms of health and disease, and there are thousands of examples of this. For example, women are more likely to develop certain heart arrhythmias. 80% of autoimmune diseases affect women. Certain drugs are more potent in one sex than in the other. So having the correct sex identified on medical records can potentially save lives. Not gender identity and not legal sex, because those can be changed. But here's what's happening—and this is from NYU Langone Hospital. In 2018, this child was identified as female, but two years later, the same child was identified as male. At Oregon Health & Science University, this is a surgeon's note for a man named Forrest—whom you'll meet shortly—who came in for breast implants, and it lists his sex as female. And even more—well, equally incredible—is that this surgeon's note, prepared for insurance coverage purposes, stated that this is a woman with underdeveloped breasts who needed a more feminine breast shape to help with her gender dysphoria. Again, this was so the insurance companies would cover the cost of the prosthetic breast insertions. And if someone hadn't been careful in reviewing these records, they would have thought this was a young woman who simply had underdeveloped breasts.

This brings us back to Kaiser again—Kaiser Permanente in California. This was an admission note for Layla Jane, whom you just met. She came in for her bilateral mastectomy. And it's indicated here that she is a 13-year-old male.

Now, more from Kaiser Permanente. This patient is identified as non-binary—a non-binary patient. Now, this isn't someone's Facebook page. This isn't Instagram. This is a legal document identifying a person as non-binary. Boston Children's has something interesting, and this was given to me by Simon. You'll notice it says "legal sex" up there in the top right corner. But that means that for someone whose legal sex had been changed to a different sex, it would simply state that up there. And then… Okay, they have something very interesting there. They have Boston Children's. They have an organ inventory. An organ inventory. Now, what's that? All right. You see a list of organs, okay? Breasts, cervix, ovaries, penis, testes. And what's supposed to be happening here, I guess, is that I don't know if they were indicating that Simon had all these organs, or whether someone forgot to check the boxes next to the ones he actually has. This is

not medical care. This is dehumanizing. I mean, that's a judgment call, I guess. But as a doctor, okay, this is not medical care.

Now, getting back to Forrest, his records... Oh, yeah. Getting back to Forrest, his records didn't mention it anywhere. They didn't indicate that he had gender dysphoria. Oh, I already said that. That the surgeon wrote that he suffers from a... Okay, feminine breast. I already covered that. Now, I want to move on to the next point. And this is the diagnosis "endocrine disorder, not otherwise specified," and this is an example of a lab request for estrogen that was written by Dr. Grace Evins, MD, in… Where is this? North Carolina, right? South Carolina?

Audience member:

North Carolina.

Dr. Miriam Grossman:

North Carolina. Now, this is a male patient who's on estrogen, and the doctor, likely for insurance purposes, has listed diagnosis code E34.9. Lawyers in this room, take note. E34.9. I want to explain that to you. It means "endocrine disorder, not otherwise specified."

Oh, here's another example. Sorry. Dartmouth College Health Service. Also, you see below that "endocrine disorder, unspecified." Dartmouth. Oh, I messed up. Okay. And this is another one for feminizing HRT. But let me just get back to it. Wait, sorry.

Okay. What is diagnosis code E34.9? In the International Classification of Diseases, there are thousands of diagnoses. And so they've categorized all the endocrine—these are medical diagnoses that are… Oh, I can see it over there. Okay. The endocrine diagnoses are between E00 and E89. These are endocrine, nutritional, and metabolic diseases. So, for example, there's hyperthyroidism, type 1 diabetes, and polycystic ovary syndrome. These are all medical diagnoses listed between E00 and E89. But then there's E34.9: endocrine disorder, unspecified.

What is that? It states that this is an acceptable diagnosis when clinical information is unknown or unavailable for a particular condition. Okay? It's preferable to use a more specific code, but you can use this code when it accurately reflects what is known about a patient's condition. Now, all these people here—the medical records I showed you, and I'll show you some more—are physically healthy individuals. They have no medical diagnosis whatsoever. They have a psychiatric diagnosis. But this E34.9 is being used fraudulently, I would say, in order to obtain payment for the services.

Now, this is what Planned Parenthood of Southeast Pennsylvania says: "To meet the needs of most insurance companies and patients, we typically use the code E34.9. We recognize that much of the language surrounding billing for gender-affirming care is problematic." What they mean by that is that it's referred to as a disorder. When you say "endocrine disorder," they're objecting to the word "disorder." "We recognize this is medically necessary care and will work to reduce barriers so people can get the care they need." So they're explaining why they use that diagnosis. So here's… Oops, I skipped ahead.

Okay, so what I'm going to do now is discuss the fraudulent notes written for individuals who need letters from therapists in order to obtain cross-gender hormones, opposite-sex hormones, or surgeries, and how these letters are fraudulent.

So this is actually Prisha's note. You'll meet her soon. On the first day she saw this therapist, the therapist indicated that she had a major depressive disorder, recurrent, moderate. That is a serious psychiatric condition. It is a condition that impairs one's functioning and daily life. And she also indicated that Prisha had an eating disorder—she doesn't go more than two days without eating.
That's a serious eating disorder if she sometimes goes two days without eating. Yet on the very same day

that this therapist noted this in her chart, she wrote a letter recommending testosterone, stating that there were no mood-related issues. What? She just wrote on the very same day that Prisha has major depression and an eating disorder. Yeah, just like Simon's father right here. He's like, "Yeah, what? How can you do that?" And she writes later in the second paragraph, "There is no evidence of psychopathology." What? And the diagnosis: gender dysphoria, anorexia in remission. Nothing about the depression.
Nothing about having, not that long ago, engaged in serious self-harm and cutting, and a whole host of other mental health diagnoses. So she writes in favor of testosterone on the very same day—day one.

She also had this same therapist. Am I running out of time? Oh, I am. All right. Anyway, this is another therapist's letter for Prisha to the surgeon. And this therapist wrote, "He presents with no apparent residual psychiatric symptoms and is quite stable." Oh, no, no, no. Wait. This is Laura Becker's. Okay, I'm sorry. This is Laura Becker's—the letter her therapist wrote to the surgeon. And Laura had been hospitalized for suicidal ideation just two months before this letter to the surgeon regarding her bilateral mastectomy. Two months. You cannot say that someone who is just two months out of a serious psychiatric hospitalization has no residual psychiatric symptoms and is quite stable. It's misleading. It's misleading to the surgeon. And she also wrote that Laura demonstrated excellent insight into the transition. Well, Laura was under the impression at that time that this was the only thing that would cure her symptoms. This was the only thing that would prevent her from committing suicide. That is not excellent insight. That is not informed consent. So these letters omit critical information about the patient's mental health—information that impacts their ability to provide informed consent, and information that one would hope might make the surgeon think twice before using the scalpel.

So to wrap it up, here's what Admiral Levine said about gender-affirming care. Whoops. Oh. Oh, I mixed up the letters. Well, you know what? They're all the same. They're all the same in the same bad way. So Admiral Levine said, "Gender medicine is a medical field like any other. It's all done very carefully." No, Admiral Levine, I don't think so. I don't think it's done carefully at all. I think this WPATH doctor put it more accurately. Dr. Marshall Dahl at a WPATH meeting. No audio? No audio. Okay, I'll speak for him. He said, "Not only are the medications off-label, the whole field is off-label, right? But that's all good." Well, I'm here to say—all of us are here to say—that that's not good. It's not good at all. No more misleading consumers. No more presenting as facts things that are entirely unproven or demonstrably false. Families deserve much better, and today is a great start. Thank you for listening.

Jon Schweppe:

Thank you, Dr. Grossman, for that informative presentation. Let's take—I'm going to try to reclaim a couple of those minutes. So let's take a quick seven-minute break; we'll be back in seven, and then we'll have our first panel. All right, everyone. Let's go ahead and get started again. If everyone could please return to their seats. We'll begin in the next one to two minutes. All right, everyone.
Welcome back. Please take your seats. It's now time for our first panel, "The Politicization of Science." And I'd like to introduce our moderator and legal advisor to Chairman Ferguson here at the Federal Trade Commission, Annie Chiang.

Annie Chang:

Hi, everyone. Good morning. My name is Annie Chang, and I currently serve as legal advisor to Chairman Ferguson. This morning, we've already heard firsthand accounts of the harms caused by what some refer to as "gender-affirming care" from those truly on the front lines: the parents and the survivors. We've also heard from Dr. Miriam Grossman, who has lifted the veil for us on some of the deceptive language, fraudulent medical records, and misrepresentations in letters used to support the medical and surgical procedures that constitute this type of so-called care.

Although we are speaking publicly about these issues today, we should keep in mind how unimaginable this kind of event seemed not too long ago. For much of recent history, even asking the questions we are posing today was, in many circles, completely forbidden. I hope by now you're thinking to yourself about the elephant in the room: how? And in my mind, there are two ways to answer that. First, and perhaps most obvious, how did politics and ideology creep into and ultimately take over this area of medicine?

And second, given the overwhelming success of that political and ideological takeover, how is it that we are discussing these questions today? Before we discuss those questions and hear from our panelists, who will shed light on the matter, I have the honor of introducing our four panelists: Edmund LaCour, Dr. Eithan Haim, Jordan Campbell, and Leor Sapir. I'll just provide a brief biography of each.

Edmund LaCour is the current solicitor general of Alabama. In that role, he oversees the state's appellate and constitutional litigation. He has argued three cases before the U.S. Supreme Court and dozens before other courts. Before joining the Alabama Attorney General's Office, Edmund was a partner at the Washington, D.C., office of Kirkland & Ellis, where he represented numerous clients before the Supreme Court, courts of appeals, and trial courts. Before joining Kirkland, he practiced at Bancroft PLLC in Washington, D.C., and Baker-Botts LLP in Houston, Texas. Upon graduating from law school, Edmund clerked for the Honorable William H. Pryor, Jr., of the U.S. Court of Appeals for the 11th Circuit. Edmund earned his bachelor's degree from Birmingham Southern College, his Master of Philosophy from Trinity College Dublin, and his J.D. from Yale Law School.

Dr. Eithan Haim is a general and trauma surgeon in a small town outside Dallas. He attended the University of South Florida for his undergraduate degree, followed by Florida Atlantic University's Schmidt College of Medicine, where he was a member of the prestigious Alpha Omega Alpha and Gold Humanism Honor Societies. He completed his residency in general surgery at Baylor College of Medicine in Houston, Texas, in June 2023.

During his residency, Dr. Haim served as an anonymous whistleblower in a May 2023 report by Christopher Rufo that revealed Texas Children's Hospital had been lying about shutting down its transgender program. Contrary to their claims that the program had been shut down the previous year, TCH continued and expanded the program behind closed doors.

The very next day, the Texas Senate passed SB14, a bill to ban pediatric gender intervention, which received bipartisan support—in part due to Dr. Haim's anonymous whistleblowing. The Biden administration, however, had a very different response to Dr. Haim's bravery—a response we will discuss during this panel, and one I'm sure many of you are familiar with. Dr. Haim lives with his wife and infant daughter in a small town outside Dallas, Texas.

Jordan Campbell is the newly appointed deputy assistant attorney general for the consumer protection branch of the civil division at the Department of Justice. Before accepting that position, Mr. Campbell co-founded the first and only law firm exclusively dedicated to representing de-transitioners and victims of radical gender ideology, based in Dallas, Texas. In that capacity, he represented plaintiffs across the country, consulted with state legislatures on proposed legislation regulating the medicalization of gender in pediatrics, coordinated with state attorneys general's offices, and provided policy advice. He earned his bachelor's degree from Washington and Lee University and his J.D. from Southern Methodist University. He will soon be moving his wife and seven children from Dallas to join him here in D.C.

And finally, Leor Sapir. Leor Sapir is a fellow at the Manhattan Institute. He holds a PhD in political science from Boston College and completed a postdoctoral fellowship in the Program on Constitutional Government at Harvard University. Since joining the Manhattan Institute, Leor has become a widely recognized thought leader on topics related to pediatric gender medicine, education, policy, and culture. Leor has offered incisive analysis of the institutional dynamics at play in youth gender medicine, the lack

of incentives for evidence-based practices in this area, and the growing divergence between the U.S. and other countries in medical policy.

So I'm really excited today to learn from this group of speakers with extensive experience on this panel's topic. And I want to start with Leor. You've been writing and researching in this field for years now, and you've been sounding the alarm about the ways politics has crept into medicine. To give just one example, as early as 2022, you published an article on the "affirm or suicide mantra," which you described as having become the central strategy of contemporary transgender activism—an approach whose empirical basis, you explained, is shoddy at best. So I'd like to hear your perspective, from a 30,000-foot view and in very general terms: how did ideology and politics creep into medicine?

Leor Sapir:

Thank you, Annie. It's truly a pleasure and an honor to be here. And I wanted to thank the FTC for organizing this event—a very important event. Before I answer your question, Annie, I just want to say one thing in light of the context in which this event is being held: there is growing awareness and acknowledgment among the professional class—specifically, liberal professionals—that something has gone very wrong in the field of gender medicine, that there is this child-led model where no assessment takes place and children are rushed into transition.

So it's a good thing that this acknowledgment exists. The problem is that this acknowledgment is always accompanied by another claim—namely, that there is an alternative, a careful way to practice youth gender medicine. They sometimes call it the "assessment model." And so I just want to make a few very brief comments about that because I think this is where we'll see much of the battle of ideas over the next couple of years.

So the first thing I want to say is that even this supposedly more conservative approach to adolescent gender medicine has been evaluated in systematic reviews of the evidence and has been found to be based on very low-quality—meaning very uncertain—evidence. Second, as the CASS review, I think, very helpfully pointed out, even a diagnosis of gender dysphoria is not predictive of adult outcomes. So even if you have a therapist who conducts a very careful assessment, there's really nothing that assessment can tell you about what would happen to that child if they were not treated medically.

And then the third problem is that even if there were good evidence of some mental health benefits in some children, and even if a diagnosis of gender dysphoria were predictive—which it isn't—it would still run into significant ethical problems involving informed consent because no 12-year-old can truly understand what it means to give up fertility and sexual function or to endure cognitive impairment, if that is indeed one of the consequences of puberty suppression.

So I just want to point out here that we are moving toward a debate about the "careful assessment-based" model, which itself has significant problems attached to it. Okay, so setting that aside to address your question—this is obviously a long and complicated story—but at its core, I want to argue, is a broken chain of trust. I think the previous panels explored this idea that medical professionals are misleading patients and parents, and that's true. But I think another crucial part of this story is that some people in the medical community are misleading their colleagues, and that must be taken into account.

I can't tell you how many times I've seen this, how many times I've heard this in my conversations with doctors—with people in positions of authority within the medical field—who, for understandable reasons, say, "This isn't my area of expertise. There are these other people—whom I call my colleagues—who work at my hospital, and they're gender clinicians. This is their specialty. They know what they're doing. I don't want anyone to question what I'm doing." I focus on my particular area of expertise, and I expect them to defer to me, so I'm going to defer to them. And modern medicine cannot function without a high level of

trust and deference because modern medicine involves high levels of specialization and compartmentalization.

And so that kind of deference is to be expected, and it's generally a good thing. But it also means that the medical profession—the trust that makes modern medicine possible—can be abused. And pediatric gender medicine is a prime example of what happens when that trust is abused. It is a classic example of a broken chain of trust. So the leading authority on gender medicine in the United States is, of course, WPATH, the World Professional Association for Transgender Health.

WPATH publishes a document called the "Standards of Care," which are essentially clinical recommendations. The eighth and most recent Standards of Care were published in 2022, and WPATH has managed to embed its Standards of Care—and, more broadly, its approach to understanding human nature, sex, gender, gender identity, and so on—in virtually every relevant aspect of U.S. healthcare. State Medicaid authorities and commercial insurers incorporate WPATH's Standards of Care into their determinations of covered benefits.

Hospitals conduct WPATH-aligned training programs—also known as the Global Education Institute—and operate specialized pediatric gender clinics that rely on, or claim to rely on, WPATH standards. Major U.S. hospitals and medical schools integrate WPATH-aligned standards into their residency, fellowship, and continuing medical education programs. Around 20 medical associations, including the powerful American Medical Association, have repeatedly assured state and federal regulators that WPATH standards are credible and deserve deference.

And of course, as we saw, the Biden administration cited WPATH standards of care in its policy memos and had the Department of Justice attempt to enforce those standards through litigation. In short, in the United States, gender medicine is WPATH, and WPATH is gender medicine. In a few minutes, you'll hear from my co-panelist, Solicitor General LaCour, about what his team discovered regarding WPATH standards of care during the discovery phase of their litigation, Boe v. Marshall.

Let me provide a very brief overview. In evidence-based medicine, systematic reviews of the evidence are the gold standard for evaluating what is known about a medical practice. Clinical practice guidelines are considered reliable only if they are based on systematic reviews of evidence. WPATH's previous Standards of Care, Version 7, which was published in 2012, was not an evidence-based guideline, and WPATH did not rely on systematic reviews of evidence for that guideline.

When WPATH decided to revise its standards around 2017, it resolved to do so using systematic reviews. The co-chair of the eighth standards of care revision guideline, Dr. Aseratix, said at the time that the eighth version would be "the first to be developed using an evidence-based approach."

So WPATH commissioned dozens of systematic reviews from evidence review experts at Johns Hopkins University. These included reviews of evidence regarding pediatric outcomes. But when WPATH leaders discovered that the evidence for pediatric transition was extremely weak, they prevented the Johns Hopkins team from publishing their results. WPATH claimed in the final guideline that a systematic review was not possible. It even told the authors of the adolescent chapter of SOC-8 that it was not possible to conduct a systematic review.

WPATH violated other key requirements for trustworthy guideline development. For example, it failed to manage conflicts of interest by stacking the guideline panel with clinicians who are personally, professionally, and financially invested in medical transition. It eliminated age minimums for transition procedures for political reasons, and WPATH leaders privately admitted to including medical necessity statements for the purpose of securing insurance coverage and winning legal battles.

In short, WPATH prioritized its activist agenda over any concern for patient health and well-being. And the Alabama documents provide irrefutable evidence of fraud by the leading authority on transgender

medicine in the United States. Now, the fraud committed by WPATH, as I said, is not just against patients and their parents—who are the end users of WPATH's standards of care—though that is, of course, its most troubling impact. It is also against the American public, which has absorbed WPATH's messaging about the safety and efficacy of these interventions through WPATH's allies in the media and the medical profession.

But it is also fraud, as I've been saying, against the rest of the medical community, including unsuspecting insurance companies, state Medicaid authorities, medical association leaders, hospitals, and individual clinicians—including, I suspect, some clinicians involved in gender medicine itself. Again, the broken chain of trust. But what about the other medical associations?

We often hear that gender-affirming care is supported by most major medical associations. First, it's important to note that U.S. medical groups that endorse the gender-affirming approach are at odds with medical authorities in places like Sweden, Finland, the UK, and Norway—hardly bastions of right-wing conservatism.

In 2023, the director of Belgium's Center for Evidence-Based Medicine said, "If we had to review the WPATH guidelines, we would actually toss them in the trash." He added that what WPATH recommends is "a pure experiment on children without any scientific evidence to support it." Second, even in the United States, not all major—meaning large—medical associations support WPATH's approach. Last year, for example, the American Society of Plastic Surgeons effectively sided with the CASS review, acknowledging the weakness of the evidence regarding pediatric outcomes. Among the groups that do support WPATH's approach, the American Academy of Pediatrics (AAP) has been one of the most vocal.

In 2018, the AAP allowed a young medical resident named Jason Rafferty to draft its policy statement in support of gender transition for minors. The statement asserts that children have indisputable knowledge of their transgender identity and that parents and clinicians should follow their lead. It cites WPATH's standard of care—at that time, the seventh edition—as authoritative. However, as two peer-reviewed articles and medical journals have shown, the AAP statement contains critical errors, including miscitations and misrepresentations of existing research.

A systematic review of guideline quality from the UK, commissioned as part of the CASS review, found that the AAP guideline ranks among the worst in the field. The problems with the statement were brought to the attention of Rafferty and the AAP shortly after the statement was published, but the AAP has consistently refused to engage with or even acknowledge these criticisms, dismissing them instead as transphobic.

Indeed, the AAP has gone to great lengths to silence its own members who have raised concerns about the organization's unwillingness to conduct or rely on systematic reviews of evidence. The AAP continues to insist to this day that gender transition for minors is evidence-based, safe, and effective.

In a 2023 interview published in the Boston Globe, Jason Rafferty, the author of the AAP statement, said that gender-affirming care is about "affirming and validating the child's sense of identity from day one through to the end." He explained that when a child declares a gender, "We operate under the assumption that what they're telling us is their truth, that the child's sense of reality and feeling of who they are is the navigational beacon around which to orient treatment."

In 2023, following a multi-year campaign by some of its pediatrician members who refused to be silenced, the AAP finally agreed to conduct a systematic review of the evidence, even though by that point several such reviews had already been published and the AAP could easily have relied on them. It has been two years, and to my knowledge, there is no indication that the AAP has begun that review or that it intends to adhere to accepted standards for systematic reviews.

So now let me turn to the Endocrine Society. In 2017, the Endocrine Society published a clinical practice guideline on gender medicine. Despite acknowledging the poor quality of the evidence, the guideline makes

strong recommendations in favor of puberty blockers and cross-sex hormones, a move that has drawn criticism from some of the world's leading experts in evidence-based medicine. The Endocrine Society explained its decision by citing the "values and preferences" of pediatric patients seeking endocrine treatments. It stated that it places a higher value on "avoiding an unsatisfactory physical outcome once secondary sex characteristics have become manifest and irreversible" than on "avoiding potential harm from early pubertal suppression."

In other words, according to the Endocrine Society, helping a teenager achieve his or her cosmetic goals is more important than preventing harm from the use of off-label drugs. It's important to note that the clinicians who wrote the Endocrine Society's guidelines are themselves gender clinicians with conflicts of interest, and most were WPATH members.

Now, a key element of WPATH's strategy has been what I've called "credibility laundering." Medical associations with a broader scope and larger membership have specialized subcommittees dealing with LGBTQ issues, which today primarily means gender medicine. And these groups are aligned with or even affiliated with WPATH. For example, Dr. Aron Janssen of Lurie Children's Hospital is co-chair of the American Academy of Child and Adolescent Psychiatry's Committee on Sexual Orientation and Gender Identity Issues.

Incidentally, he is also a WPATH member and co-author of WPATH's eighth standard of care. It is not just medical associations that create a broken chain of trust. Medical journals are also responsible. We now have a large body of evidence demonstrating that medical journals have lowered or abandoned their editorial standards when publishing research purporting to show benefits from pediatric transition, and they also suppress or decline to publish critical commentaries on these studies.

Leaders in the medical field may be forgiven for assuming that if a study reports an improvement in mental health as a result of cross-sex hormone therapy, that report is credible because it underwent peer review. Again, the broken chain of trust. So to summarize, the medical transition of minors is a good example of medicine's failure to self-regulate. That failure is due not only to the broken chain of trust, which I've highlighted here, but also to the climate of intimidation that activists have created within the medical field against any medical professional who dares to question gender medicine or its foundational concepts.

As Dr. Hilary Cass wrote in her important report from last year, "There are few other areas of health care where professionals are so afraid to openly discuss their views, where people are vilified on social media, and where name-calling echoes the worst bullying behavior." This must stop.

Annie Chang:

Thank you so much, Leor, for that very in-depth review of how we got to where we are today. And speaking of the broken trust in the medical field, we're really lucky to have Dr. Haim join us. I'd like to turn to you next. Your perspective on this panel is particularly interesting, both because you're a medical doctor and a surgeon, and because you've had personal experiences going head-to-head with these ideological and political behemoths in medicine. I just want to touch on this briefly. I know it's a long story about your personal experience here.

Eithan Haim:

Yeah, and thank you all so much for being here, and especially to the FTC for hosting us. But yeah, my name is Dr. Haim. I'm a general surgeon in a small town outside of Dallas, and I was the whistleblower who exposed that TCH was lying about the existence of their transgender program. And I'm sure many of you are wondering: there's so much deception in this field. Where are the doctors? Why aren't there other doctors speaking up? All of this happened when I blew the whistle during my residency, and I witnessed it firsthand myself.

There is a code of silence that exists among physicians in the profession today. If you break that code, you'll be targeted in the most vicious way possible—because when I found out that the hospital I was working at, Texas Children's—which is one of the most amazing hospitals in the country for caring for children—had this program that was harming these children and had no basis in scientific or biological reality.

They were subjecting these children to these procedures and lying about it. So I blew the whistle in May 2023. A law was passed the very next day. More whistleblowers spoke out, including Vanessa Sivich, whom you'll hear about later today. And the hospital said they were shutting down the program. But in response to that, I was targeted by the most powerful federal behemoth in human history. They tried to send me to prison for 10 years. I was charged with more felonies than some of our country's most prolific criminals. And this was for a crime I had never committed—one that the DOJ could never even define—where no patient had actually been harmed.

They were using HIPAA as the basis for their indictment, even though the victims they claimed were the hospital and the doctors—not the patients, but the hospital.

Annie Chang:

Thank you, Dr. Haim. Moving on, I'd like to delve deeper into your medical expertise. You touched on this briefly regarding the code of silence. Why, in your view, have politics and ideology been allowed to persist in this field of medicine?

Eithan Haim:

It's been a decades-long process in which the medical profession has been taken over by radical left-wing ideologies. And as this infiltration took hold in these institutions, people who spoke out were increasingly vilified. So people would suffer the traumatic experience of speaking out and then having their professional lives damaged. Either they would be fired, or they would be denied promotions. They would sometimes be targeted by state medical regulatory authorities. And in cases like mine, they would be targeted by the federal government.

So there are real consequences for doctors who speak out against this. And this is happening to professors at medical schools as well—the clinical doctors who teach medical students in residency programs. All the people who are promoted or hired are not those who hold conservative values—or even just non-radical values. Essentially, being an average person eliminates your chances of being hired at these prestigious academic centers.

Annie Chang:

I'd like to shift gears a bit to the second question I posed at the beginning. We're talking about this "cone of silence"—how nobody is speaking up. So I want to really explore how we've come to be here today. How are we here today asking these questions and having these discussions? I think we owe a great deal to some of these panelists, including Dr. Haim. We also owe a great deal to the work being done at the state level—whether it's the FTC or the federal government.

But state legislators and state enforcement officials are willing to go all out on these disputes. We saw that in United States v. Skrmetti. So let's start with state enforcement. I'm sure the Supreme Court's decision in Skrmetti is at the forefront of all our minds—the decision that upheld Tennessee's Senate Bill 1, which, under a rational basis review, prohibits healthcare providers from performing or offering to perform a medical procedure on a minor if the procedure is intended to enable the minor to identify with or live as a purported gender identity inconsistent with the minor's biological sex.

Many other states, including Alabama, however, have also passed similar laws. Today we're joined by General LaCour, who was at the forefront of that litigation in Alabama. General LaCour, can you briefly describe what you were seeing at the state level, particularly in Alabama, before all the litigation eventually culminated in Skrmetti?

Edmund LaCour:

Absolutely. Thank you, Annie, for having me here today. I think Alabama was seeing what many states were seeing: a rapid rise in the number of children identifying with gender dysphoria and a similarly rapid and unexplained rise in the number of clinics treating them with these untested therapies. Arkansas was the first state to enact a law in 2021 setting age limits. Then Alabama followed in 2022, Tennessee and other states the year after. And nearly every one of these laws was challenged almost immediately by the ACLU and other activist groups.

And they followed a similar playbook in every state. They would show up and demand immediate preliminary relief from the district court. They would present a carefully crafted narrative along the lines of the assessment model Leor was discussing a moment ago. And then they would appeal to WPATH. It was their key weapon in their arsenal—arguing that these are evidence-based guidelines for providing medically necessary care to these children who are in deep distress. "And, Your Honor, if you don't do something, they might take their own lives."

And so many of these district court judges, who really knew nothing about this, were forced to make rulings very quickly. In Alabama, as well as in other states, preliminary injunctions were issued that prevented us from enforcing our laws. In Alabama's case in particular, the district judge really relied on WPATH in his preliminary injunction order, but we saw that as a great opportunity because the WPATH guidelines had essentially been treated as constitutional in that case. And we said, "Well, Your Honor, that makes them the most relevant factor in this litigation. So we should be allowed to conduct discovery into how these guidelines were developed. Were they the product of dispassionate science or impassioned advocacy?"

And what we uncovered was truly a political, medical, and legal scandal far beyond what we had even imagined at the start of the litigation. As Leor mentioned, the Biden administration was involved throughout the process in attempting to shape these guidelines for the purpose of implementing federal policy. So there was this circularity where the federal government was trying to alter the guidelines and then rely on those very guidelines to alter federal policy.

Most shocking, once again, was the instance in 2022 when, after years of development, SOC-8—version eight—was finally released on the WPATH website, and the guidelines included age limits for hormone treatments and surgeries. Now, many would argue that these limits were too low, but at least there were age limits in place. And then, all of a sudden, the guidelines disappeared from the website, and a new version appeared the next day that had no age limits whatsoever.

And WPATH did not explain why this happened. Well, the investigation revealed at least part of the reason: Admiral Levine—again, a senior HHS official at the time—had been given an embargoed final copy and then immediately began pressuring WPATH, for political reasons, to remove all age limits from the guidelines. And then the AAP, which Leor also mentioned, joined in, saying, "We will oppose your guidelines if you don't abolish all age limits on surgeries and hormone treatments."

And we have emails from WPATH authors going back and forth saying, "Well, should we really let U.S. politics dictate these international clinical guidelines?" We feel bad about giving in, but that's exactly what they did. And then we have emails saying, "Let's all get on the same page and fight the misinformation they were spreading to the public." As a result, there are some verifiable falsehoods in the guidelines that remain on their website to this day.

So WPATH states in the guidelines that all statements went through what's called the Delphi process, which Leor could probably explain far better than I could. But it's essentially a process where you consult various experts, try to reach a sort of consensus, and that consensus serves as its own form of evidence. Dr. Coleman, who chaired the guidelines, said, "It's really the only evidence we have." But because Levine intervened at the end and said, "You need to change this statement and remove all age limits," that process never took place.

Or rather, that new statement—which says, "No age limit is needed"—did not go through the process. So that's a verified falsehood contained in the guidelines. Leor referred to the issue of conflicts of interest. WPATH claims that they followed the recommendations of the National Academies of Medicine for developing guidelines free from serious conflicts of interest.

Again, we show that this is not true. The National Academies state that only a minority of those involved in guideline development should have some sort of interest in the procedures. However, Dr. Coleman testified under oath in a deposition in the Alabama case that most people—not a minority, but the majority—involved in SOC-8 did have a financial or non-financial interest. In fact, all 119 authors were members of WPATH, and Dr. Marcy Bowers—who also oversaw the guidelines' development—stated that, in her view, it was important for every author of the guidelines to be an advocate for comprehensive transgender care as defined by WPATH.

So again, we now have guidelines based on these undisclosed conflicts of interest, which raises serious problems. And I think that's how you end up in a situation where they can use the terms "evidence-based" and "medically necessary" in such a loose manner that they become almost meaningless. Speaking of "evidence-based," I mean, Leor already touched on this a little bit: Dr. Robinson at Johns Hopkins had been contracted by WPATH to conduct a systematic evidence review—to examine all the evidence that might be available and determine whether there was strong evidence, weak evidence, or no evidence supporting any of their recommendations.

In 2020, Robinson was already able to confirm to HHS that there is "little to no evidence when it comes to children and adolescents." HHS responded, "It's good to know there's little to no evidence." And then, years later, "We're telling the Supreme Court that there was overwhelming evidence to support these treatments."

Leor has already touched on how WPATH was suppressing evidence reviews. In fact, they required final approval of any article that used any of the data. And anyone publishing an article based on the data had to "use the data to advance transgender health in a positive manner." But, again, the point of evidence-based medicine is to examine all the evidence that might support or contradict your hypothesis—not to simply cherry-pick the evidence that supports your view and disregard the rest. So, I mean, that bias undermines the entire process. But to make it appear neutral, WPATH imposed an additional requirement on its authors, stating that in their manuscripts, they had to declare to the world that they were "solely responsible for the content of the manuscript and that the manuscript does not necessarily reflect the views of WPATH." I mean, that's very hard to reconcile with WPATH having final approval of every manuscript.

The last thing I'll touch on regarding medical necessity—as it's referred to—is sort of the child-driven model. There are phrases like "embodiment goals" that appear in the emails we receive from WPATH. I think those emails—and even the guidelines themselves—made it clear that, in their view, wants are being treated as needs. And so, as one author put it—in her view—"It is crystal clear that SOC-A refers to the necessity of treatment in its broadest sense for gender dysphoria because it refers to the symptom of distress, which is a very, very, very"—that's three "very"s—"broad category and one that any well-intentioned clinician can use for this purpose."

And so when you redefine medical necessity in that light, you end up with strange statements like this in the guidelines: “A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary, gender-affirming medical and surgical treatments.” But of course, if there is no good evidence available, calling it medically necessary clearly puts the cart before the horse. Yet that is precisely what we find in the guidelines today.

One final point on medical necessity. SOC-A, for the first time, includes an entire chapter devoted to men who identify with a eunuch gender identity. The chairman of the Associates admitted under oath that even though no diagnostic manual recognizes “eunuch” as a medical or psychiatric diagnosis, WPATH’s official position is that castration may be “medically necessary” for a healthy man with no mental health conditions who identifies as a eunuch and wishes to be castrated.

So when the same guidelines state that it is medically necessary for middle schoolers—like the ones we heard from earlier this morning who are experiencing gender distress—to undergo surgeries and receive hormones, one must ask: What does WPATH really mean by “medically necessary”?

Annie Chang:

Thank you so much, General LaCour. And you mentioned that you obtained all this information during discovery, so I have two follow-up questions on that. First, I’ve read speculations online that, obviously, your case didn’t make it to the Supreme Court—Skrmetti’s did. I’ve heard online that the Biden administration chose not to petition for certiorari in the Alabama case because you received all that discovery. Is it your understanding that you were able to uncover that information and that they wanted to keep it under wraps?

Edmund LaCour:

That was absolutely our view because, after we obtained the documents, the same lawyers from the Department of Justice under President Biden were suing Alabama and Tennessee. And Tennessee’s case was proceeding on a very truncated six-week record at the preliminary injunction stage, and they decided to seek certiorari even though one reason the Supreme Court might decline to hear a case is because the record is sparse and underdeveloped—and the United States has argued against the Court taking other cases on precisely that ground.

Meanwhile, we’d been litigating for a year and a half. We had built up a substantial record and were preparing to go to trial. And just a few days later, they asked the Supreme Court to hear the Tennessee case. They actually filed a motion in the Alabama case saying, “Whoa, whoa, I know we sued Alabama and we need relief really quickly, but let’s just put this litigation on hold. Let’s hit pause.” Just like they say with puberty blockers, “and just wait and see if maybe the Supreme Court is interested in taking up Tennessee’s case because that could resolve a lot of issues.” And at that time, the discovery was still entirely subject to a protective order.

Now, once documents that have been produced under a protective order are entered into the court record as litigation documents—such as through a trial or a motion for summary judgment—the burden shifts to the party seeking enforcement of the protective order to explain why the public shouldn’t see these documents. And so that’s what I think they were trying to prevent from happening. Fortunately, we were successful in opposing that stay motion and then another stay motion filed with the SPLC. A few months after that, we filed our summary judgment brief, which included a lot of the evidence I’ve been talking about today, and that really helped shift the narrative and expose some of the scandal.

Annie Chang:

And so the Alabama case was stayed. And my second follow-up question is: that effectively ended when Skrmetti's petition was granted by the Supreme Court. What did you do?

Edmund LaCour:

Well, it actually ended a month before the Skrmetti decision. They came to us and said, "We want to dismiss our case with prejudice."

Annie Chang:

Of course.

Edmund LaCour:

Which means we lose completely. Even before Skrmetti was decided, though, we took that as a sign that if Skrmetti had gone their way, ours would have been the last case they'd want to proceed with next. Because even if heightened scrutiny is applied, when you see that the guidelines they've staked their entire case on are based on this kind of advocacy rather than science, that would be a terrible blow to them in terms of pushing this narrative. So they walked away a month before the Supreme Court even issued its decision.

Annie Chang:

And then you filed an amicus brief in this case?

Edmund LaCour:

Yes. So in October of last year, we filed an amicus brief in Skrmetti, laying all this out, really calling the United States to account for making their representations to the court when they knew what we knew, and explaining what we had uncovered about WPATH—which, again, had been cited multiple times by the private plaintiffs and by the United States in getting the court to take the case and in making their case before the court. That brief was cited extensively by Justice Thomas in his excellent concurring opinion. And so it was an honor to be able to do that work.

Annie Chang:

Thank you so much. I'd like to turn to private litigation and Jordan. Jordan is now serving in the federal government, but prior to that—and I believe some of you here are former clients of his—you left your position as a partner at a boutique firm in Texas, where I'm sure you were doing quite well for yourself, at a firm dedicated to representing members of the detrans community who have been harmed by what some have described as gender-affirming care. Before we get into the details of your work here, I'd just like you to share what motivated you to open this firm that specializes exclusively in this area?

Jordan Campbell:

Yeah. First of all, thank you for having me. It's an honor to be on this panel. And when I say that, I truly mean it's an honor to be with these three guys because I have no right to be here. They're so much smarter than me. All I can really do is share what I've learned from my clients and literally hundreds of others whom we were unable to represent due to the statute of limitations—which is a whole separate topic. My background was in big-law firms, specializing in commercial and antitrust litigation. So, moving into gender litigation was a drastic career shift.

What led me here was essentially what we heard this morning—the stories and testimonies of people I didn't even know existed, known as detransitioners. The more I read and the more I heard from them—and I hope others here feel the same—the more I realized I couldn't look away or do nothing. I saw that there was truly no one who would stand up for them. There was no one who would speak up for them, and there were certainly no lawyers who would represent them. So I said, "Okay, well, I'll be one of those people; I'll step up and try to represent them as best I can."

So it's not that I didn't know a lot about the medical field. I've certainly learned from people like Leor, who've become good friends of mine. I've known Eddie for a long time and have certainly learned a lot from their litigation. And by the way, for nerds who like to read amicus briefs, that's the best amicus brief I've ever read. You should definitely read it. But it wasn't any of that—it was hearing from my clients, hearing from others, and just thinking, "Yeah, I feel like I need to do something."

Annie Chang:

Thank you for that. So we heard a little bit from General LaCour about litigation tactics used in state lawsuits to keep this information out of the public eye. I was wondering—in private litigation, you were suing, I'm sure, healthcare institutions and medical practitioners, and sometimes perhaps governments. I was just wondering if there's any evidence or facts you uncovered that you're able to share today. Keeping in mind, I know some of it is subject to a protective order.

Jordan Campbell:

Yeah. I'd just say there are certainly tactics at the practitioner level that we saw that were very common. I literally can't tell you all how many times I've heard people—clients or potential clients we've interviewed—tell us about the "suicide myth" they were told, which is: "Would you rather have a living son or a dead daughter, or vice versa?" It's a very, very common tactic. The surgical letters, by the way—which Dr. Grossman also highlighted for us this morning—are a very common tactic. I'd actually say those are some of the more detailed letters you'll come across. It's more common to see even more generic letters that are even more fraudulent—letters that, in just two quick paragraphs, say… We even had one client whose doctor signed a letter stating that they could certify this patient meets all the WPATH guidelines, which include months—if not years—of dysphoria. And the doctor said, "I've been treating this patient since the day they signed the letter."

So I mean, the most blatant evidence of fraud is when someone says, "I know this patient and I know they meet all the criteria, and I just saw this patient today," but then signs off on it right there and checks the boxes. So these letters are certainly a very, very common tactic. The suicide myth is another common tactic.

I'd just say that, generally speaking, the one thing that really blew my mind—the more we delved into the records, the more we saw from these institutions—was simply the absolute, unquestioned rush toward "affirmation" with zero guidelines. I can't tell you how many patients we've spoken to who, the very first time they spoke to a clinician, they were prescribed cross-sex hormones or puberty blockers or both—which goes against even the "WPATH Guidelines," which they all claim to follow, but in practice, none of them actually do. That's what really stood out to me: they don't even play by the rules they claim to follow.

Annie Chang:

So there's one last question I want to ask all of our panelists, and Leor touched on this briefly at the beginning. We're here today in the wake of Skrmetti, following the state's enforcement action, and after private individuals have sometimes put their livelihoods on the line to allow us to ask these questions and hear from people

today about what's been happening. So what's next? What's next in dismantling the bias, politicization, and ideology that have crept into medicine?

Eithan Haim:

If I may begin, I think one of the best strategies—especially for Jordan Campbell moving forward and anyone in the Department of Justice with the authority to enforce the law—is what Dr. Grossman showed us earlier.

As a surgeon, if I used diagnosis codes that were that fraudulent, I'd be in prison. That's a real crime—not like the bogus charge they brought against me. And all the Department of Justice has to do is enforce the law. These laws already exist; these people are committing crimes. If the investigations are completed and prosecutions are brought, then these people will be held accountable, and there's a very good chance this will stop—even in blue states.

Jordan Campbell:

We're working on it, Dr. Haim. Obviously, there's certainly a legal angle that I'm sure the FTC may be interested in—and the Department of Justice is certainly interested in it. But I would also say, more broadly, that it's a cultural issue—and it has been. I'd say the pendulum is swinging right now, and the reason for that is that I simply believe the truth is finally coming to light. The spotlight is finally being shone on what's going on. And ultimately, I believe the truth will prevail.

So, as far as how this moves forward—how do we make progress in this area and reclaim it?—I think it's through panels like this that what's actually happening is being brought to light. I think ultimately that's what moves hearts and minds, and that's when people wake up and realize this can't be right. And ultimately, that's probably what changes things.

Leor Sapir:

I would say, consistent with what I said earlier, that I truly believe—both for intrinsic reasons and for strategic reasons—we need to show understanding and compassion toward medical professionals and mental health practitioners who, for understandable reasons, have trusted their colleagues and have been misled. I think we need to continue moving forward with evidence-based medicine, continue insisting on the importance of examining evidence, considering the underlying clinical rationales, and the concepts of transgender medicine, as Dr. Grossman very helpfully pointed out. But at the same time, we need to show some understanding and try to help create an exit strategy for medical and mental health professionals who have become entangled in this issue.

I don't think it does us any favors to demonize those who don't deserve to be demonized, and I especially believe we need to show understanding and compassion for the children and their families who have crossed the Rubicon—who have medicalized the issue and committed their lives to these procedures. Above all, we cannot demonize parents. I mean, for me, that's always been my red line: never demonize parents. Parents have been constantly misled and lied to. So we need to show understanding and help create ways out. That's what I would say.

Edmund LaCour:

Building on something Jordan said, I think getting the word out is so critical. One problem we faced early on was that some of the things that were being done were just so horrible that most people

wouldn't believe it. "No, that can't be true." It's like this idea—that surgeries aren't happening, and if they are, it's a good thing. But then you hear from the people who've been so harmed by it, and that can—I hope—open people's minds. But I also agree with Leor that there are some people in the medical industry who have been deceived, and there are some who are doing the deceiving. And for those in the latter group, I think it's going to be important to continue investigating.

Annie Chang:

Let's give a round of applause to our panelists. Thank you so much.

Jon Schweppe:

Sorry. I should have turned that on. We now have another presentation for you on the medical harms of so-called gender-affirming care for minors. Michael Laidlaw, M.D., is an academically trained, board-certified endocrinologist who has been in private practice in Rocklin, California, since 2006.

In 2018, he wrote an influential article for Public Discourse titled "Gender Dysphoria and Children: An Endocrinologist's Evaluation of I Am Jazz," after recognizing a strong push to incorporate gender ideology into his local school system. From there, he went on to publish in medical journals and to speak and educate on the topic of the harms caused by puberty blockers, opposite-sex hormones, and surgeries in locations such as California, Washington, D.C., the UK Parliament, and before the Florida Medical Board. He has worked and testified on behalf of states, including as an expert witness for important legislation to stop the use of harmful hormones, puberty blockers, and surgeries provided to minors for the purpose of gender transition. Please welcome Dr. Michael Laidlaw to the stage.

Dr. Michael Laidlaw, M.D.:

Okay. Thank you. Thank you for having me here. Thank you, Chairman Ferguson, Mr. Schweppe, Brandon Showalter, all the truly excellent speakers here today, and thank you, guests.

Let's see, next slide. I think we're waiting for the audiovisual equipment, so I'll just move on. I'm here in D.C. It's very nice to be here. Next year will mark our 250th Independence Day, and we just had a great Fourth of July in our corner of California, but I couldn't help wondering: What would the Founding Fathers think about what's happening today? What would they think if someone couldn't define what a woman is or what a man is, or if you could administer chemicals—hormones—they knew nothing about to magically transform a boy into an adult woman or a girl into an adult man? Thank you. All right.

So with that, again, I first really… took a deep dive into this when this book—if you've heard of it, *I Am Jazz*—was read to kindergarteners in our local school system, and a parent urged me to read it as an endocrinologist. This is a propaganda book aimed at very young children—kindergarteners and elementary school students. I found at least a couple of things in there that were false claims—that a boy could be born with a girl's brain, that a doctor could somehow diagnose a child as transgender. There was a lot of information missing about the types of medical harms that can result from this treatment.

Today, I'm going to talk a little bit about what gender dysphoria is, how normal human sexual development works, what gender-affirming therapy, hormones, and related topics entail, and who the major promoters are. You've heard a lot about that. I'll go through that briefly. I'll also discuss nations and states that have turned away from this approach to care, suicide deaths, and my conclusion.

What does all this hinge upon? I think Dr. Grossman covered this well: objective biology versus subjective feelings. Gender identity is an internal sense of being a boy, a girl, or some variation. Gender dysphoria is a legitimate psychological diagnosis listed in the DSM-5, characterized by extreme discomfort with one's sex and perceived gender, leading to significant distress and impairment in functioning lasting at

at least six months. It's important to know that, depending on which study you look at, as long as children aren't treated with hormones, the majority—50 to 98 percent—will stop exhibiting these symptoms or outgrow them by adulthood. It's also important to know that many of these people, as you've heard today, have other coexisting psychological conditions such as anxiety, depression, autism, or self-harm.

Now, as an endocrinologist, I prescribe hormones to patients. Hormones are very powerful medications that alter both the body and the mind. So if I'm going to give insulin to a patient, I'm going to make sure I have objective evidence of diabetes. I want glucose test results. If I'm going to refer a patient for thyroid cancer treatment, I want a biopsy to confirm that this person needs that treatment. So, as I said, we're going to radically alter people's bodies—including children's bodies—with hormones. How can I prove that this person is transgender? Where do I find evidence of their gender identity? Can you perform a CT scan, an MRI, chromosome testing, or other tests? And the answer is: you cannot.

Again, there are only two sexes, in case you missed that earlier. Sperm comes from your father, an egg from your mother, and there are no other gametes out there. There aren't 14,000 other gametes. There are only two that make up you and all of us. You can examine the chromosomal evidence found in all cells with nuclei in your body: XX for a female, XY for a male. These trigger different processes, sometimes in a sex-specific way, within cells.

During normal development, your reproductive tract and organs actually develop between weeks 8 and 12. And so there are primitive tubules. At first, some of these could develop into male structures and some into female structures, but what happens is that you develop into one or the other, and the other tubules are completely eliminated. This means you can follow one path or the other, but you cannot switch paths later on. We have no medical way of doing that.

Again, sex is determined at birth. You can tell as an adult, or even as a four-year-old. A child might look at their little brother or sister and know for sure. It's not assigned at birth. No one flips a coin or draws a lottery ball to say, "This is a male or a female." It's very easy to identify. There are people with disorders of sexual development, which are outside the scope of this discussion and really not relevant here, but it doesn't change the sex—it's simply a disorder of sexual development.

I'm going to talk about what I call gender-affirming therapy, which really has four phases: one or more involving social transition, puberty blockers, cross-sex hormones, and surgical modifications—which you'll hear more about from Dr. Lappert.

Now it's important to note… Is there any water, by the way? It's important to note as we're getting water. Oh, sorry, I wasn't paying attention. So doctors and pediatricians can examine patients and determine what stage of pubertal development they're in by looking at what we call the Tanner Stages. Tanner Stage I refers to the undeveloped prepubertal individual, and Tanner Stage V refers to an adult. At this stage, the reproductive organs are fully present and developed. Stages II through IV represent various intermediate stages of development. For our purposes, it's important to know that fertility is established around Tanner Stage IV—sometimes as early as Stage III.

Now, this entire amazing process is controlled by glands, one of which is the pituitary gland—a small, pea-sized organ in your brain—which signals the testicles to produce testosterone or the ovaries to produce estrogen. This sets in motion all the processes involved in the development of puberty. Sometimes, however, people can develop conditions that disrupt this communication, causing puberty to stop or preventing it from starting at all. This is diagnosed and treated by endocrinologists. However, other types of medications, such as Lupron—which you may have heard of—can also chemically interfere with this process and halt puberty.

Now, this has legitimate uses in cases of central precocious puberty in very young children—say, three- or four-year-olds who go through puberty early—but there is no FDA approval, and there is no solid evidence, as you've

seen, for using this for the purpose of gender transition. And as you might imagine, puberty blockers interfere with this normal progression and the normal development of fertility.

So there are various side effects of blocking normal puberty. In males, penile and testicular growth is stunted, which complicates future surgeries. Sexual dysfunction—as you might imagine—includes impaired erections, orgasms, and ejaculation, as well as the prevention of sperm production. In both sexes, there is disruption of normal brain development—which occurs under the influence of hormones—and disruption of normal bone development.

In females, if puberty is halted at an early stage—as recommended by WPATH and the Endocrine Society at Tanner stage II—an early menopause-like state develops, characterized by the blocking of normal breast development, decreased blood flow to the vagina and vulva, and sexual dysfunction, including thinning of the vaginal epithelium, vaginal atrophy, and anorgasmia. Of course, this also interferes with menstruation and leads to infertility. And you'll hear more about infertility from Ms. Lahl later.

You can also read the labeling and note that there are many neuropsychiatric effects of puberty blockers listed right on the labeling. For many, this ultimately leads to sterilization because, first, these medications have impaired or perhaps destroyed the sex organs. And then many—particularly those from earlier studies—go on to have their testicles or ovaries removed, which constitutes complete sterilization.

Now, I just want to talk a little bit about bone development. The pubertal phase and through the 20s is a critical time for bone development and the establishment of normal bone density. As you can see at the bottom here, the chart shows ages and bone density for children and adults. You can observe a rapid increase in both males and females from age 10 through the late 20s.

What happens with puberty blockers is that, compared to their peers, they are unable to build as much bone mass and end up with lower bone density than would otherwise be expected. This results in a plateau in bone density, which is significant because it can increase the risk of osteoporosis and debilitating fractures later in life. While taking cross-sex hormones later on may mitigate some of these effects, as you'll see, that is not a healthy approach either.

Here is a woman who underwent a mastectomy, and you can see signs of what we call hyperandrogenism, or high testosterone levels. You can see the abdominal hair and the facial hair. And I just want to show you—and I think this was covered earlier—that the normal range of testosterone in women, who also produce testosterone, is 10 to 45, or 10 to 50, as shown in blue there. But the orange range shows what they're recommending for this gender transition—levels roughly 6 to 100 times higher than normal female levels.

This leads to multiple risks: an increased risk of heart attack and death due to cardiovascular disease, high red blood cell counts, potential liver dysfunction—as you heard earlier with Kayla—hypertension, and various potential risks to the reproductive tract, including ovarian, breast, and uterine cancer. Some of these risks are still being studied. Of course, there's also hirsutism (excessive hair growth), deepening of the voice, and sexual dysfunction and fertility issues.

This is a controlled substance and is being used off-label. And this is important because this data comes from a paper on the Food and Drug Administration's Adverse Event Reporting System. I want to point out the similarities to anabolic steroid abuse, which we've actually addressed in a commentary. In the Adverse Event Reporting system, they found evidence of aggression, reported anger, euphoria, depressed mood, dissociative identity disorder, affect lability, emotional disorders, antisocial or self-destructive behavior, homicidal ideation, and suicidal ideation. Many of these are similar to what is observed in anabolic steroid abuse.

Now, let's talk about estrogen. Using estrogen in very high doses—perhaps 2 to 40 times higher than normal estrogen levels in men—leads to an increased risk of heart attack and death due to cardiovascular disease, as Dr. Schwartz has thoroughly documented in his research. There is also a two- to five-fold increased risk of thromboembolism—deadly blood clots—as well as a potential risk of stroke and high

triglycerides. The risk of breast cancer in men—and men can develop breast cancer—has increased by some 22 to 46 times, depending on the source. Benign brain tumors, such as prolactinomas. Germ cell neoplasms are other possibilities.

I'm going to skip over some of this because they've done a good job of discussing WPATH. WPATH is an advocacy organization, as you heard earlier. They removed the age guidelines primarily—as we learned from our excellent attorneys in Alabama—because of Admiral Levine working behind the scenes at the American Academy of Pediatrics, which had been trusted since 1930. Not anymore.

The Endocrine Society is otherwise a legitimate medical organization. I've been a member since 2006. They do great work—except when it comes to gender issues. They published guidelines in 2009 and 2017. And just to emphasize—I think Leor Sapir mentioned this—9 out of the 10 authors of the 2017 guideline were WPATH members or affiliated with WPATH. So I've often been asked, why are medical organizations following this kind of treatment? I think it's because WPATH, early on in 2009, got involved and realized, "Why not use the hormone association to legitimize what we're doing?"

I'm going to move on. Again, systematic reviews of the evidence have been conducted. Common themes that emerge when examining this evidence include limited high-quality evidence for most interventions, primarily due to methodological flaws, small sample sizes, lack of control groups, lack of long-term follow-up, and unproven mental health benefits. As a result, many countries have moved away from this approach, including the UK. There's Dr. Hillary Cass, whom you heard about earlier. And we have our own HHS report, which is still under peer review, but in many ways expands on the Cass reports and is very comprehensive and worth reading. I don't have time to go into it. But I want to conclude by discussing death within this treatment paradigm, because that is the ultimate outcome that physicians are trying to prevent.

Now, if you look back to 2011, a study was published comparing the general population of Sweden as a whole to some 300 or more individuals who had undergone hormone therapy and surgery. As you can see, the bottom axis shows time and years, and the top axis shows survival, with 100% at the top. The top two solid lines represent males and females in the general population. If you look at the dashed lines—which represent what they call trans men and trans women—you can see how their survival rates dropped off rapidly after 10 years. In fact, the all-cause mortality rate was nearly three times higher, and the rate of completed suicide was 19 times higher.

Now, what about children and young people? This is Dr. Johanna Olson-Kennedy, whom you heard about earlier—a gender clinician and researcher at Children's Hospital Los Angeles. And here's a quote you've heard, something she tells parents: "We often ask parents, 'Would you rather have a dead son than a living daughter?'" Which is quite a claim, in a way. It's a question, but it's also an assertion that if your child receives these hormones, they will live—even though they may identify as a different gender than you had expected. And if not, they will die by suicide.

If true, this might be an important way to approach the discussion. But if not true, it would be seen, in my opinion, as an extreme form of coercion. Jane Robbins is an attorney and author. She alerted me early on to a study funded by the NIH, and we sought more information through FOIA requests to the NIH. There's a lot to discuss here, and we'll cover some of it on Miss Friday as well, but the title of this now ten-year NIH study is *The Impact of Early Medical Treatment on Transgender Youth*. It involves four sites—academic institutions across the country.

They were examining two treatment groups: one involving puberty blockers, starting treatment at a very early age—say, 8 for girls or 9 for boys—and monitoring the effects over two years; and another involving cross-sex hormones, starting at age 13, though that age was later lowered. They were studying mental health, psychological well-being, metabolic and physiological parameters, bone health, and so on.

We discovered information about this around 2018. And in 2019, one of my colleagues, Dr. Will Malone—who is also an endocrinologist—and my colleague Hacsi Horvath from the epidemiology department wrote a letter to the Office for Human Research Protections requesting a moratorium on this study due to all the issues I mentioned earlier, which would clearly arise. We stated, "We contend that neither children nor their parents can meaningfully consent to permanent infertility or other potentially serious medical harms to treat a non-medical condition. We questioned whether these parents were fully informed of the health risks or the possibility of tragic regret."

We received a reply from the NIH essentially stating that they would not impose a moratorium, as that would only halt data collection. In any case, these parents had been informed of what would happen, and the NIH was not going to take any action regarding it. Now, in 2023, a study was published in the New England Journal of Medicine detailing the outcomes of cross-sex hormone therapy—or at least some of them—for 315 patients who received this treatment.

The most common adverse event was actually suicidal ideation in 11 participants. And two children or young people actually died by suicide, which made me think, "That's what we were trying to prevent with this, wasn't it?" Apparently not. Now, in medicine, it has been common practice for centuries to perform autopsies on patients—especially those with rare or unusual conditions—and to compare the findings with their clinical course during life in order to advance our understanding of various conditions. For example, adrenal insufficiency is one condition I'm familiar with where this has been done.

So, in *The New England Journal*, what did you find about these deaths? Well, nothing really. It's just a statistic. Were they male or female? We don't know. What were their ages? We don't know. What kind of psychological care did they receive leading up to their deaths? What were their diagnoses? Were autopsies performed on the study participants? If not, why not? What were their testosterone, estrogen, progesterone, or blood levels? What did the first responders' reports say? None of this is known at this time. So, in my opinion, information is being withheld.

And so, the first participant was enrolled in this study in 2016. We wrote our letter in 2019, and then *The New England Journal* published this data in 2023. And I was quite surprised because we had been following the annual progress reports, and I never saw any mention of a death. So, it was concealed. That is, until our wonderful attorneys in the state of Alabama subpoenaed HHS documents in late 2023 and discovered that the first death had actually occurred way back in 2017, before we had written our letter. And I could not find any information about the second death.

Now, someone we do have information about—and many of you here probably know about Yaeli Martinez and her mother, Abigail Martinez. The only reason we know about her case is because her mother has been very vocal about it. Yaeli suffered from depression. She was referred for gender transition at Children's Hospital Los Angeles by a school psychologist who said she needed gender transition, and she was administered testosterone.

Her mother says that her daughter was taken away by the county and placed in foster care. She committed suicide by jumping in front of a train in Los Angeles County at age 19. The mother says that around 9:30 p.m. that night, her daughter walked onto the train tracks facing an oncoming train. She got down on her knees, raised her arms, and simply lay down on the tracks. So, if you want to find out more about this case report, you could look in medical journals and find it there. No. But you can file a public records request with the Los Angeles County Coroner's Office—which is what I did, excuse me—and found the record.

And I don't want to be graphic here. But you can get an idea of it from this. She was identified as a 19-year-old woman. Importantly, she had scars on both arms. These were not from a train collision. They were old, healed scars from her history of self-harm, I would say. And her body was so badly mangled that her mother wasn't even allowed to see her afterward.

So, we'd like to prevent that from happening. We'd like to prevent other deaths from occurring. We'd like to prevent all the stories we've heard today of young people being severely injured or mutilated as a result of this treatment. Just to make it clear: this is not the standard of care. I skipped over that slide, but even the Endocrine Society has stated this. We do not have the technology to turn girls into boys or boys into girls, so children may believe otherwise. Medications are being used off-label at high doses without proper FDA risk assessment. Multiple harms are evident or predicted. Proper long-term studies have not been conducted. Multiple systematic reviews of the evidence have found that the evidence of benefit is of poor quality.

Young people have been permanently maimed and killed during the course of these treatments. And finally, the WPATH Standards of Care 8 is an extreme document that poses a grave danger to minors and should not be followed by any clinician or physician. Thank you.

Jon Schweppe:

Thank you, Dr. Laidlaw, for such an informative presentation. We now have one more panel before lunch, and I appreciate your patience. We had a lot to cover today. So, let's continue with a focus on the science. What does the science actually say about gender-affirming care? Our moderator is Myles Lynch, who serves the Federal Trade Commission as one of our attorney advisors in the Chairman's office.

Myles Lynch:

I guess it's not morning anymore, so good afternoon, everyone. I know we're running a little late right now and you're probably looking forward to lunch, so I won't give a long introductory speech. But this panel is made up of medical professionals who, building on what we just heard from Dr. Laidlaw, can help us understand what the science really says about the benefits and risks of gender-affirming care.

First, I'd like to introduce—I'll let them take their seats first—Jennifer Lahl, founder of the Center for Bioethics and Culture Network, a nonprofit organization that educates the public, policymakers, and others on bioethical issues. In this role, Lahl combines years of experience as a pediatric critical care nurse and a senior-level nursing manager with a passion for advocating on behalf of vulnerable populations. Lahl's writings have appeared in various publications, including Cambridge University Press, the San Francisco Chronicle, and the American Journal of Bioethics.

Her latest book, *The Detransition Diaries*, was published in 2024 and co-authored by Kallie Fell. She has produced 11 documentary films, 3 of which explore gender-affirming care. Her films *Trans Mission: What's the Rush to Reassign Gender?*, *The Detransition Diaries: Saving Our Sisters*, and *The Lost Boys: Searching for Manhood* were released in June 2021, September 2022, and January 2024, respectively. She is frequently interviewed by the media and has been invited to speak alongside lawmakers and members of the scientific community on issues such as human egg and womb trafficking.

Next is Michelle Cretella. She is a pediatrician, writer, researcher, educator, and speaker. She is the former executive director of the American College of Pediatricians and the current chair of its Adolescent Sexuality Committee. She serves as a pediatric spokesperson and educator for the Association of American Physicians and Surgeons and the Catholic Medical Association. Dr. Cretella serves as a peer reviewer for the *Journal of American Physicians and Surgeons*, *Issues in Law and Medicine*, and the *International Journal of Behavioral and Healthcare Research*.

She became a leading physician critic of pediatric transgender interventions following a 2017 interview with Tucker Carlson in which she detailed their harmful effects and called them medical child abuse. Dr. Cretella received her medical degree from the University of Connecticut School of Medicine in 1994.
She completed her internship and residency in pediatrics at the Connecticut Children's Medical Center in Hartford, Connecticut, in 1997. She completed a fellowship in college health through the University of

Virginia in 1999 and practiced pediatrics with a special interest in behavioral health from 1999 through 2012. At that point, she left clinical pediatric practice to devote more time to leading the American College of Pediatricians. Lauren Schwartz is a psychiatrist and psychotherapist in private practice. She is board-certified by the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association, and a senior fellow at Do No Harm. Throughout her career, she has advocated for upholding the highest standards of care in medicine and mental health. Her recent advocacy focuses on gender-affirming care, particularly on interventions she believes lack scientific substantiation, such as puberty blockers, cross-sex hormones, and surgical procedures performed on minors and vulnerable adults.

Her efforts have highlighted the critical importance of high-quality medical guidelines, and she asserts that low-quality evidence should never be considered authoritative when determining what constitutes life-saving, evidence-based care. In 2024, Dr. Schwartz co-authored an open letter to the APA regarding its textbook *Gender-Affirming Psychiatric Care*, which garnered over 7,200 signatures, including those of clinicians, educators, and researchers.

She has actively testified against legislation that she believes compromises ethical medical practice and jeopardizes the well-being of vulnerable patients. Most recently, Dr. Schwartz collaborated with other medical and research professionals to publish an open-access review. This review compiles over 50 studies highlighting extensive health risks associated with feminizing hormones in natal males.

And finally, Patrick Lappert is a plastic and reconstructive surgeon who has been in practice for over 30 years. He is board-certified as a general surgeon and has served as the U.S. Navy's chief of Plastic and Reconstructive Surgery at the Portsmouth Naval Hospital. He also served as the reconstructive surgery specialty leader for the Surgeon General of the U.S. Navy. He founded the Pediatric Craniofacial Reconstructive Surgery Unit as well as the Wound Care Center for the Portsmouth Naval Hospital, which was then the largest military hospital in the world.

Dr. Lappert retired from the Navy after 24 years of service with the rank of captain. He then worked as a plastic surgeon in private practice for 18 years. He recently retired from the practice of medicine and surgery. Dr. Lappert has served as an expert witness in numerous legal cases concerning gender-affirming care in state and federal courts. He was actively involved in the legislative process that led to Alabama's law protecting minors from gender-affirmation care, and he has authored chapters and books on the scientific evidence underlying gender-affirming medical and surgical care, as well as on the pastoral care of individuals harmed by the gender-affirmation industry.

So, if I may begin by asking Ms. Lahl a question: Can you explain—I know we just heard a little bit from Dr. Laidlaw—what fertility preservation is?

Jennifer Lahl:

Actually, let me read my remarks so I can stay on track. Oh, sorry. Thank you. Thank you. Very good. Yeah. Fertility preservation is an assisted reproductive technology offered in the hope of preserving a person's fertility so that they can have a biologically related child in the future.
There are several different methods. One is freezing eggs, ova, or oocytes; you can freeze sperm; you can freeze embryos—that is, you create embryos from eggs and sperm and freeze them. Or, as is often the case with prepubescent children, you can perform ovarian or testicular tissue cryopreservation, which is an option available only to prepubescent children because they do not yet have eggs or sperm.

Fertility preservation was first tested, used, and perfected in the field of species at risk of extinction. So, it was a method used to try to preserve various species. It then expanded to adult cancer patients, where the cancer treatments they needed could negatively impact, harm, or destroy their fertility. And then in the

early 2000s, it actually expanded to include pediatric cancer patients so that children also affected by cancer might have the opportunity to one day grow up and have a biologically related child.

But now, we've seen it expand into the realm of gender-affirming care as a service that's offered. I'm probably the only person in the room who, when the Cass review came out, immediately looked to see what Dr. Cass said about fertility preservation. And I was saddened and a little shocked that she recommended in Section 10 that all children be offered fertility counseling and preservation before being placed on a medical treatment pathway.

And if I could just highlight a few things Leor said: "If we move to this assessment model—if we move to this model where we can do it better—we can provide effective care for these children. And also, if we trust the experts—who wouldn't want to trust Dr. Hillary Cass?" We have to be mindful of—and I think this is what I'm about to say—that perhaps we don't want to offer this to children. As you mentioned in my bio, I used to be a pediatric critical care nurse. But for the past 20 years, I've devoted most of my energy to the fields of fertility, infertility, and assisted reproductive technologies.

I was deeply concerned—as a nurse and as a filmmaker—when I learned that children, before their puberty was blocked or before they were put on cross-sex hormones or offered surgeries, were being offered fertility preservation as part of their care. And again, knowing that the younger the child is, they're going to be offered the actual freezing (cryopreservation) of ovarian or testicular tissue at Tanner stages 2 to 3, when they have not yet developed mature gametes.

It's one thing to offer the possibility of having a biological child to a cancer patient—whether an adult or a child—who needs treatment that could potentially save their life. But it's an entirely different matter to offer fertility preservation as part of their care to a person with healthy fertility whom we know we are going to harm. The research that Dr. Laidlaw cited on one of his slides—which we published in March 2025 in *Frontiers in Endocrinology* under the title "Fertility Preservation: Is There a Model for Gender-Dysphoric Youth?"

We found only two reported live births in pediatric female patients who underwent ovarian tissue cryopreservation. Only two of those young women—who were 9 and 13 years old at the time their tissue was frozen—were able to successfully give birth to a live baby. Another case was reported involving a 14-year-old girl; however, the report did not specify whether she had gone through puberty or not. However, after four rounds of IVF, this young girl was finally able to give birth to a live baby, though she did deliver prematurely—a risk associated with IVF pregnancies in general.

However, in each of these three cases, all of these patients had to undergo gonadotoxic therapy to treat their cancers—one of the reasons they were offered fertility preservation. As for the male population, we found zero reported cases of success among young men who were offered the option to freeze their testicular tissue. A significant unknown for both of these groups is that we do not know how many attempts were made.

So, of the three young girls who successfully gave birth to live babies, did only three young girls attempt this, or did 3,000? We don't know. So, you have to take that statistic with a grain of salt. For those who have gone through puberty and were offered fertility preservation of their eggs and/or sperm—this is no longer considered experimental—but all the data we have is lumped together. So, these young people who, as part of their gender-affirmation care, were offered and accepted the option to bank their eggs and sperm are lumped in with people struggling with infertility. They're lumped in with Silicon Valley women who are simply freezing their eggs to protect their biological clock.

But we do know that, among all these data points that are lumped together, the CDC data overwhelmingly shows that over 50% of all IVF cycles fail. And I don't know what will happen with the CDC data because

the team at the CDC that tracked all this was laid off as part of the DOGE's staff cuts. So, we're not sure if we'll continue to track this or if this marks the end of the data we'll have.

According to the CDC data, embryo freezing actually has the highest success rate for live births. I mean, the whole point is to achieve a live birth through all of this. It's the freezing of embryos. And we know that among the gender-dysphoric youth population, they aren't freezing embryos because they aren't in a relationship with anyone yet. They're just freezing their own eggs or their own sperm. But when it comes to the gender-dysphoric population, if they want to have a child, they also need to consider the financial costs. I mean, it costs about $1,000 a year to freeze, store, and bank your eggs. So, if you're an 8-year-old and you're going to be freezing, banking, and storing your eggs for two decades, you have to consider the financial costs.

And we don't know from the medical literature regarding eggs and sperm that have been frozen for that many years what the success rate is for any of them resulting in conception, the creation of an embryo, let alone a live birth. We also have to consider the fact that if this involves, say, a trans woman—a man who froze and banked his sperm—who then grows up and is in a relationship with another man, there are no eggs in the couple, and there is no uterus in the couple. So, they're going to face double the risks and complications associated with third-party conception.

So, it's clear to me, for all these reasons, that offering fertility preservation to the gender-dysphoric population is deceptive. As the chairman said in his opening remarks, this is a misleading claim. I mean, when you're offered fertility preservation, you think you're preserving your fertility—fertility as in having a child—when in fact you're freezing your gametes with absolutely no guarantee that you'll have a live birth. Thank you.

Myles Lynch:

Thank you for that. Dr. Cretella, could I ask you, as a pediatrician, to share your experience with gender dysphoria and gender-affirming care before it became such a major issue?

Dr. Michelle Cretella:

Right. I think it's important for the public to know how gender dysphoria was treated before the surge in trans identities and the surge in diagnoses of gender dysphoria. I would say that in the United States, 2013 was likely the turning point. That was when the Diagnostic and Statistical Manual, 5th Edition, was published and changed the diagnosis from gender identity disorder to gender dysphoria.

And one point I want to make is that no genetic or biological trait or condition suddenly appears on the scene. And across Western cultures, Western countries, and industrialized nations, gender identities and dysphoria have grown at exponential rates. This is a sign. This rate of growth is a sign of a psychosocial condition—one that is predominantly psychosocially constructed. We have to understand that. That's a scientific principle. And that has been suppressed.

We've heard from Dr. Laidlaw earlier, and I think also from Miriam Grossman, that it's science fiction to tell parents, children, and vulnerable young adults, "Oh, you just have a brain that's not on the same page as your body. You have a girl's brain in a boy's body or a boy's brain in a girl's body"—science fiction.
No one is born with gender dysphoria. Everyone is born either male or female with a specific sex. So, that has to be… That concept of, "Oh, you're just born with the wrong brain." That is the fundamental fraud right there. I have to get that out.

But prior to 2013—and the best way for me to illustrate this—pediatricians almost never encountered this issue. During my training, which spanned from 1994 through 2012—nearly 20 years—I had just one case that was a very classic example of a little boy. I'll just call him Andy. This case is available online, although it was censored. This family brought their son in for his 5-year-old well-child checkup, and they were concerned

because, increasingly from age 3 to 5, he had started playing more and more with girls' toys. In preschool, he would dress up like a princess. And by the time he was 5, he was saying he was a girl.

At that time, again, pediatrics hadn't yet been taken over by gender ideology. So, I referred him and the family to a family therapist, and they engaged in very traditional child play therapy. And over the course of several visits, well, it came out that he believed Mom and Dad loved girls more than boys. Why? Because when he was 3, after being the king of the hill—he had no siblings—a little sister was born, and she had profound special needs. Mom and Dad had to shift their focus. They were all about "sissy," all about "sissy." Children aren't little adults; from ages 3 to 5, especially, they engage in magical thinking. They can misinterpret what's going on. And he honestly thought during one play session—with Barbies here and trucks there—"Mommy, Daddy, you don't love me when I'm a boy." So, once that issue was brought to light, oh my goodness, over the course of a year, they were able to change the dynamic. And yeah, he came to realize, "Yeah, I am a boy, and Mommy and Daddy do love me."

Another time—and this might have been around 2007 or 2008, somewhere in there—I received a call from a mother. She was going to bring in her twin girls—identical twin girls—for their 12-year-old well-child checkup. And this mom called me and said, "Dr. Cretella, I didn't want to say this in front of the girls, but Lee"—I'm just going to call them Lee and Ann—"Lee refuses to wear girls' underwear. She'll only wear boxer shorts, and she cuts her hair like a boy and only wears boys' clothes now. Do you think this is a problem?" And I said, "Well, come in. We'll talk and see what's going on." So, Lee and Ann were identical twin girls. And again, this was part of their 12-year-old checkup. From a very early age, both girls were very active. Ann was always a girly girl, and she was a dedicated ballerina. Lee, from the very beginning, was always into rough-and-tumble play. She was Dad's buddy. She loved her dad. And now, at age 12, she was totally into ice hockey and had never been into dresses.

So, I reassured Mom, "Hey, from the start, these were personality differences—a classic tomboy. What else is going on? How's Dad doing?" "Oh, we got divorced. We got divorced within the year." And now, Dad—he wasn't physically abusive or anything like that. He had the girls every other weekend. And while I was examining Lee on her own, I said, "Hey, I see these are your favorite clothes. Hey, tell me why you wear these?" Just gesturing toward the boxers. "They feel so good. They're just so comfy." All right.
And she had told her mother the same thing, separately. So, what I ended up doing was referring them to a family therapist to address this. I didn't focus on Lee or her tomboyish traits, but I explained to them, "When families go through a divorce, it's a huge adjustment, and it affects us all." And I said this to all of them together—the two girls and their mom—"It affects everyone differently. And it can be really hard to talk about how we think and feel. We don't want to hurt Mom or Dad's feelings, but counselors who specialize in this can really help you share your feelings, and it can be really healthy. It's really healthy to do this."

And then, in private, I said to the mother, "This clothing"—the boxers in particular—"is probably partly about fashion and comfort, but psychologically, she's probably missing her dad and the whole 'boy thing,' and the haircut coinciding with the divorce. That could be part of it." And I just encouraged her, "Celebrate the fact that you have a ballerina and a hockey player at home. Let her make her own clothing choices and just focus on open communication." Also, regarding her divorced husband and family therapy.

Both girls thrived through high school. Today, poor Lee would have been told, "Oh, you're gender non-conforming," which—sure, okay, she's gender—"And you're 12. Wow. We really should postpone your puberty. We want to pause your puberty," i.e., put you into a state of illness. Puberty is not a disease. The absence of normal, timely puberty is a disease. So, she would have been placed on a medical treatment pathway so that she could have time to really decide whether she is male, female, or non-binary.

So, in the past, children had a greater chance of having their personality traits—their unique personality traits—affirmed and of being guided through a critical developmental stage in which they could truly come to embrace their true physical and personality identities, if you will.

Myles Lynch:

So, Dr. Cretella, what would you say a responsible pediatrician should do today in those kinds of cases?

Dr. Michelle Cretella:

Yeah. When fellow pediatricians ask me, "What can we do?"—because if I say these things, I'll get fired or my career will be over—I refer them to therapyfirst.org, which has wonderful resources for both clinicians and families. I tell them that, as pediatricians, we can screen for mental health issues, such as anxiety, depression, and underlying traumas. We call them ACEs, or adverse childhood events. That's critical, because every pediatrician can screen for ACEs, depression, and anxiety. Every pediatrician can do that and then refer patients for treatment for those underlying disorders. Of course, you need to know who you can trust in your local mental health community, but therapyfirst.org is phenomenal, and I do refer many doctors and parents there.

Myles Lynch:

Thank you. Dr. Schwartz, since we're discussing mental health and all of this from a psychiatrist's perspective, can you explain to me where you fit into the gender-affirming care process? When are you brought into this process, and what is your role?

Dr. Schwartz:

Sure. Absolutely. Well, first, I'd like to start by thanking everyone here for having us to discuss this, and I know I only have a short amount of time, so I don't want to miss the opportunity to say, first and foremost as a psychiatrist in clinical practice every single day working with patients, that from a gender-affirming perspective, repeating a medical fallacy over and over, louder and louder, doesn't suddenly make it true. What you've already heard today—and will continue to hear—is that this is life-saving. It's medically necessary; it's evidence-based. It's widely accepted in medical and mental health circles as safe and effective—and it absolutely is not. So, as a psychiatrist, I work with patients every single day. I prioritize conducting a primary assessment with them. I apply the biopsychosocial model.

I discuss family issues and developmental challenges. Are they going through difficult times? Are there events in their past or present—or traumas they've experienced—that have influenced their situation? I focus on health and well-being. We work together. I'm looking for a differential diagnosis. I look for medical causes. Often in psychiatry, from a diagnostic standpoint, I rule out factors that may be contributing to symptoms—whether it's depression, anxiety, distress related to gender, or other issues. We discuss all of these matters. Then I discuss the risks versus benefits with the patient. I think that's the key point—even if you take nothing else away from this—to realize that this is a highly exceptionalized approach to treatment from an affirmation perspective. It's as if, all of a sudden, we ignore everything else. There's diagnostic overshadowing. We don't look at anxiety, we don't look at depression; we focus only on gender-related distress and then immediately funnel these patients into an extremely harmful, medicalized pathway.

That's not medicine. In no other area of medicine do we permanently alter healthy bodies to better align with a person's current—and often underdeveloped, especially when they're children—sense of self. Our prefrontal cortices—that front part of the brain—aren't even fully developed until our mid-twenties,

sometimes not until they're 25, 26, or 27 years old. So to think that a child can decide whether or not they should go through puberty unhindered—that doesn't seem like a medical decision or a conversation I should be having with anyone, let alone a child. So when I think about what I do as a psychiatrist—and I support the mental health, wellness, and well-being of my patients throughout their entire lives, not just in that moment—my job is not to "affirm," so to speak, in that moment what the child thinks they need or what a vulnerable young adult thinks they need. My job is sometimes to hold reality when reality is really difficult and really painful, and we have to work through that—and work through it slowly.

We don't rush to medication. I think part of what has really driven this "affirming" model is that we have abandoned evidence. As a clinical psychiatrist, I rely on evidence-based data and guidelines. My own professional association, the American Psychiatric Association, published a book titled *Gender...*—I'm sorry—*Gender-Affirming Psychiatric Care* in 2023. Together with several of my colleagues who are here today, we wrote a letter asking, "How can you do this?" This book claims that puberty blockers are fully reversible and that cross-sex hormones are generally safe, effective, life-saving, and necessary. And as a psychiatrist, the exceptionalized approach to psychiatric practice is essentially telling us to "get out of our way" so they can provide harmful hormones at doses we've never prescribed before to children and young adults.

It leads them down a path toward surgeries, and that's not medicine. It's not acceptable. No parent should ever have to bury their child, and we've heard from so many today who have gone through horrible traumas because of what the medical and mental health fields are doing. We are failing patients and families, and we have to do better—and I do hope that, with the help of the FTC, we can do that.

Myles Lynch:

Just one quick follow-up: Would you say that you think it's an aberration how best practices for healthcare are being established in gender-affirming care compared to other types of healthcare? Do you think it's an aberration how best practices are being developed for gender-affirming care versus other types of care?

Dr. Schwartz:

Absolutely. Yes. It's a remarkably—and, again, exceptionally—unique development of what we're calling best practices, and I think Skirmety was a wonderful example of that. If you want to read amicus briefs, read the one submitted by the American Academy of Pediatrics, which included the American Psychiatric Association, the American Medical Association, the American Association of Medical Colleges, and 24 other organizations—one of which was WPATH. They joined forces on an amicus brief calling this care for gender dysphoria "critical," "medically necessary," and "evidence-based." That's false. It's a lie, but they submitted it to the Supreme Court. So yes, I consider it horrific.

Myles Lynch:

And Dr. Lappert, speaking of best practices, is there a diagnostic process that you, as a surgeon, can use to determine with sufficient confidence whether a patient should undergo gender-affirming surgery in order to obtain informed consent?

Dr. Lappert:

Yes. Thank you, and thank you to the Federal Trade Commission. I never imagined 11 years ago, when I first embarked on this path, that I would ever be speaking to a federal agency about what's happening in the world of medical care in the United States. The transgender treatment industry actually operates within the American medical system through the use of deceptive labeling and deceptive practices. It presents gender-affirming care as grounded in science. It claims that gender-related issues are frequently lethal if not

treated with affirmation care. It claims that gender affirmation is life-saving. It claims that gender affirmation is medically necessary and that it improves the lives of self-identified children. It claims that affirmation care is founded on an accurate diagnostic process. It claims that affirmation care is the standard of care and that all of this is based on an unassailable body of scientific evidence. All of these claims are deceptive and are made to support medical and surgical treatments that cause severe and lifelong harm.

It mislabels gender-affirming surgery as reconstructive rather than cosmetic. This deceptive labeling is used to defraud public and private insurance programs, as well as to drain families' finances, while essentially medicalizing these young people for life. Virtually all publications from the transgender treatment industry—from journal articles to gender clinic websites and legal declarations—refer to the WPATH standard of care as the foundational document that serves as the scientific basis for gender-affirming care, including surgery.

This document was allegedly produced using the Delphi consensus methodology mentioned earlier, but upon closer examination, one of the criteria for a properly conducted Delphi assessment is that it involves repeated voting processes that include members from outside the organization conducting the survey. The process requires repeated questioning and anonymous voting—none of which is reflected in the standards of care.

All participants in the Delphi methodology are members of WPATH, and we have also observed how that Delphi process was further compromised by political influence exerted by the government. There is no body of evidence to demonstrate the accuracy of the diagnosis. There is no evidence of long-term treatment efficacy that could support the designation of "standard of care." The use of the term "standard of care" is an intentional mislabeling; "standard of care" implies to us that there is a level of scientific evidence above what we call Level 3 in plastic surgery—a level sufficient to guide clinical decision-making—and that it is called a "standard of care" because failing to adhere to it risks harm to the child or the patient. There is no body of evidence to call it a "standard of care." There is not even enough evidence to include gender-affirming care in a treatment guideline as an option.

There isn't sufficient evidence to include it even there. The WPATH document and all its derivative documents falsely label surgeries such as chest masculinization—which involves the removal of two healthy breasts from a young woman—as reconstructive surgery. This is patently false. Speaking as a plastic surgeon, I can tell you that this is no minor distinction. Reconstructive surgery is surgery that aims to restore form and function lost due to trauma, cancer treatment, infection, or congenital or in utero deformities. The injured or lost part can be objectively defined, and those findings guide the surgical planning. The restoration of form and function is the key. Gender-affirmation surgery is not based on any loss of form or function. It is based on the patient's emotional life. The motivation for surgery is emotional and subjective, and its success or failure is measured using subjective assessment tools such as quality-of-life surveys.

This is the very definition of cosmetic surgery. Gender-affirmation surgery is cosmetic surgery. Portraying it as reconstructive surgery is an act of deceptive labeling because it implies evidence of medical necessity where no such evidence exists. Such mislabeling is used to mislead patients and parents and to defraud insurance companies. Proponents of gender-affirmation care, including WPATH, make highly exaggerated claims regarding the lethality of gender dysphoria. If left untreated with affirmation care, the figure typically cited is a mortality rate approaching 40% due to suicide. There is no sufficient scientific evidence in the global literature that can be cited to support that claim. The further claim—without evidence to support it—is that affirmation care, including surgery, is life-saving.
That claim is used coercively, as we've heard earlier, to obtain surgical consent from parents. Gender

affirmation surgery begins with a false claim regarding risk and then misrepresents the surgery as having proven efficacy in saving lives.

It obtains consent for surgery through the deliberate and deceptive practice of concealing existing treatment alternatives and their associated benefits. The claim of efficacy itself is based on the intentional and deceptive concealment of high-quality evidence to the contrary. For example, the most commonly performed gender-affirming surgery at present is chest masculinization in young women.

In a 2019 scoping review of the global literature published by Dr. Tolstrup—a scoping review is considered level three evidence—he conducted a systematic review of the literature by examining 849 papers from around the world that addressed gender-affirming chest surgery, and that constitutes high-quality evidence. That review reported that the level of scientific support for gender-affirming breast surgery is low to very low, meaning there is no basis for offering such surgery as a treatment option for gender discordance. To offer such surgery without presenting other therapeutic options to parents and patients constitutes an act of deception through the concealment of facts that patients and parents have a right to know if they are to give consent for surgery.

The WPATH Path document, in its chapter on surgery, further deceives by suggesting that gender-affirming surgery is effective because such surgeries begin with proper patient selection. That is stated in the first paragraph of the chapter on surgery. This is an intentional deception. The transgender treatment industry has no process or diagnostic tool that can be used to confirm a diagnosis of gender dysphoria. There is no process by which patients are selected for surgery versus those who are not. There is no testing process that assesses either risk or benefit. There isn't even a common language to describe either the condition or its treatment. As Dr. Tolstrup demonstrated in his scoping review, there is no patient selection. The patient—typically a distressed child—makes the diagnosis. The medical team does nothing to confirm, refute, or otherwise characterize the condition. On the other hand, there is a very large and consistent body of scientific evidence showing that gender-affirming surgery is very harmful to young people.

Chest masculinization surgery, which we've been discussing, results in the permanent loss of two human capacities 100% of the time. Young women lose the ability to breastfeed 100% of the time. Young women completely lose erotic sensation in that area due to the severing of the fourth nerve nearly 100% of the time. Neither the ability to breastfeed nor erotic sensation can be restored. In the case of genital surgery, there is the loss of reproductive capacity as well as the degradation—if not complete loss—of erotic sensation. In addition to these losses, there is also the additional risk of urinary blockage, urinary leakage, incontinence, the risk of fistula formation resulting in fecal leakage through the artificial vagina, chronic wounds, the need for repeated surgery to correct these conditions, and the markedly elevated lifetime risk of cancer caused by such chronic conditions in patients receiving high doses of sex hormones. When surgical procedures such as gender-affirming surgery are based solely on low- to very-low-quality evidence, then by definition those surgeries must be labeled as experimental surgery.

The failure to label it as such is itself an act of deceptive labeling. Furthermore, experimental surgery that carries a high likelihood of functional loss, as described above, can only be performed under stringent protocols governing human experimentation. Such experimentation can never be conducted on children, given that it has never been proven to be life-saving. In fact, it has not even been proven to be simply effective. Gender advocates often claim that breast and genital surgery on gender-confused minors is rare and should therefore not be a matter of national policy. The best estimate I can provide at this time is that over the past 15 years, approximately 4,000 minors have undergone gender-affirming surgery in the United States, with the most common procedure being chest masculinization for young women. That number does not account for what may be a considerable number of minors who have

undergone surgery in private fee-for-service clinics and whose records are privately held and therefore unreported.

There is also the added problem of underestimation due to the known practice—as discussed earlier—of mislabeling and miscoding these surgical procedures, such as mislabeling a bilateral mastectomy in a natal female as a gynecomastectomy, an operation commonly performed on males to correct the presence of breast glandular tissue.

They justify this deceptive practice by claiming that these women are actually men. There is deception in the consent process—and this addresses your question, as I alluded to earlier—by misrepresenting both risks and benefits, by failing to offer alternatives for care, by using the false claim of an extreme risk of suicide, and by obtaining consent under duress through a failure to disclose the experimental nature of the surgery and a failure to provide ethical oversight for such experimentation; all of this renders consent utterly meaningless.
Furthermore, the consent process overlooks the startling fact that a person suffering from suicidal ideation is, by definition, considered legally incompetent to give consent or, in the case of a minor, to give assent.

To summarize, gender-affirming surgery is not supported by any high-quality scientific evidence. It is not based on any reliable diagnostic process. There is no diagnostic tool that can be used to assess risk, select patients for surgery, or predict the likelihood of any outcome. The harms are very evident and lifelong, whereas the benefits have not been demonstrated. It is a procedure deceptively labeled as reconstructive when, in fact, these are cosmetic surgeries that—in the case of breast and genital surgery—begin with the intentional mutilation of the patient. Cosmetic surgeries that consistently mutilate patients are perhaps the most striking example of malpractice I can think of. All of these deceptive practices and mislabeling—in addition to causing irreversible harm to vulnerable young people—ultimately defraud families and insurance providers for financial gain. Thank you.

Myles Lynch:

Thank you, Dr. Lappert. Thank you for all those specific examples demonstrating how these practices disregard patient harm. Does anyone else on the panel have specific examples of gender-affirming care practices that actively disregard patient harm?

Dr. Schwartz:

If I could jump in really quickly, I think one thing that has been pointed out time and again is that this is a model of care that oversells benefits and significantly underreports harms. My colleagues and I published a paper about a month ago. We reviewed over 50 peer-reviewed studies already available to anyone providing gender-affirming care. These practitioners and providers are fully aware of this. We examined all of the harms. This is not something that's hidden. It's peer-reviewed, it's published, it's been available, and it still is. We just compiled over 50 studies that examined harms, and this is just in one area: estrogen used in natal males. Please understand that they are asking us to ignore harms. They're asking patients and parents to ignore horrible outcomes at the expense of children's lives.

Jennifer Lahl:

I'd just like to add that the same point is made in the paper that Dr. Laidlaw, Dr. Thompson, and I published. The data is there. I mean, we simply went looking for it. We found that not a single young man who was offered testicular cryopreservation went on to have a child, so it's not as if we discovered something new or novel. And I'd just like to emphasize that I don't want

us to focus on the CAS review and just remember that one small point where she recommends this—and I think it's because she's unaware of the data that's already out there. Thank you.

Myles Lynch:

Thank you both. And obviously, this event is focused on gender-affirming care for minors. I was wondering if anyone could comment on what exactly makes this different for minors compared to care for adults. Is there anything specific about children—the vulnerabilities they face—that makes this particularly problematic?

Dr. Michelle Cretella:

I think it's their vulnerability—their vulnerabilities. That's why our laws normally protect minors because children are not just little adults. Adults have better, more advanced cognitive development and function; they've lived longer lives; they've had more experiences; and they're better able to assess risks and benefits. Even adults, of course, cannot give informed consent if they're being fed lies, right? So while we're focused here on protecting minors and perhaps taking a more paternalistic approach—because we recognize that children and adolescents have underdeveloped judgment centers in their brains and have lived shorter lives— Every adult requires and has a right to the true facts in order to give informed consent. And I think those of us who have spoken out and will speak out are often defamed, and people ask, "Oh, why should we believe you over the AMA or the AAP?" I think it comes down to three things: follow the science, follow the money, and follow your heart.

Science proved long ago that sex is determined by genes alone, and there are only two. No one is born in the wrong body. What we're dealing with in this population of minors seeking so-called gender-affirming care is this: Science has also revealed that they are the most vulnerable of the vulnerable. We're dealing with children who, according to one study, have experienced an average of five traumas in their childhood. They have untreated psychiatric disorders. They may be on the autism spectrum, or they may have ADHD. Many are experiencing same-sex attractions—so that's "follow the science." It's a vulnerable population. "Follow the money." The AMA, AAP, ACOG, and APA are heavily funded by Big Pharma. This is a cash cow for Big Pharma and for all those Big Pharma-backed funds.

Those of us speaking today are not being paid to be here—quite the opposite. We are putting our reputations and livelihoods on the line. Follow your hearts. You have to ask yourselves: Is it loving for the medical establishment to offer your daughter, your sister, your LGB child, or your child with ADHD mutilation, castration, the induction of disease, and sterilization? Is that loving? I call it criminal. My profession used to call it eugenics. That's where we are, and that's what we have to get out of.

Myles Lynch:

Jennifer, do you want to add one last point, or did you cover it? All right, well, thank you all. I think it's time for lunch now, so thank you. We'll be back at 1:30.

Jon Schweppe:

Welcome back, everyone. If everyone could take their seats as we return from lunch. I just wanted to, following the last panel, thank our medical experts for such an informative session. I really appreciate all these people making the trip to Washington to share their insights with the Federal Trade Commission today. So now we'll hear remarks from Commissioner Holyoak. Unfortunately, she couldn't be here today. She's attending a family reunion combined with her mother's 80th birthday, so I think that's a pretty good reason, but this is an issue she cares deeply about, so please watch this video from Commissioner Holyoak.

Commissioner Melissa Holyoak:

The FTC staff members who are contributing to today's workshop. [inaudible 04:31:23] presented here today are my own. They do not necessarily reflect the views of the Commission or any other Commissioner. Right after I gave birth to my second daughter, it became immediately apparent that she was very ill. There had been no indication during my pregnancy that she had any medical problems, so we, like other unfortunate parents, experienced the trauma of having our newborn whisked away unexpectedly to the NICU. My husband and I learned that part of her heart was swollen and she was suffering from persistent pulmonary hypertension. It was one of the most frightening and trying periods we ever experienced.
This was not how it was supposed to be, and this is not what I had envisioned and dreamed of for nine months. I had never felt so helpless in my life as I watched her fight for her life over the next few days. During that time, we relied on the doctors to provide us with complete and truthful information as we made medical decisions regarding my daughter's treatment. Thankfully, my daughter recovered. She is now a healthy 16-year-old who has blessed our lives in countless ways, and we cannot imagine our family without her.

My heart goes out to those parents who have had similar experiences of watching their children suffer from injury, illness, or disease. I empathize in particular with parents whose children face mental health challenges. Treatments are often complex and may involve a combination of psychotherapy, medication, and other therapies, but whatever health problem a child may be experiencing, it is critical that medical professionals provide parents with complete and truthful information so that parents can make those difficult medical decisions.

Today, the commission is exploring whether to address unfair and deceptive practices in what is sometimes called gender-affirming care for minors. Recent reports estimate that 1.6 million Americans over the age of 13 identify as transgender. Some transgender individuals suffer from gender dysphoria, a medical condition characterized by persistent, clinically significant distress resulting from a mismatch between gender identity and biological sex. Left untreated, gender dysphoria may result in severe physical and psychological harm.

While some have questioned the FTC's role in this matter, there are three main reasons why the FTC should use its authority to combat unfair or deceptive practices related to gender-affirming care. First, the FTC has a strong track record of enforcement actions against unfair and deceptive healthcare-related claims. In December 2022, the FTC published guidance on health product compliance, which notes that since 1998, the commission has settled or adjudicated more than 200 cases involving false or misleading advertising claims about the benefits or safety of dietary supplements or other health-related products. For enforcement purposes, the promotion of reported health benefits may be carried out through a variety of marketing techniques, including by medical practitioners. The guidance further explains that claims about the health benefits or safety of foods, dietary supplements, drugs, and other health-related products require substantiation in the form of competent and reliable scientific evidence. Importantly, such substantiation cannot be based solely on a medical practitioner's experience.

A healthcare practitioner's observation regarding the effect of a health product on patients is anecdotal and does not provide evidence of a causal relationship; nor can substantiation be based on advisories from a medical organization, as these are based on the best currently available evidence rather than a causal link between the recommended course of action and the health benefit. Furthermore, the guidance states that a claim may be misleading if it fails to disclose significant safety concerns. Simply put, it is established law that misleading and unfair health-related claims can violate Section 5. And it is increasingly clear that there are serious questions about the risks and purported benefits of medical transition treatments for children with gender dysphoria. Justice Thomas describes the risks in the U.S. Supreme Court's recent decision, United States v. Skrmetti, which involved a challenge to Tennessee's law restricting sex transition treatments for minors.

For example, there are significant safety risks associated with the use of puberty blockers. Using puberty blockers to suppress normal puberty affects multiple organ systems, and the long-term consequences of this have not been studied. Such use may lead to decreased bone density and impacts on brain development. It also remains unclear whether patients ever regain normal fertility levels if puberty blockers are discontinued after a prolonged delay of puberty. There are also significant safety risks associated with cross-sex hormone treatments, which involve very high doses of hormones of the opposite sex. For girls, these treatments can cause increased cardiovascular risk, irreversible changes to the vocal cords, atrophy of the lining of the uterus and vagina, and ovarian and breast cancer. For boys, cross-sex hormones can cause increased cardiovascular risk, breast cancer, and sexual dysfunction. And for girls and boys alike, it is generally accepted—even by advocates of transgender hormone therapy—that hormonal treatment impairs fertility, which may be irreversible.

The claimed health benefits of treatments for transgender adolescents include a reduction in anxiety, depression, and the risk of suicide. Yet just last week, an article in *The Atlantic* discussed how these benefits have been presented to parents, reporting that a physician at Children's Hospital Los Angeles explained, "We often ask parents, 'Would you rather have a dead son than a living daughter?'" Similar reports in *The New York Times* indicate that parents were presented with this Hobson's choice, which felt like emotional blackmail. But as the *Atlantic* article reveals, the question medical providers have posed to parents did not accurately reflect the consequences of gender-affirming treatment. When Justice Alito asked a question during oral arguments in the Skrmetti case about suicide rates, the ACLU lawyer confirmed that there was no evidence to support the idea that medical transition reduces adolescent suicide rates.

Indeed, in 2024, the United Kingdom's National Health Service commissioned an independent review of the use of puberty blockers and sex hormones to treat children with gender dysphoria. This review found a lack of evidence to support the conclusion that hormone treatment reduces the elevated risk of death by suicide. Parents deserve—and the law requires—complete and truthful information regarding the serious health risks of transition treatments for minors, as well as complete and truthful information regarding health benefits that are actually substantiated. After weighing the risks and benefits, more than 20 states have enacted laws banning six transition treatments for minors. In upholding the Tennessee law, the U.S. Supreme Court acknowledged the intense scientific and policy debates regarding the safety, efficacy, and appropriateness of medical treatments in this evolving field, but noted that the court's role was not to judge the wisdom, fairness, or logic of the law before it, but only to ensure that it did not violate the equal protection guarantee of the 14th Amendment. Similarly, the FTC plays an important but limited role in this area.

The FTC does not regulate the practice of medicine. The FTC cannot make policy decisions limiting gender transition treatments for minors, but what the FTC can and should do is protect children from deceptive statements regarding such treatments. The FTC has previously taken enforcement action and will continue to do so against deceptive representations made by medical practitioners, including claims related to treatments for transgender children. Second, reviewing claims of health benefits for transgender minors is particularly important given the significant and evolving changes in protocols for treating gender dysphoria. In the Skrmetti case, the Supreme Court detailed these evolving changes in clinical guidelines. WPATH, the World Professional Association for Transgender Health, published one of the first sets of guidelines in 1979, in which it advised that hormone and surgical treatments should only be provided to adults. It later revised that recommendation in 1998 to prohibit hormone treatments for minors except in rare circumstances. WPATH further relaxed its guidelines for minors in 2022 to allow puberty blockers, hormone treatments, and surgical procedures at the onset of puberty, while still acknowledging that our understanding of gender identity development in adolescents continues to evolve.

Importantly, WPATH's changes do not necessarily reflect widely accepted practices. In fact, recent changes around the world show that there are no widely accepted practices, but rather drastically evolving standards in this area. After the UK's National Health Service published its 2024 report on the topic, NHS England enacted prohibitions on the administration of puberty blockers to new patients under the age of 18 outside of research settings and instituted a process for reviewing referrals for hormone treatments for adolescents under the age of 16, but England is not alone. Finland, Norway, and Sweden have also raised concerns about the use of puberty blockers or hormone treatments on minors with gender dysphoria and have limited such treatments in some cases by allowing them to proceed only in a research setting. And in Australia, after the state of Queensland imposed age restrictions on puberty blockers and hormones, the Australian government began developing new clinical practice guidelines.

A review of these clinical guidelines concludes—as the Atlantic article describes—that the fairest assessment of the evidence surrounding medical transition for adolescents is that it is weak and inconclusive. While relevant legal precedent already recognizes that advisory guidelines cannot serve as the basis for substantiation, what these evolving guidelines emphasize is that the risks and benefits of transition treatments for minors are far from settled, and any definitive claims or statements should be carefully examined.

Finally, the FTC should prioritize enforcement against unfair and deceptive practices, especially when there is potential for serious harm to children. As previously mentioned, these treatments result in an increased risk of cancer, infertility, and sexual dysfunction, as well as impaired cognitive development and irreversible physical changes. Given the very serious safety risks, the potential for permanent harm, and the inconclusive evidence of health benefits, it is appropriate for the commission to ensure that parents are receiving accurate information.

We will continue to prioritize enforcement that protects the most vulnerable among us, especially our children. A recent op-ed in *The Washington Post* put into words what many have been thinking but haven't said aloud. In it, MIT professor Alex Byrne discussed his participation in a review of gender dysphoria treatments published by the U.S. Department of Health and Human Services. He explained, "I'm hardly a fan of the current administration. I have never voted Republican, and as an academic from Cambridge, Massachusetts, I share many of the liberal beliefs of my community. That includes support for the right of transgender people to live free from discrimination and prejudice, but," as he explained, "medicalized treatment for pediatric gender dysphoria needs to be rigorously scrutinized just like any other area of medicine, no matter which side of the aisle is cheering it on." From the opposite side of the aisle, I agree that we should work together to scrutinize and ensure complete and truthful information about the risks and purported benefits of medical transition treatments. We owe this to our children. Thank you.

Jon Schweppe:

Thank you, Commissioner Holyoak. Let's take a moment here to thank the wonderful FTC event staff for putting on an absolutely incredible workshop. We had about 200 people here today and hundreds more listening online, so it really was a wonderful event. I'd also like to thank the security staff for keeping us safe here today. All right. So now we have Chad Mizelle, Chief of Staff at the Department of Justice, and I'd like to welcome Chad to the stage.

Chad Mizelle:

Thank you all very much. Thank you for being here. Thank you for paying attention to this very, very important issue. I'd like to start by thanking, first of all, President Trump, who has given me the honor of being able to serve all of you and the American people. I especially want to give a shout-out and thanks to my boss, the very tough Pam Bondi, who I think is doing an incredible job at the DOJ. Thank you. Well,

deserved. Well deserved. She's doing such a great job, and she's particularly tough on these issues. She was a career prosecutor for 16 years. She served as state attorney general for eight years. This is her passion. This is something she feels very, very strongly about, and I'm very happy to be here to announce some of the things the DOJ is doing in this area.

There's a basic principle of law: You cannot deceive consumers. You cannot lie to them to get them to buy your products or use your services. You cannot commit fraud. This applies to the provision of medical services, but also more generally. There is no doubt in my mind—based not only on what we've heard here today, but also simply by looking around with our own eyes—that the industry centered on providing gender-affirming care and transition services for children has perpetuated one of the greatest frauds against the American public. And that is especially true with regard to our vulnerable children and their parents. One of the most important tasks of government is to prevent this fraud from continuing. To address the consequences of this fraud in recent years, the FTC has a very broad mandate—including a specific consumer protection mandate—backed by powerful investigative tools. It is very well positioned to tackle this issue, and I would like to thank all the commissioners, and particularly my dear friend Chairman Ferguson, for the excellent work he is doing on this front.

The DOJ also has numerous civil and criminal tools to root out fraud. We are focusing these tools on everyone involved in the multi-billion-dollar industry of harming our children, and I want to highlight a couple of things we're doing. First, regarding civil and criminal fraud: Although the exact details of the targets of our investigation have not yet been made public, we have issued nearly 20 subpoenas against clinics involved in transition-related investigations. Thank you.

We are investigating violations such as healthcare fraud and false statements, all of which could result in either civil or criminal liability for these clinics. We are also investigating hospitals and other providers for fraudulent billing, false claims under Medicaid fraud laws, and violations of the False Claims Act. We are targeting false and deceptive claims made by nonprofit organizations and medical associations that have provided false, deceptive, or scientifically dubious assertions about transition-related medical interventions—allegedly as a cover for the clinics and hospitals to carry out their practices. Finally, we have issued subpoenas to major manufacturers of drugs used in transition-related medical interventions for possible violations of drug marketing laws and the Food, Drug, and Cosmetic Act. We have also prepared draft legislation. We are working with Congress on existing criminal laws related to female genital mutilation to more robustly protect children from chemical and surgical mutilation. Thank you.

And we're continuing to work with Congress to enhance the ability of injured parties to seek remedies and obtain recourse, because, as you all know, that is so important. The way to take down this multi-billion-dollar industry is for people to speak out—which is exactly what we're about to hear. We are using every tool at the Department of Justice to address this issue. Now, before I introduce the next speaker, I do want to give a shout-out: if you've been harmed by this industry, please let us know. If you're a parent, if you're a child, if you were someone who was lied to, deceived, or told that a particular pill might be reversible when we all know it's not actually reversible—we want to know about that. That will help us in all of our investigations, not just on the civil side, but on the criminal side as well. So please come forward. Come talk to us.

We have DOJ representatives here at the conference, I believe. Some of them have spoken. Obviously, I'll be here. If you have any questions about how to contact us, you can reach out to any of the FTC staff—with whom we work very, very closely—but please continue to reach out to us. Now, we're going to move on to a very important conversation with parents and survivors. Earlier, Chairman Ferguson had the opportunity to hear about the harrowing personal experiences of Claire Abernathy, Kayla Lovdahl, Simon Amaya Price, and Gareth Amaya Price, as well as Elvira Syed's truly heartbreaking story about the tragic loss of her daughter. There are far too many stories like these.

Please join me right now as we welcome to the stage Prisha Mosley, Soren Aldaco, Beth Bourne, Forrest Smith, Helen Spiegel Lee, and Gwen Turecki. We're going to invite these individuals to the stage. I'm not going to introduce them all beforehand because, as part of this, you'll see that they'll actually be introducing themselves and sharing some of their stories as well. Yes, a round of applause. Thank you. Great. To get started, I'd just like to dive right in. There isn't much I can say that wouldn't detract from the personal experiences you've all had, so to kick things off, Prisha, I'd love to give you the floor.

Prisha Mosley:

Hello. Okay. Thank you very much for having us here and for listening to our stories. My name is Prisha Mosley. I'm a 27-year-old detransitioner and mother. I am also a victim of medical fraud and abuse. When I was a teenager, my doctors lied to me, and as a result, I was medically harmed and defrauded. I was a struggling girl suffering from mental illnesses and multiple comorbidities, including panic attacks, depression, and borderline personality disorder. I experienced a sexual assault as a minor, which made me fear being a woman. I learned about being trans online on Tumblr. I felt that I identified with what I read online. I hated myself. I couldn't eat. I struggled to look at my body, and I self-harmed. This must have meant that I was trans. When I brought this up with my nutritionist, who was treating me for anorexia, I was immediately referred to a pediatric endocrinologist who agreed that I had been born in the wrong body and needed medical intervention.

I was 16 years old, and my body was perfectly healthy. No one cared that I had trauma associated with being female or that I hated my body and had delusions about how it looked. As soon as I said the word "trans," all medical ethics went out the window. The endocrinologist convinced me that I had a medical condition. I was led to believe that I had a male brain trapped inside a female body and that this incongruence would ultimately lead to my death by suicide. I was told that it was a form of intersex. It was under the guise of these lies that I was referred to a woman for a letter of recommendation to begin testosterone injections. After suing her for fraud, I discovered that she was not even licensed as a doctor or a therapist. She was simply a woman who decided that my healthy female body was wrong.

In the letter she wrote for me, she did not mention that I was often unable to eat for days on end or that I was taking a number of psychiatric medications. Instead, she asserted that I was born in the wrong body and needed to be administered the "wrong" sex hormones in order to end my mental suffering and continue living. She asked my parents if they would rather have a dead daughter or a living son. I believed I would die without transitioning. Medicaid was billed to cover my testosterone injections under "unspecified endocrine disorder," even though there was nothing wrong with my endocrine system. Now, my ability to function healthily has been taken away, and I cannot regulate my own hormones. Testosterone did not improve my mental state—it worsened it. I was put on more psychiatric medication and given muscle relaxants to manage the side effects. My self-harm episodes worsened.

No one told me that testosterone was the cause of the cysts on my ovaries. When I complained about pain, I was told I was going through male puberty—something a teenage girl cannot experience. My body was falling apart, and my doctors gaslighted me, telling me it was for the best. Testosterone mutilated my genitals before I could legally consent to sex as an adult. I was lied to about the effects it would have, and I suffer from atrophy, disfigurement, and pain. I have never had sex as an adult with a normal, healthy vagina. I didn't understand what was being taken away from me. When I gave consent, I was too young and wasn't being given accurate medical information. My consent was stolen. A year after starting testosterone injections, I was led to believe by activists and my doctors that I needed to have my healthy breasts removed.

I was told that they were causing my ongoing mental distress and that I would feel relief once my body was altered. No mental illness can actually be cured by cosmetic surgery. I suffered severe surgical complications as a result of giving birth. The forms I signed stated that I might have trouble breastfeeding, concealing the fact that my chest had been surgically sealed shut. My nipples were grafted and reattached in the wrong place, and now they are merely decorative. I was unable to breastfeed my baby, even though my milk had come in. I had no idea that I still had breast tissue inside me or that this was even possible. It was the worst pain and heartbreak I have ever felt. I wanted to die. It is impossible to change one's sex, but my doctors led me to believe not only that I could, but that I needed to do so in order to live. No mental illness or mental suffering can be alleviated by making cosmetic changes to secondary sex characteristics. Yet this was the treatment my doctors offered me, with no alternative. I was never given any other option. My doctors never used real medical terminology. They tricked me, using euphemisms like "top surgery" and pseudoscience, such as the "genderbread man." I genuinely believed that I needed drugs and surgery despite the fact that my body was healthy and I simply hated myself. My doctors defrauded me. I am not alone. No human being changes their sex or benefits from the deliberate disruption of their endocrine system or the removal of healthy body parts.

Chad Mizelle:

Prisha, thank you so much for that. I don't want to pry too much, but can I ask your child's name?

Prisha Mosley:

Unfortunately, I can't share his name because I've actually received threats against my children for showing up here today to do this.

Chad Mizelle:

Wow. I'm so sorry, Prisha. Well, thank you for sharing that. Soren.

Dr. Michelle Cretella:

First, I want to say I love Prisha. Thank you for sharing all of that. My name is Soren Aldaco. I am a 23-year-old woman from Texas, born and raised in the suburbs—the urban sprawl between Dallas and Fort Worth. But now I live in Austin, where I just graduated with my bachelor's degree, and I'm currently studying how the internet influences identity formation. Thank you. With that, I speak on my own behalf today as someone who began transitioning socially at age 11, was on the internet, and was chronically online—just like many people my age were and still are. And that's where I was first, as I said, exposed to the idea that I might have been born in the wrong body and that surgically and medically altering my body might be a good solution for my mental health issues or my general discomfort with that body, which was changing—something that's pretty normal during puberty.

But that was mostly a role-playing identity, something I used as a framework for developing a sense of self. Until I was 15, when I met my biological father for the first time. I was hospitalized; I had a bit of a mental breakdown—as I'm sure many people would have if they met their biological father for the first time through Facebook. And while I was hospitalized, the doctor noticed that I bound my chest and went by a different name than what was on my medical record, and he pressed me until I finally told him—after he'd kind of probed the idea that some people don't identify with their genitalia—and eventually pushed me until I came out as trans to him. He then called home and told my family that this was the root cause of all my problems. No consideration was given to the fact that I had just met my biological father, nor to the fact that I had a strained relationship with my stepfather—who helped raise me but who is quite severely disabled.

And so from there, I began to internalize the idea that medical transition might be a path forward for resolving this distress that seemed never-ending. And so I started attending a support group in the DFW area. There were actually several support groups in that area run by the same organization, Trans-Cendence International. And it was at that support group that I met a nurse practitioner who had a transgender adult child and was prescribing hormones to pretty much anyone who came to see him. And after just one appointment, at age 17—without ever meeting my biological parents or even knowing that the adults who had taken me in were my parents, which they weren't—he prescribed me testosterone, an estrogen blocker, and Anastrozole. He encouraged me to lie about my sex on my government documents, such as my driver's license, and I could have had my birth certificate changed as well if I'd wanted to; he also referred me to a specialist whenever I experienced a complication.

If I had vaginal atrophy, it was the gynecologist who was quick to offer me a hysterectomy; if it was dizziness, headaches, or joint pain, it was the rheumatologist, the neurologist, the cardiologist, or the orthopedist. I saw all of those specialists when I was 16, 17, 18, and 19. And so he, too, used the diagnosis "endocrine disorder not otherwise specified"—I believe that's what it was called—to get these treatments covered by my private insurer. But worse than that, that medicalization—which happened right before the onset of COVID in January 2020—led me, during that pandemic lockdown, to begin exploring the idea of having my breasts removed as a form of treatment for the stress and distress that the hormones didn't actually alleviate, because they weren't really treating anything so much as adding to the list of problems I was already experiencing.

And at that point, I had seen a therapist who had a trans ex-spouse, and she helped write a completely fraudulent letter. And by "fraudulent," I mean full of things that weren't true—such as "my client has lived as a man for the last 12 years," which, as someone who was born female and will die female, I had not. But that was especially untrue during COVID, right? When I had no opportunity to even go out in public to live life as a normal person or adult, let alone as a member of the opposite sex. So she ignored a history of sexual assault that I disclosed to her, and after I stopped seeing her, I ghosted her. She did not revoke that letter, but she did terminate my status as her client. From there, I went to the Crane Clinic in Austin, which I strongly advise you to research.

They moved from California to Texas because of Texas's—at least in my opinion—tort reform laws, which make it extremely difficult to sue them for medical malpractice. They told me they could get my surgery covered in-network even though I was out of network. They claimed to have a 90% success rate. They listed all the complications I might experience from the surgery but assured me they had never actually encountered any complications like that. And I would later find out—after experiencing complications—that this was because they cut off contact with clients who had complications. They told me nothing was wrong with me on three separate occasions until I ended up in the hospital. And when I asked, "What exactly are you guys going to do to prevent this from happening in the future?" they stopped responding to me after trying to get me to sign a non-disparagement agreement and offering me $400, which I didn't accept because I wasn't going to sign that NDA.

And I'll wrap it up here. I think the main themes in my story were ideological ties centered on a practice that catered specifically to transgender patients, featuring a lot of really affirming imagery and people laughing and feeling good—kind of like those drug commercials; I'm sure you've seen them. There was no differential diagnosis, no exploration of the root cause, and no interest in why I was feeling the way I was feeling. And there seemed to be this common thread of supporting the whole person rather than focusing on their expertise and specialty as doctors—not activists—which, to me, was like putting diesel in a gas engine. I was never made aware that I was altering a fundamental process in my body—my endocrine system. And although I was on 14 different medications when I de-transitioned in 2022, I'm now on two for Hashimoto's autoimmune thyroid disorder, which I think I may have developed as a result of the testosterone.

Chad Mizelle:

Soren, thank you. If I may ask, you mentioned what you're currently studying, and it does seem that as you continue to research this—the link between access to social media and, in many of the stories we're hearing, transitioning—are you observing that as part of your research as well as through your own experience?

Dr. Michelle Cretella:

Yeah, I'm really interested in that. In particular, I think kids use frameworks to understand how to navigate the world. That's why it's important for them to have parents who love them, to show them what kind of adult they could become. And when the internet is taking on the role of parenting—which I don't think is entirely the parents' fault, since you guys didn't grow up with that— You didn't see the consequences until our generation had already suffered them. I think it can be really easy to slip into online groups that tell you who you are instead of letting you explore it in a tangible way in the real world through all five of your senses—and not just through this audiovisual matrix that is social media and the internet.

Chad Mizelle:

Great. Thank you. Thank you so much, Beth.

Beth Bourne:

Hi, my name is Beth. My ex-husband and I got divorced when our children were young. My daughter was an excellent student. She loved gymnastics, math, and reading. She was also creative, sensitive, and empathetic. At the end of sixth grade, my daughter experienced trauma and became withdrawn. In seventh grade, she was placed in an honors class with other gifted students. Some of these students were girls who identified as transgender. This was in 2018, when teachers and counselors were being trained by the California Teachers Union on how to support LGB and transgender students. In eighth grade, my daughter started seeing a private psychiatrist to help with anxiety and some pretty serious self-harm. At age 13, my daughter came out as transgender in a letter to her father and me.
Within a few days, we received an email from her school counselor stating that our daughter had asked the school to change her name and pronouns.

That counselor also implemented a gender support plan that was not disclosed to her father or to me. When my daughter was 14, she began experiencing bouts of dizziness. So we took her to Kaiser Permanente Davis to see the pediatrician on duty. This was a pediatrician who had never seen our daughter before. My ex-husband, in the exam room, referred to my daughter by her new male name and male pronouns. And in an excited tone, the doctor asked my daughter if she would like to have her medical records updated to reflect her new name and male pronouns. This was the very first visit. The doctor then recommended that we take our daughter to the Kaiser Proud Clinic, a pediatric gender clinic in Oakland—a one-stop shop where she could meet with endocrinologists, an OB-GYN, and a gender specialist.

So the next day I called this pediatrician and said, "You had no right to suggest to my daughter that she seek medical interventions at a gender clinic when we were just there for a wellness visit." So I asked the doctor, "What would you do with someone my daughter's age if she said she wanted to transition to the opposite sex?" And she said, "Well, we refer them to the Kaiser Roseville endocrinologist." So then I spoke to the endocrinologist and asked him, "What would you recommend for someone my daughter's age who wanted to become a trans man?" And he said they would go to Kaiser's gender specialist and discuss puberty blockers and hormones with them. And when I asked, "Would you consult with our private psychiatrist?" he replied, "No, we prefer to keep all treatment within the Kaiser system."

So when I voiced my concerns to the pediatrician and the endocrinologist about what was happening, the endocrinologist said, “This is an emerging field.” Quote: “This is an emerging field,” quote. “We don’t know the long-term medical effects, but with any medical treatment, there are benefits and there are risks.” So I asked him, “What would the benefits be?” And he said, “It has been shown that young people have a lower risk of suicide and fewer suicidal thoughts if they are offered medical treatment.” He also said that “young people will feel better when they’re on hormones, and that they can stop their periods and develop the physical traits of the opposite sex.”

And the endocrinologist, of course, referred me to WPATH as the leaders in this field and to the Endocrine Society. He also recommended that I speak with Gender Spectrum, which is one of those organizations that encourages parents and families to help their children transition. Fortunately, my daughter’s psychiatrist was willing to hold a counseling session with my ex, my daughter, and me all in the same room. And she explained—because I asked her to—the risks of medical intervention with blockers and hormones, including effects on brain development, delayed brain development, and loss of bone density. So we agreed—this was when my daughter was 14—that she would not undergo any medical procedures until she turned 18.

I later realized how fortunate we were to have been able to take my daughter to a private psychiatrist to receive DBT—Dialectical Behavior Therapy—outside of Kaiser and keep her away from the Kaiser Gender Clinic. My daughter stopped identifying as transgender about four years later, during her senior year of high school. She’s now in her third year of college and is doing great. I just can’t imagine what would have happened when my daughter was 14 if we had taken her to that Kaiser Proud Clinic in Oakland. The doctors in Davis—the endocrinologist—were all caught up in this idea, and they were disingenuous when they told us it would reduce her risk of suicide or suicidal ideation.

Chad Mizelle:

Thank you. Thank you, Beth. Forrest.

Forrest Smith:

Yeah, I just want to take a second to thank everyone. So I’m from a slightly older generation of transitioners, I think—I’m right on the cusp, since my transition took place from 2015 to 2020. I’m also a man. And so one of the things I think has been happening in our conversations about transgenderism in general is that we tend to lump men and women together. But there are some interesting patterns, I think, between the two different groups. I don’t know if anyone is familiar with Ray Blanchard. He’s one of the original sexologists who used to talk about this, and I saw him responding to an interview about ROGD—rapid-onset gender dysphoria. We’ve seen a lot of ROGD in girls, and when he talked about boys, he said that with boys, he tends to see that it doesn’t just happen overnight—it tends to be something that’s been brewing for a longer period of time.

And I would certainly say that’s true in my story, which is that I’m up here. This is about minors, protecting minors. I transitioned; I began my transition at the age of 20. So I didn’t fall into that category of minors, but I still believe that young men and young people are vulnerable. A lot of the time, they’re carrying something they may have been carrying since they were children. I know in my case, when I’ve sat down recently and delved deep into my soul and my heart about this—while writing my memoir—where does the story begin? I go all the way back to the very first time. I remember my parents leaving me alone with my sister at my grandmother’s house, and I just had this thought: “This isn’t my family.” Because I was a child, and they left me at my grandparents’ house.

But that feeling—I remembered that feeling for the rest of my young adult life. Whenever I felt like I didn’t belong somewhere, those were the words that came to mind. I was still processing something that happened when I was a small child, and when you add to that dysfunction at home,

sexual abuse, online grooming, and pornography—mix all that in, and by the time someone is 16 or 18 years old, you've got a pretty tenacious identity. And I think it's good for our culture that we're talking about this the way we are now. Because when I think about the young man I used to be, it seems I was really set on a certain path, and if the transgender community hadn't evolved the way it has today, I probably still would've had issues. But as things stand today, I ended up in the same system that everyone… All the other speakers here ended up in. And so we've heard a lot about that. I don't necessarily want to… I can share more about those details, but I'll just stop there if you have any questions.

Chad Mizelle:

If you're comfortable sharing, I'd love to hear a little more about the detransition process. What was going through your mind at the time, and what prompted you to say, "I need to make a change"?

Forrest Smith:

And this also ties back to the transition. So I was briefly homeless for two months at the beginning of my transition, and during that time, I became enrolled in the Homeless Youth Continuum in Portland. And so my entire lifestyle was supported through this vast network of nonprofit organizations. Some of them are private; some of them are very good, admirable, noble organizations. I was able to live a really nice life—living the high life—through the Homeless Youth Continuum as a transgender woman; I sort of became an icon. But then, I aged out at 24. You age out, and suddenly all those opportunities are gone.

And so, regarding my transition, I was also putting off decisions about surgery during those two years when I was fully housed. Then the medical surgeries took place right at the end, when I lost my housing—which is somewhat ironic and part of the oversight within the medical system—because the surgeries were arranged by social workers at the HIC. There were people around me in some of those housing situations—I wasn't paying attention at the time—but there were detransitioners dropping like flies, and then it was actually when I went into a crisis after losing my housing that I underwent those surgeries.

That crisis was part of what ultimately led me back to detransitioning. I caught COVID and completely lost my housing in Portland. I moved back in with my parents, and that forced me to confront my family's dysfunction—to look at my family and realize there are problems, but it's not as bad as I thought it was. My parents aren't evil people. I can live with them. It forced me to confront things from my past, and there was also a lot of isolation during that period, so I kind of cut myself off from the trans people around me. It was still very difficult to receive any kind of care. Some counselors suggested that I was still feeling dysphoric because I hadn't had a full vaginoplasty.

I'd had an orchiectomy and breast implants, so I'd undergone surgery, and that regret was part of what snapped me out of it because it wasn't what I'd intended when I began the transition. I hadn't thought that far ahead. It was a gradual process. I have daily journals from that time, and it took months to work through it. First, I acknowledged that I regretted it, and then I acknowledged that I regretted it even before I believed I was a man—I still thought I was a trans-feminine person, and I regretted it.

So I had to work through layer after layer. I spent years in therapy. I found a forensic psychologist who specialized in men's sexual issues. That was a smart move. It took years, and it took years to get back into the workforce and reconnect with my family. I mentioned writing the journals, but I had a beautiful moment with my grandparents. Thankfully, I was able to reconnect with my grandparents in the last year of their lives. Both of them passed away within a year, and I had a beautiful moment out on the farm with them where I actually had this very clear realization: "This is my family."

That's my grandpa, that's my grandma. So the detransition—it's been five years now—and it takes a lot to rebuild your whole life when it's not just the medical damage; it's a much deeper social damage. It's damage to your entire sense of self, right? You build a wardrobe, you build a whole life, you build all your paperwork—everything. You have to change all of that. It's a really deep hole.

Chad Mizelle:

Wow. Thank you. Thank you for sharing, Helen.

Helen Spiegel Lee:

Hello, everyone. Thank you very much. So I'm going to read my statement because I'm not very good at this. When my son was three years old, my ex-wife, with the help of medical and school professionals, set him firmly on the transgender path. In the fall of 2014, my son's preschool teacher informed me that my son wanted to be referred to with she pronouns. This happened just one month after the traumatic dissolution of my marriage. At that time, I had joint custody, and it became a constant battle. I told everyone that my son had not expressed any of these preferences to me. I wondered if he was trying to get more attention from my ex and if she was using gender to divide his loyalties. None of this seemed genuine, but every time I asked reasonable questions or expressed curiosity or doubt, I was met with suspicion. Overnight, I became the dreaded "non-supportive parent." At the same time, my ex was constantly engaging with school staff and medical professionals, and she demanded that her family and friends support my son's "rebirth," as she called it, as a transgender girl.

The gender-affirming model does not welcome questions or inquiry. Time and again, almost everyone told me that I must accept my daughter, that failing to accept the statements of a three-year-old was tantamount to abuse and would lead to self-harm. It made no sense. I was now in a world where up was down and down was up. It was a time of unrelenting despair. I couldn't eat; I couldn't sleep. I barely functioned at work. My unwavering love for my son was all that really kept me from giving up. Back then, I was angry about gender ideology and the medicalization of minors. I was frightened and vulnerable. I needed help. In 2016, I made an appointment to see Gender Management Services (GeMS) at Boston Children's Hospital.

I took my son to GeMS three times. At first, I went with my ex, but as we grew increasingly at odds, we attended separately. We saw Dr. Amy Tishelman, a clinical psychologist and the director of research at GeMS, once a year in 2016 and 2017. And finally, in 2019. For four long years, my son lived as a boy with me and as a girl everywhere else. The situation was traumatic for both of us. I was constantly worried about the effects on my son of being torn in two. At one point, I even tried to use the girl's name, but I couldn't do it. I simply could not participate in the charade. Over the years, Dr. Tishelman noted time and time again that it was difficult to determine the impact of the parents' conflict on the child's gender presentation in each home. Even with the documented uncertainty regarding my son's presentation, Dr. Tishelman, at one meeting, pressured my son to convince me to go along with it.

Her notes are quoted as follows. Following my meeting with Rosa, I met with Ms. Spiegel and her partner, and again, with Rosa's permission, shared that Rosa had told me she'd like them to refer to her as Rosa and use female pronouns. Rosa agreed to come into the room, and the four of us met together. At that time, Rosa reiterated to her mother and partner that she wanted to be called Rosa and that she wanted to be a girl. My wife and I were stunned, but we smiled, and the meeting concluded. My son was six years old, and within the gender affirmation model, he and the therapist were in complete control. At the final visit in 2019, Dr. Tishelman had my son fill out a gender worksheet, assigning numbers to how he felt. Tishelman's conclusion was that, as of today, he reported that he is neither a boy nor a girl, but something different. Again,

there was ambiguity, but she probed deeper. Dr. Tishelman advised us that we should start considering puberty blockers for Rosa.

Finally, I filed for full custody. Things were moving at breakneck speed toward medicalization, and I had no other recourse. At the trial, Dr. Tishelman was called to testify. My ex had Dr. Michelle Forcier as her expert witness, and she also testified. Dr. Michelle Forcier is a pediatrician affiliated with Hasbro Children's Hospital in Rhode Island. She is perhaps better known now as the "chicken lady" in the film *What Is a Woman?* The court's findings document that Dr. Tishelman cautioned that failing to strongly support gender-diverse children can lead to suicidal ideation and attempts. This, of course, has never been proven. At the same time, Tishelman also testified that there is insufficient research on children undergoing social transition, and that opinions on the matter vary. Dr. Forcier also agreed with Tishelman that there was insufficient evidence.

The court findings state, in Dr. Forcier's own words, that research on gender dysphoria is in its infancy. At my trial in 2019, both of these experts in their respective fields admitted that the evidence was lacking. It is chilling to recall that during our visits to GeMS, Dr. Tishelman repeatedly emphasized the importance of accepting Rosa and ultimately suggested the use of puberty blockers, while completely failing to acknowledge that evidence regarding the social and medical transition of children was scarce. My son was never gender dysphoric. My son was never transgender. It was all a lie.

Chad Mizelle:

Helen, thank you so much. Thank you for sharing that. Gwen?

Gwen Turecki:

Sure. Hi, my name is Gwen Turecki, and I'm a mom from Michigan. My son was around 14 when he sent me a text saying he was a girl, and at first I thought, "Hey, he's in theater class, and they're just dressing up like girls." The next text mentioned HRT, and by that I meant cross-sex hormones. At that time, I dove into research. He was away, so I was able to get on the computer. I have a background in Library and Information Science. So I found Dr. Grossman. I found Jennifer Bilek, pro-trans sites, anti-trans sites, and, crucially, parents who were speaking out about the inconvenient truth regarding trans issues. I connected with other parents and quickly realized this was a cult, and I guided my son out of it using proven cult intervention techniques. Basically, what I did was take strategies that had been developed for other cults and tailor them to my son's specific needs.

We explored the depths of transgender ideology, starting with his pediatrician's office. And the reason I did this is that my son and I have a very close, loving relationship, and he would expect me to follow a protocol. So we went to his pediatrician's office, who referred us to the University of Michigan's Mott Children's Hospital gender clinic—notably, the pediatrician we were referred to was not his regular doctor, and this is at a different children's hospital. She was in the process of transitioning her teenage daughter, and it was like, okay, let's jump down the rabbit hole. Here we go.

At Mott's Gender Clinic—because I had made an appointment—since, according to the protocol, to get someone out of a cult, you take it slow and bring your child closer. My son and I have always been very close, but we share a bond through music. We spent more time digging through record crates for albums together, because we're into that kind of thing. So at the Mott Children's Hospital Center, there's a three-hour session with everyone together. So his father [inaudible 05:27:31], my son, and myself. The therapist explained that the purpose of the session was to help our child connect with what was happening in his mind and align his self-image with his body, citing WPATH as a standard of care. When I asked why there's been a 4,000% increase in the number of trans-identifying girls in the UK, I was told society has simply become more accepting. Amazing. She explained that Western societies have become more accepting

in terms of ways of thinking. Please note that my son's father immediately affirmed and agreed with the therapist.

I sat in the office and listened as she wove a narrative—one not based on biological reality—that opened the door to possibilities of changing physical appearance without even considering underlying factors such as going through puberty during the COVID lockdown. Basically, these children's social fabric was torn to shreds. The second hour was with my son alone, and I was unable to ask about the session due to patient confidentiality. The third hour had all four of us together again, including the therapist, and she kept saying to my son, "I feel like there's something you need to tell us." She was coercing my son into self-doubt. So I recognized this as—as I said—coercion, and began to steer the conversation away, asking about the next steps.

"What do we do next?" And after just one three-hour session, she said, "Hey, the next step is to contact the endocrinologist." That's when I put a stop to it and turned to his father and my son and said, "We're going to talk about this at home." I needed to take control of the situation. Seriously, it was like Alice in Wonderland. It was crazy. The rest is history now. And now I have a thriving, healthy 17-year-old young man with an exceptionally bright [inaudible 05:29:44] future. My son was assessed for giftedness and had that trajectory. Had we followed the path set by the University of Michigan's Mott Children's Hospital, the story could have ended tragically. My son is exceptionally talented and gifted, just like Elvira's daughter. Thank you very much.

Chad Mizelle:

Gwen, thank you for that. If I may ask, regarding that next step—that conversation at home with your son—was that a one-time thing, or was it a process that took several months? Is there anything you could share about

Gwen Turecki:

That? Sure. Okay, so that really didn't happen. I wanted everyone to take a step back, and because his dad was supportive, I had to walk that fine line. So anyway, taking it slow, taking it slow, also bringing us closer, bringing us closer.

About three months after that visit, I walked into my... And I could sense he was feeling stressed because I think part of it was that he felt heard. So about three months after I walked into his room, I said, "Hey, sweetie, how do you feel about cross-sex hormones now?" And he said, "Mom, that's like putting lipstick on a pig." My heart leapt. Okay, but we weren't out of the woods yet, right? So fast forward, maybe another four months, he walks into the kitchen—granted, at this point my kid is like six feet tall; I raise them to be big—and he says, "I'm thinking about growing a mustache. What do you think, Mom?" I'm like, "That's a great idea." Inside my head, I'm doing backflips, thinking, we made it. And so after that, I've been helping coach other parents—[inaudible 05:31:42] parents. I have parents in South Africa and Australia, thanks to X. It's easier to do that. There is a way to get your kid out of this.

Chad Mizelle:

Thank you. If we could just give one more round of applause for everyone out there, thank you. As you've all heard, it's certainly not easy emotionally to stand up and share your stories, but as Prisha told us, speaking out—especially against a multi-billion-dollar industry built on lies and deception—puts both themselves and their families at risk; whenever you start exposing those lies and deception, they'll come after you. And so thank you all again for everything you've done, for what you're doing, and for sharing your stories. Thank you, thank you, thank you. All right, with that, I think we're going to continue with the program, so I'm going to hand the mic back over to John.
Thank you all.

Jon Schweppe:

Thank you, Chad. And what an exciting announcement from the Department of Justice. Now let's shift gears a bit. We've spoken with medical professionals, parents, and survivors and heard their stories. But as the truth emerges, it's important to note that a number of truly courageous people took great personal, professional, and financial risks to blow the whistle on the gender industry. And I'm pleased to announce that we have six of these whistleblowers at this workshop today. Earlier, you heard from Dr. Aton Heim, and now we have a panel featuring five more. These are individuals who truly paved the way for this moment. So I'd like to introduce our moderator for this panel. He serves the Federal Trade Commission as a special advisor in Chairman Ferguson's office: Ian Mason.

Ian Mason:

Well, as John mentioned, today we've heard the personal stories of young people subjected to so-called gender-affirming care and their parents. We've heard doctors and researchers explain their conclusions about these practices, but our understanding—especially the public's understanding—of what's happening depends on another key element. The accounts of whistleblowers—actual participants in this industry who had the courage to come forward despite potentially devastating consequences for their careers, their reputations, and their families. We're grateful to have five of them with us today. Jamie Reid is the executive director and co-founder of the LGBT Courage Coalition, which advocates for cultural and medical approaches that accept and support gender nonconformity without medical intervention. In February 2023, *The Free Press* published her explosive firsthand account of her time at a pediatric gender clinic. Jamie holds a Master of Science in clinical research management from Washington University and a BA in cultural anthropology. She co-hosts the Informed Dissent podcast, has been profiled in the New York Times, advocates for legislation across the country, and addressed a rally on the steps of the U.S. Supreme Court during the oral arguments in U.S. v. Skrmetti.

Tamara Pietzke is an independent clinical social worker in Washington state. She earned her Master of Social Work from the University of Washington, and after more than a decade as a mental health therapist in community and healthcare settings, she founded her private practice in 2024. In 2023, she gained national attention for speaking out about the mental health field's approach to youth gender transition, raising concerns that providing information without adequate assessment could lead to a backlash—including the loss of her job and an ongoing state investigation.

Leta Boylan is a former psychiatric nurse at a taxpayer-funded facility for teenagers and adolescents. During her time there, she became aware of a series of institutional policies that promote and reinforce social transition among minors while concealing such treatments from their parents. Because of Leta's unwillingness to lie to parents and engage in dishonest, incomplete documentation, she was targeted by the facility's administrator and fired in December 2024.

Vanessa Sivadge is a pediatric registered nurse who exposed the illegal use of Medicaid to cover sex hormones and transgender treatments for minors at Texas Children's Hospital. After blowing the whistle, Vanessa received a visit from two FBI agents in July 2023. Despite this and other threats, Vanessa came forward in June 2024 with journalist Chris Ruffo to expose the Medicare fraud, medical malpractice, and illegal billing at the gender clinic. Two months later, Texas Children's Hospital fired Vanessa. Vanessa has since launched an advocacy organization committed to fighting for the protection of children in the state of Texas called Protecting Texas Children.

Sara Stockton is a licensed marriage and family therapist, lecturer, researcher, and clinical supervisor with 15 years of experience specializing in gender dysphoria among youth and families. In 2023, she co-developed one of the U.S. mental health assessments for evaluating youth readiness for medical gender transition. Published in the *Journal of Marital and Family Therapy*. Growing concern that

prevailing clinical approaches were harming young people, Stockton publicly addressed these issues in the 2022 documentary “What is a Woman?” She testified before state legislatures on bans regarding transgender care for minors and served as an expert witness in family court cases involving child protective services.

So we’re here today largely because of your stories raising awareness of these issues. So why don’t we start with those stories themselves? We’ll just go down the line. Vanessa, if you’d like to start.

Vanessa Sivadge:

Thank you so much. My name is Vanessa Sivadge. I’m honored to be speaking on today’s panel, “Blowing the Whistle on Gender Medicine,” to add my voice to the growing number of medical professionals who recognize gender medicine for the farce and fraud that it is. For 10 years, I’ve had the privilege of working as a pediatric nurse in Houston, Texas. In 2018, I accepted a job at Texas Children’s Hospital, the most prestigious and largest children’s hospital in the United States and Houston. And I thought at the time that I had reached the peak of my career, convinced that I would be working here until I retired. A couple of years later, in 2021, I transferred to a multi-specialty outpatient clinic, unaware that a fully operational and well-established gender clinic was active at my workplace. The things I saw over the next few years are etched in my memory forever. Eventually, I was asked to do things that went against my nursing ethics, my personal beliefs, and most importantly, my faith in Christ. I had a crisis of conscience one day when a physician—the transgender physician—asked me to provide patient education, which is not uncommon. Nurses do a lot of patient education in the hospital. But on this particular day, I walked into a patient’s room and the doctor asked me to instruct the patient on how to administer an intramuscular injection. What I didn’t know was that this child—this boy—was going to administer estrogen to himself to affirm the false identity he had adopted. And realizing that I had enabled him to do that was devastating to me.

I considered quitting my job. I could no longer play an indirect role in perpetuating these harms against children. Until one day in May 2023, when I read an article by an anonymous whistleblower at Texas Children’s Hospital who had courageously come forward to expose that the hospital had been secretly providing transgender treatments to children and had hidden this from parents and lawmakers in the state of Texas. And I knew this to be true because I was the nurse—one of the nurses working at this clinic that was supposedly nonexistent. This person is Dr. Aton Heim, without whom I would not be here today.

We didn’t know each other at the time. We had no idea who the other person was. But what I did know was that someone within the hospital shared my concerns and was deeply worried that these children were being harmed. So a couple of days later, I came forward anonymously to corroborate his testimony as a nurse working at the clinic where this was happening.

And that was supposed to be the end of the story. I was going to go back to work, and things were supposed to return to normal. But two months later, in July 2023, my husband and I were having dinner on a Monday night when there was a knock at the front door. And lo and behold, when we went to open the door, there were two federal agents flashing their badges. They said they were from the FBI and specifically asked to speak with me by name regarding issues at my workplace and in a video that has now been viewed over 6 million times—because our Ring camera captured this exchange at the front door— these agents informed me that I was a person of interest in an investigation targeting a leaker—not a whistleblower, but a leaker who had allegedly violated patient confidentiality laws by breaching HIPAA—which was, of course, a complete fabrication and a total lie. And I knew at that moment that they were lying to me. They were trying to turn me against Dr. and use me to eventually testify or speak out against him if it ever came to that. Thankfully, it didn’t.

But they told me they couldn't protect me if I didn't help them, that I was in danger, that my career and my safety were at risk—and it was the most terrifying encounter we've ever had at our front door on a Monday night. And so that really set the stage for what happened next. I went back to work, of course; no one knew that this had happened, but I think we saw this a lot during the Biden-Harris Department of Justice era, where whistleblowers—people with a medical conscience and a moral backbone, pro-life people—were targeted because of what they believe or simply because they believed they were doing the right thing. And so we were no exception to that.

But I went back to work and discovered that not only had the hospital lied to the public about the existence of this secret program, but they were also fraudulently billing Medicaid for these cross-sex hormones and puberty blockers—which, in Texas, is a violation of state law. I saw children who had been intentionally misdiagnosed. I saw false diagnoses. I saw all these things that were deeply troubling and completely—100%—illegal. And I knew that I had to come forward at that point to expose the fact that the hospital was committing fraud against the federal government. And so, in June of last year, I came forward publicly, revealing my identity; I was promptly placed on leave by the hospital, and in August of last year, the hospital fired me. This was illegal for a number of reasons. I had also submitted a request for a religious accommodation.

So we retained the Burke Law Group, led by Marcella Burke, who is an incredible attorney. And I'm so grateful for attorneys all across the country who are true defenders of the truth and who stand on the right side of this issue. Then Donald Trump was elected president, and three months later, the Trump administration—under the leadership of Secretary Kennedy at the Department of Health and Human Services (HHS)—announced a formal investigation into Texas Children's Hospital for illegally terminating my employment. And I'm very, very grateful for that.

And to wrap up, I now have the privilege of serving as the founder of Protecting Texas Children. Our mission is to safeguard the innocence of every child by affirming biological truth. We work toward building a future where children can grow up happy, healthy, and whole—not by erasing who they are, but by learning to embrace how they have been beautifully created by God. And so I'll end here. What is happening in clinics across the country is not rooted in rigorous science, nor is it grounded in ethical medical practice. It is a marketing campaign masquerading as healthcare. It is a billion-dollar industry that thrives on misleading claims, emotional manipulation, and the systematic erasure of informed consent. The issue of gender medicine has shattered political boundaries and united voices from the right, the left, and the center. Not because of ideology but because of conscience. This is not a partisan battle. This is a battle of good versus evil. And at the end of the day, there are no Democratic children, there are no Republican children—just American children. Thank you.

Ian Mason:

Thank you so much, Vanessa. Jamie, if you'd like to go.

Jamie Reed:

Good afternoon. My name is Jamie Reed, and I hold a Master of Science in Clinical Research Management from Washington University in St. Louis, Missouri. I am also a lifelong Democrat, a mother of five boys—three of whom were adopted from the foster care system—and I am a lesbian. I am also a public whistleblower from within a pediatric gender center. I participated in the transition of nearly 1,500 unique patients ranging in age from 3 to 26 over the course of almost five years; I was once a true believer in pediatric gender medicine. Now I understand. I was part of an industry built on fraud, deception, and—in layman's terms—"we were running a racket." Patients with significant comorbidities were treated using unethical and deceptive informed consent practices. They were never properly assessed, informed of their condition, or given a diagnosis. A diagnosis itself is the first required step for

any consent to be valid and not fraudulent. These were also vulnerable patients who required specific safeguards.

First, they were minors and should have been provided with all the safeguards we would want for all children. Second, they had significant comorbidities, often falling within the definition of a stigmatizing complex medical condition, with some even meeting the criteria for a legally recognized medical disability. We were harming children with disabilities. These comorbidities include, but are not limited to, autism spectrum disorders, anxiety, depression, borderline personality disorders, eating disorders, self-harming behaviors, somatization disorders, learning disabilities, ADHD, and significant histories of trauma. Third, many of the patients who presented before the social contagion cohort would eventually, if not medically treated, become homosexuals like me. That is, they would identify as gay, lesbian, or bisexual as adults. The entire diagnosis is based on regressive stereotypes and self-reported feelings from minors and their parents. My clinical experience shows that these so-called “biopsychosocial assessments” are not consistent, comprehensive, or truly diagnostic.

For an assessment to be diagnostic, there is a very simple way to prove whether it actually is. It is so simple that so many of us actually forget it. There must be a statistically significant number of patients who will never meet the diagnostic criteria. So, in layman’s terms, there has to be a statistically significant number of patients and parents who would have been consistently told “no” by these centers. That never happens. I may hold a Master of Science in clinical research, but that is not a prerequisite for understanding the basic concept of medical diagnostics. Parents and the public have been deceived into believing that these assessments are diagnostic, that they are consistent, that they are comprehensive, and that no child ever receives treatment without one. If the assessment met the criteria of being consistent, comprehensive, and diagnostic, the diagnostic provider should be able to easily produce their assessment tools, submit them to the FTC for analysis, and they should also be universally consistent across all of our states.
This has never happened, and they have not shared any data to show a percentage of those referred are being turned down because this is not happening.

But—and this is a huge “but”—even if this field were actually doing what it claimed to do, even if it were conducting a true biopsychosocial assessment and denying treatment to a significant percentage of the patient population, please know that those who would be approved would be homosexuals, like me, and especially gender-nonconforming homosexuals. Under the Dutch model, we would still be deemed acceptable to be rendered sterile without sexual function, with destroyed endocrine systems, and allowed to die prematurely simply because we are gender-nonconforming homosexuals. And so, to some of those not here today—to Laura Edwards-Leeper, to Annelou De Vries—we homosexuals are no longer willing to be harmed for the sake of straight people’s comfort, and we are fighting back.

I personally witnessed the consequences of prescribing these treatments without proper informed consent; one of my patients, after undergoing a radical bilateral mastectomy at age 19, called begging for her breasts to be reattached. This harm has not been limited to children or minors. Another patient’s cognitive function was so impaired that they could not tell me where they lived or explain what type of identification they possessed. Multiple staff members expressed concern about the patients’ ability to consent to any medical procedure. Despite these and similar red flags with many patients—including one who even stated they wanted to have biological children—they were prescribed a treatment that would ultimately render them sterile for life. We, as clinicians in the gender industry, openly stated, “It doesn’t matter if patients even met the diagnostic criteria.” We didn’t care. Whether patients even had “gender dysphoria”—we didn’t care. If a patient said they were trans, then they were trans. Parents were unaware that patients were self-diagnosing, that clinicians had completely abandoned the diagnostic process entirely. Parents who didn’t agree with our practices were isolated and abandoned by our centers. We tore married parents apart, and we tore children away from caring parents who told us no.

Imagine, in a different field, if children walked in claiming they had a malignant cancer; if they went to an oncologist and that oncologist—without lab tests or biopsies—agreed to their demands for chemotherapy and surgery; and if the clinicians then billed our insurance for those procedures and medical visits, making money for the hospitals and themselves based on this deception. This is precisely what we were doing at the gender center. And then we turned this deception into a racket. We created specific lists of affirming therapists who would do exactly what we wanted. A therapist could only get on that list if they complied. We needed a letter for insurance.
So guess what we did? We wrote it. We made it a fill-in-the-blank form. We drafted it in advance. And I know this because I am the one who not only created this letter but also emailed it to all of those same therapists for hundreds of our patients.

I wish I could tell you that I became a whistleblower the first time I heard the nurse say, “But Dr. Lewis, we’re committing insurance fraud.” Because those words were spoken, and I wish I’d spoken up sooner. The final blow to my ethical medical conscience—and what finally led me to speak up—was that we significantly harmed our patients. We didn’t just deceive them or their parents. I hurt children. And I said to that same Dr. Chris Lewis, “Chris, we’re harming patients.” And he said, “I know, but what do you want me to do about it?” I harmed the very children I was hired to protect. St. Louis Children’s Hospital. Its mission statement is simple: St. Louis Children’s Hospital will do what is right for children. We did not. And all of us must now come to terms with what we have collectively done.

Ian Mason:

Thank you so much. Tamara, if you’d like to.

Beth Bourne:

So apparently I was supposed to prepare a written statement, but I didn’t. So here goes nothing. My name is Tamara, and when my story began, I had been working as a therapist at MultiCare Hospital in Washington State for about five years. In March 2023, a client came in and said they identified as a wounded male dog. A female client came in and said they identified as a wounded male dog. And I didn’t know what to do with that information. I’d heard people come in before and say, “I feel like I’m actually transgender.” And I’d just treated them the same way I treated any other client. We simply worked through all the different issues in their lives that were causing them distress. I never felt like I had to have an opinion because I just trusted that the people working in these gender clinics knew what they were doing. So I thought, “Okay, whatever—we’ll just keep going. I’ll do what I know how to do. We’ll treat anxiety, depression, and other issues you’re facing in your life.”

But at that point, when this client came in and said that, I thought, “Okay, so at what point is someone’s identity actually a mental health condition? At what point do we need to hit pause and address this as if something is going on that requires mental health intervention?” So I emailed my boss and my colleagues and said, “Hey, I had a client come in who said they identified as a wounded male dog, and I’m not really sure how to handle this. At what point does someone’s identity become something we treat as a mental health diagnosis?” And they said, “There’s no situation where that would happen. If this client isn’t saying that this identity is causing them any distress, then it’s fine. You just basically say, ‘Awesome, I’m glad you know who you are,’ and you continue to be a therapist.”

My boss was also copied on this email, and I was like, I don’t know how to process this. So I kind of just set it aside and kept thinking about all this—what’s going on here with gender identity and the way we’re treating these people and these young children who are just trying to figure out who they are. What’s happening here? And then in September 2023, we had a mandatory training on gender-affirming care. None of our trainings up to that point had been mandatory. And I know I’m going

sound so naive, but I'd never heard the term "gender-affirming care"—those three words together—before. So I was like, "What is this?" And I just had a bad feeling that, since it was mandatory training, we'd walk in and be indoctrinated and threatened—basically, have our jobs put on the line.

And so the training was supposed to take place after Labor Day weekend. So every night that weekend, after I put my kids to bed, I sat in bed and researched everything I could about gender-affirming care. And I realized it wasn't that easy to do. I'd Google "what are the dangers of gender-affirming care," and the results would be "How to be a good friend to your LGBTQ…" And I was like, what's going on? I went into this situation so naive. I truly had no idea; I was processing it all.
And any article I found or any organization I came across that said, "We're hurting people."

I had written a letter saying that I would not attend this training. So I wrote this letter and said to all the people I found who were speaking out about the fact that we're harming children, "Please read this for me. Tell me I'm not wrong because I might lose my job over this." So I sent it to complete strangers online and said, "Please tell me that the information I'm putting together here isn't wrong." I got emails back saying, "You're not wrong. You're absolutely right. But you have to attend this training because if you don't, you'll make yourself irrelevant. They'll just fire you. And then you'll lose your influence. So you have to go."

So then we went over some questions I could potentially ask. I don't know if you can tell, but I'm not the type to stir up controversy. I don't want to make anyone feel like I'm attacking them. So I went into this meeting, and I can tell you with certainty that I was so gentle and so cautious in the way I presented these questions. But there were 122 of my colleagues there. And when the opportunity arose, I said things like, "Hey, if countries in Europe are putting this on hold, why are we mandating this for our clinicians now?" It was a virtual training session, and the chat box exploded with comments like, "You're harming our patients. Keep politics out of this." And again, I'm so stupid. I was like, "Politics? I didn't say anything about the president. I don't understand what you're talking about." And I just couldn't believe the hostility. The person leading the training said, "I want you to understand that we're not going to… No more of these questions from you. This is not up for debate."

So I left the training, and my boss called me and said, "That wasn't the right time or place to ask those questions." I was like, "Oh, okay. I thought they'd said we could ask questions. So I just assumed." And so after that, I kept emailing my boss and the person who led the training, asking them these questions via email so I could keep a record of what they were saying. And I just wanted to make sure—am I crazy here? What's going on? And they just kept giving the same response over and over again. No matter what I asked, at no point did anyone say, "Okay, hey, let's look at this. What are you seeing online? Let's look at this research together and figure out whether or not there's anything here that we should reevaluate."

And I just thought they would—we're here to help people. Why wouldn't that be a conversation they'd want to have? Instead, they just decided I'm a monster. So they basically just kept saying over and over again, "I want you to understand that we're not going to agree on this issue. This is best practice. MultiCare will not tolerate anything less." And there's no reason why a person's mental health would affect their identity. It doesn't matter if they've experienced trauma in the past. It doesn't matter if they have co-occurring disorders. It doesn't matter because they know who they are, and you're not allowed to question that at all." And so, once again, I didn't really know how to respond to that.

Then I had a client come in—a 13-year-old girl who was mostly nonverbal. When we talked, she would just keep scrolling on her phone and rocking back and forth. I kept trying to engage her, but it was very challenging. She had a history of trauma—really intense trauma. Shortly after I started seeing her, I noticed she had an upcoming appointment at the gender clinic—her first one. I asked her how she felt about that. She said she didn't know she had one. Then she kept

scrolling on her phone, and we talked about something else. And then after that initial appointment, I read the note, and it said, “Ask your therapist for a letter to start testosterone.” And I could tell it was a form letter because I later went back and thought, “Okay, yeah, they’re all the same.” But it said that she had so eloquently expressed how distressed she was in her female body, and I was like, “There’s no way she doesn’t talk. That just doesn’t happen.”

So then her dad asked me to write a letter to start testosterone treatment. And I thought, “Finally, now people will actually listen to me. This is clearly not a good candidate. This is a child who’s dealing with so many other issues.” So I emailed my boss and the person who conducted the training and said, “Hey, can we review this client’s chart together? They want me to write this letter for this young child to start testosterone treatment. And I just feel like there are so many reasons why that’s not a good idea.” And then I don’t think I even got a response. But my boss came into my office a few days later and said, “I want you to know this has gone over my head. The person who conducted the training has reported you to risk management.” And again, I’m so clueless.

I thought, “Finally, risk management and I can have this conversation together. We can look at how we’re hurting this client and realize that we are hurting people.” And so I met with risk management numerous times. They ultimately determined that I was the risk. They took the child away from me, said I was incompetent to work with gender-distressed young people, and just handed the client over to someone who would automatically write that letter, no questions asked. Shortly after that, I left MultiCare. I thought, “I can’t work for an organization I don’t respect.” So I went somewhere else. And three weeks after starting that new job, my article in the Free Press was published. My new employer called me at 7:00 that night and said, “You’re just not the right fit for this position.” I lost my job. A single mom of three little kids. I thought, “This is a nightmare.” I’m so grateful for the Courage Coalition because I don’t know what I would’ve done if that support hadn’t been in place. But I ended up opening my own practice. Around the time I was opening my own practice, I received letters from the state saying I was under investigation for not being gender-affirming and for suggesting that gender dysphoria is a mental illness—and that’s where we are today.

Ian Masson:

Thank you so much. Lita, if you’d like to go.

Lita Boylan:

Hi. I am very grateful to the FTC for this forum. My name is Lita Boylan. I’m an LPN and a CHES. I worked as an agency nurse in the psychiatric hospital at North Central Healthcare in Wausau, Wisconsin, from 2017 until December of last year. North Central is a taxpayer-funded facility. On the adult unit. In 2017, I had a 19-year-old trans-identified female patient who had already undergone a double mastectomy and who nearly bled to death because testosterone caused her ovaries to become polycystic and then they virtually exploded.

On the adult unit in 2018, I had a trans-identified male patient in his 20s who had been so brutally abused as a child that he was legally blind and had an IQ of about 70 due to a permanent traumatic brain injury. He was prescribed four times the amount of estradiol found in oral contraceptives, despite the fact that he was unable to live independently or hold down a job. During the pandemic, North Central Healthcare opened a brand-new youth psychiatric unit, and by 2023 it had become not just one of the units where I worked, but the primary unit where I worked.

On many days, every single female minor patient identified as transgender. It was unusual for us to have no transgender patients on any given day. Most teenagers experienced suicidal thoughts at some point. This is not a pleasant part of the human experience, but it is also not an uncommon one. If a child who is struggling

discloses suicidal thoughts at school, it sets off a relentless cascade of interventions that occur without parental input or consent. School staff are legally required to report the incident to law enforcement, who will take the child to the emergency room, where the child undergoes medical tests, is placed on a 72-hour hold, and then transferred to a facility like the one where I worked.

All of this is done without parental consent. Sometimes it is done without any contact with the parents at all. The North Central administration is led by an individual who is well-known for a previous scandal in the state of Wisconsin at a state-run facility that serves children. She had an unwritten but brutally enforced policy that clinical staff were to call the children whatever they wanted to be called and that we were not to inform the children's parents of their desire to socially transition. The implied threat of suicide is used in relation to gender dysphoria in a way that is utterly contrary to the standard, which acknowledges both the suggestibility of people who are actively experiencing suicidal ideation and the long-observed phenomenon of suicide clusters, which occur especially frequently among young people.

In other words, they come in, say they're suicidal, and we say, "Gosh, we shouldn't discuss that unless you're trans, in which case we have to do whatever you say." Payers are billed fraudulently using misapplied codes. Medicaid fraud was commonplace. It was openly discussed during rounds. Most of the children who came in had insurance through their parents' employer. If they did and the child said, "I don't want my parents to know," the staff had figured out that if they omitted certain codes for insurance purposes, it would trigger a letter that would then reach the parents. We were on the same campus as county social services, which meant that social workers from the inpatient unit would go talk to social services, triggering a CPS investigation. Especially if the parents weren't married to each other, what would end up happening is that the child would be placed on Medicaid, and then they could bill Medicaid repeatedly for a 72-hour stay—which was also fraudulent because they were misusing codes.

So I know HHS and the DOJ are here. I don't know if this falls under the FTC's jurisdiction. Guys, I used to work for an ACO. Codes are my second language, so right now we have CMS, which won't let you bill for—I believe it's I-110—for essential hypertension. It won't wait for an RAF score, but we can bill for—what is it?—the E-290 code, which is for an unspecified endocrine disorder. So we can do that for kids, but we can't bill for essential hypertension for adults with government-funded healthcare. Make sense of this. My young patients, as young as 11 years old, would want to both impress and fit in with their somewhat older peers. They would frequently change their names and pronouns. This was always kept a secret from their parents. Clinical, educational, medical, and mental health professionals—perceived as authorities who had already proven they could override the wishes of the child's parents—were now also in the business of hiding things from parents.

There is no acknowledgment on the part of the administrators—who act as accountants, have no clinical background, hold no scientific degrees, never interact with patients, do not conduct assessments, and lack any understanding that science is not an outcome but is in fact a process—that affirming a cross-sex gender identity in children is not a psychologically neutral act. It sets off another unstoppable cascade of interventions, but this one results in permanent sterility, disrupted endocrine systems, sexual dysfunction, mutilated genitalia, and an increased risk of completed suicide, as shown by every high-quality study conducted on this issue.

Without exception, every single trans-identified female minor patient I treated described herself as either neurodivergent, same-sex-attracted, or a survivor of sexual assault. Some girls were all three. Most were on self-harm precautions and presented with significant scarring. The best part of my job was meeting with parents alone and telling them emphatically, "You have to let yourself off the hook. This is bigger than any one family." The trust that parents and families place in us to care for their beloved children is an awesome responsibility. The parents in my community pay a property tax to fund a facility that

usurps their rights and inflicts iatrogenic harm on their children. There is no way for parents to consent to treatments that are neither acknowledged nor explained. How will they ever trust us again?

Ian Masson:

Thank you so much. Sarah, if you'd like to wrap things up.

Sarah Stockton:

Good afternoon. Thank you again to the members of the FTC for hosting this event. My name is Sarah Stockton, and I am a licensed marriage and family therapist. Since beginning my training at Syracuse University in 2008 with a focus on sex and gender issues, I've spent over a decade developing standards for assessing youth with gender dysphoria, signing hundreds of letters of affirmation and letters authorizing medical interventions, and training other counselors to do the same—but today I'm here as a whistleblower. I have seen children and teens rush into irreversible medical decisions—sometimes after just one session—promised reversible solutions with no chance to learn other ways to manage their distress. I've watched families left heartbroken.

At Syracuse, I helped develop a comprehensive assessment for youth questioning their gender based on the Dutch protocol, emphasizing thorough evaluations to allow time to explore identity before resorting to medical interventions. We were told to promote this option so that a child wouldn't have to experience "the wrong puberty." Our 2013 assessment tool was designed to give teens and families space to consider past, present, and future expectations while ensuring that interventions like puberty blockers were carefully weighed. But what I witnessed was very different. By 2015, gender clinics began popping up, and organizations like Planned Parenthood started prescribing hormones without these thorough evaluations. Families were told that puberty blockers were fully reversible, despite emerging evidence of risks such as bone density loss and infertility.

Vulnerable teens, including those on the autism spectrum or in foster care, were funneled into medical interventions for what were often social difficulties or trauma—not necessarily gender dysphoria. In one case, I met a father very similar to Simon's who came into my office because the parents were going through a divorce and the child was requesting puberty blockers. I was very concerned about the implications of the story the father was sharing with me. One of the issues we haven't discussed enough—and I think we need to address—is Munchausen syndrome by proxy. I asked the court to give me some time to speak with the father about his reasonable concerns regarding puberty blockers. The court overruled me, and within one month, the father took his own life.

Soon after, a former patient of mine—a gay man who was seeing me for anxiety issues—came into my office distraught after reporting that he had been harmed by another therapist who rushed him into medical transition. He was so upset and had nowhere to turn for help. I had never heard of the term "detransitioner," and I had never encountered someone who was this distraught and harmed by what had happened. I tried to help him by emailing and calling his providers. They would not provide any guidance or resources on what we could do—no recommendations other than to continue with his transgender identity. He did not report gender dysphoria. He wanted help because dating was so difficult for him as a gay man.

We had been assured that regret was rare—if it existed at all—and that affirmation was the only path. Almost every professional I encountered validated that I wasn't just treating children but saving them. Yes, saving children. In reality, the system was failing them by prioritizing affirmation over developmentally informed therapy. Ignoring the fact that in mental health, what we focus on often grows, not diminishes. The pressure to affirm intensified after the pandemic, as I saw spikes in trans identification,

particularly among youth on the autism spectrum—those who were isolated and online during lockdowns. It seemed to me that many were adopting a trans identity to cope with other issues, not necessarily because of deep, persistent dysphoria.

Schools normalized rapid affirmation, leaving no room for gender-nonconforming kids to explore non-medical paths through the natural distress of adolescence. When I raised concerns about a group of four teens transitioning all at once within a single month, I was silenced and told I had no basis for questioning it. My staff, colleagues, and even the courts warned me of professional consequences for questioning the one-size-fits-all approach. Even though I had been trained under this protocol and had denied treatment to adults who were suicidal, when it came to children, it didn't matter. Suicidal tendencies only meant I had to affirm them more quickly. I eventually decided there was nothing I could do, so I quietly opened my own private practice and stopped helping youth entirely.

Many years would pass, and in 2022 I could no longer remain silent. My clients—many of whom were teachers—were sharing stories of desperation, needing guidance, yet unable to discuss developmental concerns without risking their careers. Inspired by public discussions, I spoke out in the documentary *What is a Woman* and at Syracuse University in 2023. The result was a swift backlash. Petitions with thousands of signatures were launched against me, and I faced public disavowal by my former mentor and co-author of the publication. I was terminated from the university where I had worked for 15 years and blacklisted by organizations—despite having spent 15 years there without a single formal complaint against me, and with every single evaluation praising my exemplary service. And then my group practice collapsed.

But I am here because the truth matters. Our children deserve comprehensive, developmentally informed assessments, not rushed affirmation that they may not fully understand. They need safe, open-ended spaces to explore distress without being pushed toward irreversible medicalization. The FTC must continue investigating misleading claims—such as "life-saving" and "reversible"—that undermine informed consent. I urge you to reinforce rigorous standards for youth gender care, protect professionals who raise concerns, and ensure that gender-nonconforming children have the time and support they need to find their path without being harmed.

In retrospect, the promise of saving children often meant recommending interventions that would ensure that they and their legacy would no longer exist. It would mean that I would risk their fertility and their sexual function, bypassing all the safeguards we apply in every other area of therapy. You would find it very strange if I told you that I was playing with dildos with typical 10-year-old children. But in this gender-affirming care, that's not only what was taught to me—it was promoted. We were part of a drug assembly line, taught that gender-affirming care was the only solution.

Today, schools and medical organizations are endorsing the gender-affirming model, medicalizing distress, while social media tells children that finding an identity is the most important part of development—even if it means disconnecting from their embodied selves. I continue to work with individuals experiencing gender dysphoria and those who are gender non-conforming, assisting families in custody cases and collaborating with legislators to establish safeguards for children. We need to rebuild trust in the medical community while caring for a generation of children who now face disorders of sexual development that we, in part, have caused.

When we talk about concerns regarding suicidal tendencies, my greatest fear is that the largest group that will ultimately take their own lives will be the detransitioners—because they are unaware of their options and have no way out. If you cannot transition your sex, there is no way to detransition your sex. And these children are also being told that this is a possibility. I already have children coming in and saying, "It doesn't matter if I transition my sex; I can detransition it." You cannot. Our children and their families deserve care, time, and honesty—not promises the medical system cannot keep. Thank you.

Ian Masson:

I want to thank all our panelists today, not just for being here, but also for their courage in coming forward in the first place and letting us all know what's happening in their lives. Thank you so much.

Jon Schweppe:

Thank you, everyone. Thank you. Thank you, Ian, and once again, thank you to the brave whistleblowers for all they've done to protect children. Folks, to save time, we're going to skip the break and move straight into our next presentation, followed by one more panel discussion, which will be moderated by Commissioner Mark Metter, so please stick around for that. Erin Friday is a licensed California attorney and has been a registered Democrat for more than 30 years. She is the president of Our Duty USA, a national nonpartisan organization dedicated to protecting children and vulnerable adults from the influence of gender ideology, and a director of Genspect USA. She is heavily involved in legislative advocacy, frequently proposing and opposing bills related to gender interventions.

She has authored multiple amicus briefs in cases before the Supreme Court and federal courts of appeals, drawing attention to the perspectives of detransitioners and parents of gender-confused children. Her work and viewpoints have been featured in respected outlets such as The Wall Street Journal, The Economist, The Daily Signal, The Federalist, Daily Wire, The Epoch Times, PragerU, The Sacramento Bee, and Post-Millennial. Erin has appeared on CBS, Fox News, and NewsNation and has been featured in films both in the U.S. and abroad, establishing herself as a significant voice in national discussions on parental rights and child protection. Ladies and gentlemen, please welcome to the stage, Erin Friday.

Erin Friday:

Good afternoon. I am honored to speak today as an awakened Democrat from California. I know—it's an oxymoron. I am offering a roadmap for investigations into the nefarious gender industry. Dismantling the worst medical scandal in human history requires an understanding of the collusion among nonprofits, the medical community, and our government, which has created a new category of humans who were inconceivably born in the wrong body. This has led to an ever-growing billion-dollar industry dedicated to "fixing" them. My goal is this: to see the dismantling of the deceitful gender industry for both minors and adults. And to ensure that the individuals who set society on this course are held accountable both civilly and criminally, including every medical society that has abandoned ethics and science in deference to the transgender mafia. In 2007, endocrinologist Norman Spack and his protégé, psychologist Laura Edwards-Leeper, opened GeMS at Boston Children's Hospital, the first pediatric mutilation clinic. Dr. Spack and Leeper abandoned the established treatment of watchful waiting for children who were distressed about their sex. This cohort of children had a desistance rate of 98% if not affirmed. Not only did they adopt the flawed Dutch treatment protocol, but they streamlined it, moving children even faster toward medicalization because, according to Leeper, there were staff shortages.

There are now over 400 gender clinics in the United States. There is money to be made, and some doctors enjoy playing God. In 2023, I attended a conference where Dr. Edwards-Leeper proudly recounted that Dr. Spack would tell people, "Everyone needs a Lara," because she claimed that her mental health assessments could distinguish between which children would benefit from sex trait modifications and which would not. When I asked if she followed up with any of her patients to confirm her "superpowers," her answer was no.

Notably, she rarely refused to approve gender interventions for any of her minor patients. We've already heard about Amy Tishelman; we'll hear a little more about her. Psychologist Amy Tishelman joined GeMS in 2013. She recently testified that she had only just requested the creation of a database to track the outcomes of the more than 1,000 children whose bodies the clinic had altered. Boston Children's has been

experimenting on children for 18 years without follow-up, while simultaneously reducing the mental health assessments from 20 to 10 to two hours before prescribing puberty blockers, cross-sex hormones, and surgeries.

Dr. Spack and Edwards-Leeper's methodology exemplifies the incestuous nature of gender medicine and the falsification of medical papers that reach predetermined conclusions through data manipulation and circular referencing. They leveraged their prestige to convince other medical providers to adopt their unsubstantiated treatment protocol. In 2009, Dr. Spack contributed to the Endocrine Society's guidelines, which declared puberty blockers to be fully reversible. That is untrue. Despite acknowledging that the evidence supporting the safety and efficacy of blockers was low or very low, the guidelines were cited in the 2012 WPATH SOC 7 as a basis for recommending the blocking of children's puberty.

Well, that is likely because Dr. Spack also happened to be on the executive committee for the WPATH SOC 7, so he was citing his own work. In 2012, Edwards-Leeper and Spack published a paper in the American Academy of Pediatrics and again stated that puberty blockers are reversible, citing the Endocrine Society guidelines and WPATH. This circular citation strategy has created a false impression that independent groups supported their conclusions. Another example of manipulation can be found in the $10 million NIH study led by Dr. Olson Kennedy, the head of Children's Hospital LA. That study failed to show that children's mental health improved while on blockers. Back in 2021, Olson Kennedy presented the one-year results from her study at a USPATH conference, the U.S. arm of WPATH. But at the two-year mark, Olson Kennedy withheld the disappointing results.

She finally published them in 2025. So why the delay? As Lior pointed out, it was because she feared her findings would be exploited in court to halt the prescription of puberty blockers for children. Thus, this pediatrician prioritized a political agenda over children's well-being. Since the results of the NIH puberty blocker study were not what Olson Kennedy had hoped for, she attempted to downplay the study's shortcomings in the abstract. She concluded that the children's mental health would likely have worsened if their puberty had not been blocked, but her study lacked a control group, meaning there is no way to substantiate this claim. Her obviously false conclusion is emblematic of the blatant activism at all costs in gender medicine.

As Dr. Laidlaw stated, Olson Kennedy employed the same manipulative tactics with the hormone study results, omitting the tracking of suicides—the most frequently cited basis used to justify gender interventions—because two out of the 315 children had committed suicide. Under any normal circumstances, this level of harm would have brought the study to a halt, but Olson Kennedy buried the lead. This type of manipulation is rampant throughout gender medicine. When the so-called experts are ideologues who stand to benefit from the results, scientific rigor disappears.

Let's spend a little more time on Joanna Olson Kennedy. She is captured on video stating that if girls miss their breasts after top surgery, they can simply get new ones. She is proud that she has performed sex trait modifications on children who are in foster care, homeless, involved in prostitution, and struggling with drug addiction. She has said it's no big deal if she transitions children who ultimately turn out not to be truly trans because those children are resilient. She has stated that being trans isn't the worst thing, and after all, whose fault is it if she transitions a cis child? Her answer? The child patient. She was merely providing what the child wanted.

Olson Kennedy opened Children's Hospital LA, the largest pediatric clinic—which is soon to be closed. It is well known for the pressure Olson Kennedy and her wife—a woman who identifies as a man—put on families. Inside that clinic, they would separate parents and children into different rooms. They would bring in celebrities and other people who identify as trans to talk to the children and speak persuasively to them, telling them about all the different interventions they could receive, while others worked on the parents in a separate room, making them feel guilty into accepting their newly designated son or daughter. Olson Kennedy

partnered with public and private schools through Gender Spectrum, a now largely defunct advocacy group whose mission was, and I quote, “to bring gender ideology into every classroom.” She, along with other clinicians, uses schools as pathways to recruit and identify her victims. Here is an example. This is a California middle school advertising a Gender Spectrum conference featuring gender surgeons and clinics in its weekly newsletter. Middle school. This slide is from a second Gender Spectrum conference to which children in preschool and older were invited. Those who have read the WPATH files—which I recommend you all do—may recognize Dr. Satterwhite. He has examined preschoolers. This surgeon performs genital removal surgeries. Think of a Ken doll’s crotch.

He also performs surgeries that leave a person’s natural genitalia intact while adding artificial genitalia of the opposite sex. Keep this in mind as you hear the phrases “life-saving” and “medically necessary.” Then there’s Scott Mosser, who was caught on video stating that he has no age limit for removing girls’ breasts. He also contributed to the adolescent section in WPATH’s SOC version eight. What we really need is a network map showing the connections and reach of each provider, because it’s quite staggering how a few people can create an entire industry that preys on the vulnerable.

For nearly two decades now, gender providers have been prescribing puberty blockers, hormones, and surgeries to children without fully understanding the effects, while influential medical societies, major hospitals, and providers assure parents that these interventions are life-saving and improve mental health. These are not mistakes. These are acts of intentional deception. For example, Jason Rafferty’s 2018 AAP transgender policy is riddled with errors and dramatic claims without any citations.
Despite a highly publicized analysis by James Cantor, the AAP did not waver from its position but doubled and tripled down on it. It should come as no surprise that Dr. Rafferty earns his living at a gender clinic. The AAP, as Lior stated, promised a systematic review. That was in 2023. Two years later, it appears they haven’t even started it. I believe that’s because the AAP knows—and has always known—that there is no scientific basis for altering children’s sex characteristics. Investigations must be conducted into influential medical and mental health organizations that publicize false statements, knowing that their members will blindly rely on their protocols. I recommend starting with these organizations. Focusing on puberty blockers: the number of children being prescribed puberty blockers is increasing at an unprecedented rate. These figures do not include Kaiser Permanente. We heard earlier about Kaiser; they are a major player in the trans industry and appear to profit both as an insurer and a provider, and that needs to be investigated.

I think a reasonable estimate is that by 2024, the number of children placed on puberty blockers will be close to 4,000 new patients, especially in light of the admission by Dr. Jeremi Carswell, director of Boston Children’s Hospital, that puberty blockers are being handed out like candy—which, in her view, is great in some ways. Great. This is despite her own acknowledgment that puberty blockers are not reversible.

Puberty blockers are profitable. The drug Lupron, manufactured by AbbVie, costs around $27,000 for a six-month supply. A six-month Supprelin implant from Endo Pharmaceuticals can cost $210,000.

UCSF is a leader in altering children’s sex characteristics. Its pediatric clinic was founded and is led by Madeline Deutsch, who also serves as president of USPATH. We really need that diagram showing all of these connections.

The infamous Dr. Diane Ehrensaft, who also works at UCSF, teaches that 2-year-old boys who unbutton their onesies are communicating that they’re really girls, and girls who dislike barrettes in their hair are communicating that they’re really boys. She also believes that there are an infinite number of genders, including a “Prius” gender. I can’t make this up.

So this screenshot is from UCSF’s website as of June 25 of this year. It clearly states that puberty blockers are safe and fully reversible. I wonder why, then, its consent form states otherwise. This is a consent form from 2021. Let me point out a couple of interesting statements. First of all, it says that children with trans identities need to have their puberty postponed, that the medication is not permanent, and that

blockers treat the trauma of unwanted puberty. Puberty isn't a choice. It's something all humans go through.

Next, it says that the long-term effects and safety of puberty blockers are not fully understood. Well, I thought it was reversible. Isn't that what it said? Bone density will decrease, but is expected to return to normal. Now, lawyers, let's focus on that word "expected." Expected? In other words, you think so? Maybe? Then again, we don't know. Oh, and puberty blockers might affect fertility. This consent form directly contradicts UCSF's website. This is purely and simply deceptive practice. In this example, the child's doctor was Stephen Rosenthal, who partnered with Johanna Olson-Kennedy on the NIH study that still hasn't released the results regarding the effect of puberty blockers on a child's physical health.
Rosenthal also contributed to the Endocrine Society's and Pediatric Society's guidelines for transgender health, both of which state that blockers are safe. Rosenthal and Olson-Kennedy need to be at the center of the investigation.

Dr. Marci Bowers. He is the current president of WPATH. He justifies the eunuch identity for children because the word "eunuch" appears in the Bible. Again, I can't make this stuff up. As this country's most prolific castrator—having performed over 2,000 penile inversion procedures, including on children—he admitted during a Duke symposium that puberty blockers started at Tanner stage 2, combined with estrogen, result in a life without any sexual pleasure for males. How does one explain to a nine- or 10-year-old that he will never experience sexual pleasure in a way that he can understand and consent to? We all know the answer. It can't be done.

Incidentally, billionaire JB Pritzker, the governor of Illinois, and his trans-identified brother are major contributors to Duke.

A 2024 Mayo Clinic study reports mild to severe glandular atrophy and changes in testicular cells in males treated with blockers. It states that this finding calls into question the reversibility of blockers.
Despite this admission, as of this June, the Mayo Clinic's website continues to state that puberty blockers are reversible. Almost every major medical clinic or gender clinic advertises on its website that puberty blockers are reversible or merely a "pause button," knowing full well that these statements are untrue or, at best, unverified. Some have been scrubbing their websites since the executive order and FBI investigations were announced. I watched it happen in real time.

I want to highlight one particularly dangerous gender clinic: Seattle Children's Hospital. Not only does it claim that gender interventions are life-saving and that puberty blockers are reversible, but it also partners with its autism center. Youth with autistic traits are overrepresented in the rapidly growing cohort of children and young adults adopting trans identities. They tend not to conform to rigid gender stereotypes, leaving them vulnerable to believing that there is something wrong with them. Combining the autism and pediatric gender centers provides a steady stream of patients for expensive and lifelong gender treatments. Seattle Children's is not alone in this marketing scheme.

Seattle's gender clinic authored, and the AAP published, a perspective advancing the notion that refusing to modify a child's sex traits constitutes medical and emotional abuse. Parents who refuse to consent to having their daughter's breasts removed or her sexual function destroyed are viewed as abusers by the largest pediatric medical society in the United States. And if I recall correctly, Seattle Children's had one of the most prominent booths at this year's AAP convention, where some detransitioners and I were escorted out of our paid-for booth because we dared to try to educate pediatricians. So yes, the AAP is aware of the harms but continues to support gender procedures.

This is a screenshot from Whitman Walker Medical Clinic, a clinic right here in DC, that provides services to patients aged 10 and older. Please excuse the vulgar language. It's not mine—it's theirs. Whitman Walker claims that females can grow a male phallus from testosterone. Of course, that claim is an outright lie, although

prescribing testosterone to females is genital mutilation. That part is true. I want to highlight one surgeon who deserves immediate investigation.

And this is Dr. Sidhibh Gallagher, a plastic surgeon in Florida. An FTC complaint was filed and ignored under Biden, but I hope this administration will investigate this predator who targets the young, the overweight, and the vulnerable. She advertises on TikTok, Instagram, and YouTube using childish antics to sell her services while posting pictures of the lavish lifestyle her young victims' bodies provide for her. Here are a few examples. Here she is celebrating her success in a potentially fraudulent insurance claim.
Here are a couple of pictures of her victims. Note that this young girl has scars all over her body from cutting herself. Dr. Gallagher was more than happy to let her pay for her to use her scalpel to make even deeper cuts. The woman on the side has no nipples. Humans have nipples.

Turning to cross-sex hormones. There are two major online distributors of cross-sex hormones: Plume and FOLX. Both are supposedly accessible only to adults, but their marketing suggests otherwise. Plume started with seed funding from Craft Ventures, one of California's most prestigious venture capital firms, raising over $38 million. Both of these online cross-sex hormone distributors are capitalizing on market predictions of substantial growth in the gender industry. In 2022, cross-sex hormone sales amounted to a $1.6 billion business. Planned Parenthood is also reaping the benefits of this market. This is why they want to silence us.

Let's examine one of Plume's ads. That young woman looks like a minor to me, or at the very least, the ad suggests that Plume is marketing to minors. It also appears that Plume is getting into the surgery business or perhaps partnering with surgeons who will remove the healthy breasts of young girls. Plume, by the way, is affiliated with Stork, so Plume sterilizes the person and Stork finds them a baby. This slide also shows a screenshot from a Plume newsletter that a child can sign up to receive. I received it and pretended I was 16 years old.

Now, why would Plume be publishing information—in its "Stuff We Think You'll Like" section—that runaway minors in New York are able to obtain hormones? To attract more clients, luring children to run away from their parents who won't affirm them. FOLX also markets to children. FOLX had its senior director of audience development, Kai Proschan, speak to kids from Friends for Youth at the Chan Zuckerberg Center. The kids there appeared to be about 10 to 14 years old. I was actually there. Kai, a man wearing an outfit fit for a red-light district, spoke about medical transition to a group of at-risk children. These online services are designed to circumvent parental consent and detection. A website called Gender Mapper directs children to both FOLX and Plume if their parents refuse to give consent. Since both of these online services use telehealth, adults can easily order medications for minors; the drugs arrive in unmarked packages, and it's easy to change the delivery addresses. Mental health providers across the country have colluded with the medical-gender complex in their abject failure to safeguard against transgender interventions. Websites like the Gender Affirming Letter Access Project and Do Something: Identity(ies) facilitate approval letters for gender interventions for free or within an hour with no follow-up, without conducting proper assessments for minors or adults. Any medical provider who is merely checking a box is not providing mental health care. They are simply order-takers. The FTC can pursue every single one of them for deceptive advertising.

While this may fall outside the FTC's jurisdiction, I do want to raise the issue of the connection between colleges and the transgender movement. Many colleges have transgender clinics right on campus or are affiliated with them, providing an endless stream of paying customers. Parents send their kids to college for an education, and their daughters come home with missing breasts and facial hair, while their sons are on estrogen. I don't know if I can play this. It should work? Okay. I'll conclude with a video that sums up everything that's wrong with gender medicine. This is from a WPATH seminar in which Dr. Dan Metzger admits that talking to a 14-year-old about gender interventions causing infertility is like talking to a blank wall, and the regret that follows is very real.

Glenna Goldis:

I think when we're doing informed consent, I know that's still a major gap—we just go through the motions, we try to talk about it, but most of the kids aren't in any kind of mental state where they can really, really, really discuss it seriously. That's always bothered me. But we still want the kids to be happy—happier in the moment, right?

Erin Friday:

Yeah. Medicine should never be about giving a child what they want at a single moment in time. The entire field of gender medicine—even for adults, because we can't forget about the adults—is a complete sham based on false science. Talk to a parent of a 17-year-old who identifies as the opposite sex; their biggest fear is time, because they can hold the line until that child turns 18, and then there are no more restrictions. So the entire field of gender medicine is a complete sham based on false science. Thank you.

Jon Schweppe:

Thank you, Erin. That was a very informative presentation. Before we begin our next panel, I'd like to remind everyone—as the chairman mentioned during his speech this morning—that the FTC will be issuing a public request for information related to this workshop in the coming days. Be sure to check our website and social media channels for more details on that and how you can submit comments, but feel free to start preparing them now.

We'd love for the people here today—especially those who didn't get the chance to speak, and especially those watching online—to have the opportunity to share their stories with the FTC.

Now, first of all, I just want to thank you all. I know this was a really long day. It was a bit of a marathon. We're on our final panel, and I'd like to welcome to the stage my friend, the newly appointed—but already hitting the ground running—FTC Commissioner Mark Meador.

Mark Meador:

Thank you, everyone. Why don't we invite the next group of panelists to come up now? While they're making their way up, I just want to thank all of you for being here today and everyone in the chairman's office who invested their time in organizing this workshop. I know it was a major undertaking. These are incredibly important conversations to have, both here at the commission and as a nation. We also know that these conversations can sometimes be difficult. And let me be clear: every person deserves dignity and respect, and the Commission certainly recognizes that.

In my view, treating people with respect and dignity means being honest with them—including about the effects of medical interventions, the evidence base, and the anticipated outcomes—and this is especially important when we're talking about decisions involving children. That's what today's workshop is about. It's about honesty, the foundation of all the work we do here at the Commission to protect consumers.

And that brings me to the topic of our panel: what the FTC can do as an agency to address the unfair and deceptive practices that exist in the field of youth gender medicine. Because as this workshop draws to a close, it has become clear that a great deal of work is needed. And so I'd especially like to thank the distinguished members of our panel today, and I'll now introduce them one by one. First, we have Josh Payne. Josh is a founding partner at Campbell Miller Payne PLLC, a national law firm based in Dallas, Texas, representing detransitioners and others harmed by gender transition procedures.
Josh has served as lead counsel on behalf of detransitioners in medical malpractice litigation in Arizona, Massachusetts, New Hampshire, and North Carolina. He also serves as lead counsel in a wrongful death

case in Tennessee on behalf of the parents of a young adult son with autism who committed suicide after being placed on cross-sex hormones.

Next, we have Glenn Goldis. Glenn. Glenna Goldis—sorry. Glenna is a consumer protection attorney in New York City with experience in government and civil legal aid. She is speaking today in her personal capacity, not on behalf of her employer. Glenna has successfully prosecuted deceptive practices in sectors such as for-profit education, debt collection, telecommunications, and bail bonds. A gay rights advocate, she publishes a newsletter about the transgender movement called *Bad Facts*. Glenna holds a J.D. from New York University School of Law and a B.A. in philosophy from the University of North Carolina at Chapel Hill.

Next, we have Brandon Showalter. In addition to being a longtime friend of mine and an avid singer, Brandon is a journalist with the Christian Post who has reported extensively on the developments of gender ideology around the world and other bioethics issues. He is the creator and host of the Christian Post's "Generation Indoctrination" documentary podcast series and has been featured in several documentary films on the subject. He holds degrees from Bridgewater College in Virginia and the Catholic University of America.

Next, we have Paul Dupont from the American Principles Project. Paul is the policy director for the American Principles Project, where he is responsible for helping to develop and implement the organization's public policy agenda. He has been with the American Principles Project (APP) for 12 years, having served in various roles ranging from communications to operations and research. Paul has been particularly involved in supporting APP's advocacy on transgender issues, from defending North Carolina's HB2 in 2016 to promoting efforts to end taxpayer funding of gender transitions today. He is a graduate of Villanova University, where he earned a bachelor's degree in political science and humanities.

And last but not least, we have Jay Richards from the Heritage Foundation. Jay is the director of the DeVos Center and the William E. Simon Senior Research Fellow at the Heritage Foundation. He is also a senior fellow at the Discovery Institute. Jay is the author of 14 books, including two New York Times bestsellers. His most recent book is *Fight the Good Fight: How an Alliance of Faith and Reason Can Win the Culture War*.

Thank you all for being here today—let's just jump right in. So under the FTC Act, an act or practice is deceptive when, first, it misleads or is likely to mislead a consumer; second, a consumer's interpretation of a representation is reasonable under the circumstances; and third, the misleading representation is material. So Josh and Glenna, can you tell us about some of the representations that providers have made regarding so-called gender-affirming care—both the need for it and its effects?

Glenna Goldis:

Yes. Thank you, Commissioner. Thank you. First, I just want to express my gratitude to the FTC for hosting this event today and for inviting me to be on this panel. We've heard a lot of deceptive representations all day today. The other speakers have been accurately identifying them, in my opinion, all day. I'd like to delve deeper into some of the foundational false claims in gender medicine that really show us that the problem goes all the way to the root of this practice.

And this can actually be awkward to focus on because the false claims aren't just made by gender doctors. In much of the country, that jargon is now part of our everyday vocabulary. For example, "sex assigned at birth"—many ordinary people use it because they think it's the polite thing to do. But once you realize how harmful gender ideology is, I think people might start to stop using those phrases.

So I'll start with "sex assigned at birth." The doctors addressed this effectively earlier. Sex is not assigned at birth, so that is a false statement. The words "assigned at birth" imply that sex can change. So for young

patients—especially in a gender clinic—they come in because they want to change their sex. And when doctors tell them that sex is just an assignment, they get the idea that they'll be getting a sex change. And it's important to note under the FTC Act that it does matter who the target audience is. So even if you're an adult and you think, "Well, that phrase is harmless. I know what 'sex assigned at birth' means. I know it's just meant to be polite." Well, we must consider it from the perspective of the patient population hearing it—and these are distressed children—so it is deceptive toward them.

Second—and this is a major point—is gender identity. Doctors claim that consumers and patients have a gender identity that is incongruent with their bodies, but it's impossible for gender identity to be different from a body or the same as a body because gender identity, as defined by gender doctors, has no definition and no properties. So this is an important point. I think a lot of people assume that gender identity means wanting to be one sex or the other, and gender doctors almost make it seem like that's what they mean because they say that gender identity can be male, female, or something else. But it's a trick, because—remember—gender doctors believe that a male is anyone who says they're a male. So it's a circular definition, like "gender identity is someone who has a male gender identity."

And then the doctors just double down on their deception when they try to add more verbiage to make it seem like gender identity does have properties and isn't just a circle. So just to give you some examples, Jack Turban wrote in the New York Times that the most basic part of gender identity is a person's transcendent sense of gender. And this was in the New York Times. He did not define the term "gender" after referring to its transcendent sense. Instead, he wrote that gender, quote, "goes beyond language."

Another gender specialist—a pediatrician—wrote that gender is, quote, "a multidimensional concept with complex expressions, and that it is related to and distinct from sex in ways that modern science is still exploring." So she'll know the definition of gender in the future once science has finished its work. And just a side note on that—I'll try not to go off on too many tangents about this—but a lot of the time, gender experts tend to use language that implies they'll soon have the answer to questions about gender. Science is almost there. And they say, "Look, this is a really new area of study." It isn't. All of this goes back to the early 1960s. Institutions have been investing in it ever since—major universities, in particular. There has been very little change in the underlying theories since the early 1970s, when they coined the term "gender dysphoria." So whenever they try to use that excuse—like, "Oh, we're new"—that's not true. They're not new. This stuff is all very old. It is not cutting-edge.

And finally, I'll just give you one more example. Daniel Shumer, a pediatric endocrinologist in Michigan, doesn't have a coherent definition of gender either. And when he was recently deposed, he admitted that when he explains gender to patients, quote, "I have oversimplified." So he's not as complicated as the woman with her complex, multidimensional concepts. He boils it down to some other thing that isn't true.

So with all that being said, it seems safe to say that patients don't know what their doctors mean by the term "gender." And doctors don't really have any clear definition for it. They seem to be using it as a placeholder to lead the patient to believe that since they have this gender-related problem, they need a gender-related solution—which is gender-affirming care. So that's kind of the function it's serving. I think that whenever you see the term "gender"—pretty much anywhere in the world of gender or gender medicine—it's deceptive.

So I'll just give you one more foundational false claim they make. And this comes from, for example, the American Psychological Association and the American Academy of Pediatrics. They claim that sexual orientation means attraction to a gender. Sexual orientation… There's no scientific basis for saying that. The studies are about sex—sexual attraction to people based on their sex. And remember, gender has no definition, so it's not even possible for that claim to be true. And this is really important because it leads people to believe that gender-affirming care will allow them to

date and form relationships as if they were members of the opposite sex or a non-binary sex—I'll try not to get sidetracked on that. So this is playing out in the real world.

In the gay community, we see these young women pursuing gay men, trying to form relationships with them. They think it's viable because they have a male gender identity. Their doctor told them so. And these institutions are telling them that sexual orientation is based on gender. So this just leads to a lot of discomfort, sadness, and awkwardness for everyone involved. And that's putting it mildly. So again, this is a truly significant deception being imposed on these young people.

Mark Meador:

Thank you. Josh?

Josh Payne:

Thank you, Commissioner. I'd like to address both the problem posed by the people making these statements and the solution. And the deception is evident when viewed in its entirety, but you can look at it from both angles. They frame the problem by saying your child will commit suicide if this intervention isn't carried out and if you don't agree to it, and then they present a solution that they claim is rock-solid. So you have a drowning victim, and here's the life raft.

And because deceptive communication is viewed holistically, it is clearly a deceptive message. The message is, "You are dying, and here is your lifeline." That is the core deceptive message. Another aspect of this—one with which the FTC is well acquainted—is implying that something is FDA-approved. And again, when viewed in its entirety—you're in a doctor's office, someone there wearing a white coat, exercising authority over you, presenting a lifeline to you—you assume this has every conceivable seal of approval out there, and there is no hint in the parent's or patient's mind that the FDA hasn't vetted this and hasn't approved it. And so, the lack of a disclaimer stating that this is absolutely not FDA-approved—not even really reviewed—and that it is entirely an off-label use is one of the pieces of evidence from earlier today. The entire thing is off-label. That's a vital disclaimer, and it's not being provided.

Mark Meador:

Thank you. Turning to the issue of unfairness, under the FTC Act, an act or practice is unfair when it, first, causes or is likely to cause substantial injury to consumers; second, cannot be reasonably avoided by consumers; and third, is not outweighed by countervailing benefits. So I was hoping Brandon, Paul, and Jay could tell us a little bit about some of the harms that are alleged to have resulted from the push to get young people to undergo aggressive gender-related medical interventions.

Brandon Showalter:

I'll go first, and I'd like to thank you, Commissioner Meador, and the FTC for hosting this event today. The harms are incredibly brutal. I've seen things that have turned my black hair gray, and they'll make you age pretty fast. You don't want to see the kinds of things I see in my inbox or hear from parents about what has happened to their children.

And I'll say this: when we talk about unfairness and deceptive trade practices—because it's based on an irretrievably flawed premise that it's actually possible to be born in the wrong body—any medical treatment aimed at that end is guaranteed to cause harm, period, because it starts with a lie. That's just it. And it leads to the horrors I'm about to describe. I'll just talk about three cases of harm I've seen. I haven't seen the full story, but I've seen part of it and heard about it.

One detransitioner man walked into his appointment, and reportedly, the first thing he was told by an intern working in the intake office was, “If you think you’re trans, you are trans.” He went all the way down the trans path. His story was featured in Abigail Shrier’s book, *Irreversible Damage*. I also reported on his story. He was put on hormones and eventually underwent an orchiectomy—the removal of his testicles. And he was never told—not even during his appointments—that they were using anatomically incorrect language; they castrated him for $1,000. That poor man experienced severe suicidal thoughts due to his post-operative regret, severe endocrine complications, and when he tried to have sex, he even ended up ejaculating blood. And to this day, the weirdest email I’ve ever had to send was to Dr. Laidlaw, asking if it’s really possible to ejaculate blood. And yes, it is—after you’ve been castrated.

Another woman on Instagram who was led down this path underwent phalloplasty surgery and ended up having to undergo over two dozen “corrective revision surgeries” because they mangled her down there so badly that she had to urinate out of her anus into an ileostomy bag. And she was posting about this carnage inflicted on her body on Instagram. It’s gruesome.

Another woman has the worst story I’ve ever heard—and she’s featured in the documentary podcast that I produce and host. I can say her name; her name is Amy Atterbury. I just have to honor her because it’s the worst story I’ve ever heard. She had to be in the next room while doctors disfigured her daughter’s forearm to create a fake penis. Medicaid paid for her to undergo a double mastectomy and have all her reproductive organs removed, but her daughter’s forearm was cut up to create a fake penis, and she had to be in the next room for 13 hours while the doctors did what they did to her. And reportedly—I’ve heard—there are some other corrective surgeries underway that are either planned or may have already taken place. As far as I know, they’re not speaking out right now, but they’ll have to perform some sort of revision surgery where they cut the sex organ in half and reroute her urethra.

You want to talk about... I mean, I really try to avoid making any comparisons to the Holocaust because I just don’t like to. That’s a uniquely horrific episode in history. But I sometimes receive emails from Jewish readers who say we’re living in a culture of Mengeles. This industry needs to be dismantled from top to bottom because it all begins with deception and the lie that it’s actually possible to be born in the wrong body, and there are products and services marketed to that end.

Mark Meador:

Thank you.

Jay Richards:

Well, I knew we were coming up at the end, and I assumed the harms would be discussed in great detail by other speakers and panels. In fact, Erin said almost everything I was planning to say just before this, so let’s just briefly summarize the manifest, obvious, and documented harms of so-called gender-affirming care. We won’t even talk about social transition—just puberty blockers, cross-sex hormones, and surgery, which have been discussed in this room today. Reduced bone density and bone strength from puberty blockers. The state of Georgia didn’t include puberty blockers in its bill restricting these procedures because the sponsor had been told that they were entirely reversible. Puberty blockers are just reversible. We know that’s not true. You know it’s not true logically because you can’t turn back time.

And so, if a child has his puberty blocked at age 13 while his peers go through puberty, and he stops taking them four years later, that part at least is obviously not reversible, and we know there are serious physiological effects from this. It likely harms brain health. This is a topic of ongoing research. I happened to come across a report that will be released very soon, which focuses on the adverse event reporting system. So not the Bayer case, not the vaccines, but the FDA’s other reporting systems regarding puberty blockers. Just look at all the reports. There are very profound and underappreciated effects on mental health and cognitive

development from puberty blockers alone. Remember, we haven't even gotten to cross-sex hormones yet. There's psychological distress. There's obviously infertility—at least if these are continued and insofar as they mark the beginning of a treatment pathway leading to infertility—as well as stunted growth, which is quite well known at this point.

Now let's turn to cross-sex hormones. Again, this is already fairly well known: risks to heart health. We don't have long-term data on this—by definition, because we're still in the early stages of this experiment involving children, giving girls massive amounts of testosterone. But we can be quite certain that it will have an impact on heart health. Infertility, for obvious reasons. There appears to be a significant increase in cancer risk, which is also being discussed today. Mental health harm. Many detransitioners, especially women, describe an initial euphoria from testosterone—the same experience men receive testosterone supplementation have. But this is sort of a "honeymoon" period, and after a year or two, many detransitioners report actually quite harmful and distressing mental health effects.

Again, the kind of regret and detransition wasn't supposed to happen, but cross-sex hormones have very specific physiological effects. Some of the detransitioners who spoke today, for instance, commented on the depth of their voice, which in the grand scheme of things may seem superficial, but it's a reminder of the kind of permanent effects these drugs have.

And then, almost inevitably, when we get to the surgeries—this is sort of obvious, and Brandon has given us a few examples—but these are not "one-and-done" surgeries. Most of us who've had surgery—I had to have a quadriceps tendon reattached to my knee in 2019—underwent one surgery followed by a few months of recovery.
The so-called gender-affirming care—in which you create facsimiles of the other sex or of no sex, depending on the doctor's sort of metaphysical theories on these matters, right?—that's not a one-and-done process. These procedures usually require maintenance. They very often require follow-up. In some cases—and I know there are detransitioners in this room—it can take years just to heal the wounds from the initial surgery. That's the reality of the situation.

And then, the one thing that wasn't discussed quite as explicitly as I think it should be is that there is iatrogenic harm right from the start of this procedure. Puberty blockers alone—even if they were reversible on their own—we know that if a child is placed on the transition pathway and starts taking puberty blockers, he or she is much more likely to continue down that pathway toward a full transition. In other words, it fast-tracks children—based on a truly bizarre and almost certainly false diagnosis—all the way to the end. The question of whether puberty blockers alone are sterilizing doesn't quite answer the question. Even if they weren't, if they fast-track children onto a protocol that leads to sterilization, then yes, they are.
These are clear harms.

Now, any surgical or medical intervention carries risks, so why would anyone be willing to accept this? It's almost certainly because of the false trade-off that parents are presented with. If you're a parent—and I'll say I'm someone who works on this issue—I have no personal connection to it. I don't have a child or family member who has struggled with this. But I do know this as a parent: the worst scenario you can possibly imagine for your child is suicide. And so, if you think, "Okay, suicide is the worst," and then you're told by a trusted doctor, "I have a way out for you, though." It sounds terrible in the abstract, but it will prevent the worst outcome. It's only through that emotional blackmail, I think, that most parents would ever have considered starting this process in the first place, and that's precisely why the FTC has jurisdiction over this issue.

Mark Meador:

Thank you.

Paul Dupont:

I don't know what else to add about the harms—the obvious harms—that this causes. I mean, I think the panels we heard from earlier, what Brandon and Jay just talked about—I mean, the harms are numerous and obvious. I don't know if I'd be jumping the gun, Mark, by moving on to the second part of the definition of what makes a practice unfair—that it cannot be reasonably avoided by consumers. When Erin was up here earlier, she mentioned Dr. Johanna Olson-Kennedy and how she said she wouldn't have any issue with transitioning patients who would later regret it because, well, that was what they were asking for at the time. And I feel like that's often used as a weapon against detransitioners who later regret it—as in, "Oh, well, you should take responsibility for your reactions." And that kind of ties into this question: Can this be reasonably avoided?

And I think we have to consider the fact that the system that's been established was really designed to create a pipeline that's easy to get into and almost impossible to get out of once you're in it. So, a few points on that. I mean, obviously, we've heard—again—all the testimony earlier today about the emotional blackmail used right from the start, telling parents, "Would you rather have a dead son or a living daughter?" or vice versa. The ways in which, right from the start, the… Sorry, the ways in which patients are essentially pushed into this and pressured into it through fear-mongering and the like, and then the fact that they aren't fully informed.

This came from a Free Press article about Planned Parenthood, which I think is a particularly bad actor in this regard. Free Press on Planned Parenthood. Planned Parenthood's materials for clinicians state that atrophy can begin within just three to six months of exposure. But on the brief patient consent form—which is about three pages long and was signed by both Hineman and Anna—this was referred to only as genital dryness. There's a lack of informed consent from the very beginning.

And then, once patients are in this system, they're encouraged to continue no matter what's happening. And that, again, is by design. This is from WPATH Standard of Care 8: "We recommend that healthcare professionals maintain existing hormone treatment if a transgender or gender-diverse individual requires admission to a psychiatric or medical inpatient unit, unless contraindicated." That means if they're experiencing some sort of psychiatric episode, the WPATH Standards of Care state that hormones should continue to be administered regardless.

And again, I think we've heard examples of that throughout today. And again, that's not a mistake—it's by design. That's what their Standards of Care state. They're in the pipeline. They're continuing to be pushed down this pipeline. And oh, by the way, if they do have regrets, if they do want to detransition, well, insurance will cover the initial cost of transitioning, but in many cases, various forms of detransition care are not covered by insurance. So there's a financial obstacle to getting off the pipeline as well. I think when you put all that together, you really can't help but conclude that this cannot be reasonably avoided by consumers.

Mark Meador:

Thank you. Looking ahead, if there are in fact legal violations associated with gender-affirming medicine for youth, a critical question will be: what are the appropriate remedies or solutions we should be seeking? Josh, Glenna, and Paul, in your view, what does relief realistically look like for American consumers and patients?

Josh Payne:

An important point to make is that, Commissioner—as you know, of course—the FTC is able to impose civil penalties in certain circumstances. While it does not necessarily distribute that money directly to individual consumers, through its consumer protection authority, it regulates conduct, incentivizes certain behavior,

and discouraging bad conduct. And once it determines through its investigations who it believes it should enforce the law against—the major players and targets—it can bring administrative cases against those individuals. That can take time. But it's useful because, at the end of the process, an order is issued that can be enforced through civil penalties—not just against the respondent, the target, but also against what they call "non-respondents," or parties not involved in the proceeding who are aware of the order and must still comply with it. And if they fail to do so, they subject themselves to those civil penalties.

The FTC—I almost said the FDA—the FTC can engage in rulemaking. Again, that's a time-consuming process that the FTC initiates when it perceives the practices in question to be what it calls "prevalent." I think much of what we've been discussing today—and I know from representing detransitioner clients and handling medical malpractice cases, as my firm does—these practices are indeed prevalent, which would give the FTC the authority to issue rules limiting this conduct.

And finally, what I believe has historically been an underutilized tool in the FTC's toolkit is its ability to go to court and seek injunctive relief. And that's probably the quickest way to stop the misconduct. If an investigation is ongoing, or if an administrative case is in the pipeline or pending—the FTC handles all of that in-house—it can separately go to a federal judge and obtain virtually immediate injunctive relief following a sort of mini-trial or evidentiary hearing where it can present its case and argue, "This is urgent."

And interestingly, this applies not only to ongoing violations but also to prevent anticipated violations. It is not a valid defense for a hospital system or pharmaceutical company to argue against the FTC's request for injunctive relief by saying, "Well, we aren't violating the law yet." If there is an imminent threat and they are about to violate the law, the FTC is still entitled to seek that injunction from the court to stop the anticipated violations. Those are the key remedies available. And I would draw particular attention to the remedy of injunctive relief, which may not be the FTC's immediate instinct—naturally, they might think, "That's not where we want to go," since they can handle so much internally—but I think it's a very useful tool that the Commission should certainly consider.

Mark Meador:

Thank you.

Glenna Goldis:

One of the major societal harms resulting from this scandal is the decline of medical institutions, particularly medical societies and medical journals. You heard about that earlier today. We have these institutions—which are essentially healthcare lobbying groups, such as the American Medical Association and the American Academy of Pediatrics. But the fact is, Americans want these institutions to provide them with reliable information that appears objective. Everyone in America wants that. But unfortunately, we've seen that, in reality, these organizations have become politicized on gender issues. They've dismissed dissenting views. They've only published material that supported their own positions and have even published errors at times. And of course, the associations have issued endorsements—or de facto endorsements—of practices that are not evidence-based and that are harmful.

And so, I don't think the government should step in and force them to be objective. That's not possible. But I think that by taking action against them—by seeking injunctions, as Josh says, against their deceptive activities—that will put pressure on them to change. And also, simply the act of conducting thorough investigations as part of pursuing a prosecution and making that public will be really helpful in exposing the medical associations to the public and to themselves, so that they see a way back—because they're at the point where they're going to start losing members. Pediatricians are going to think, "You know what? This group isn't representing me well. They're actually making me look bad. I don't like what they're doing. I'm not going to pay dues anymore."

They could lose other sources of revenue as well. There have already been reports that the American Medical Association has lost influence on Capitol Hill because it's simply perceived as being so aligned with the left. And as I said, it is fundamentally a lobbying organization, so this is a major problem for it. It has its own reasons for responding to the FTC's actions and reforming itself.

Mark Meador:

Thank you.

Paul Dupont:

And I'll just add to that: I think, obviously, both Josh and Glenna here have covered many of the different avenues the FTC can pursue. I think there's also a broader government-wide approach here as well, right? We had representatives from the DOJ here earlier, and they certainly have a role to play in this. The memo released by Attorney General Bondi earlier this year outlined a number of different pathways, which it sounds like they are pursuing—enforcing statutes against female genital mutilation, addressing violations of the Food, Drug, and Cosmetic Act, and the False Claims Act. I mean, we've already heard about billing fraud issues numerous times. There are all sorts of avenues for holding people accountable, I think.

And then, regarding the FDA, all of these drugs are being used off-label. The FDA certainly has the authority to commission a review of the off-label use of puberty blockers and to warn manufacturers of the consequences of promoting such off-label use, if they are doing so. Which, again, I think definitely presents an avenue for investigation. There's certainly a lot the FTC can do, and I think there's also a lot that other state agencies can do as well.

Mark Meador:

Thank you all for those comments. Investigating the effects you've all outlined regarding gender-affirming medicine for youth and the claims made about them will certainly be a priority for the agency moving forward, but in doing so, we'll need the best available information we can obtain. As we explore this topic in accordance with the law, Jay and Brandon, who should we at the FTC be talking to as we investigate, and what are some of the key questions we don't yet have answers to?
And generally speaking, what does a comprehensive investigation look like?

Brandon Showalter:

Well, one of the things I've appreciated about today is that names have been named. Erin said a moment ago that some doctors from California should be at the center of the investigation. Start with the people who've been named today and just start digging around, and you'll uncover a hornet's nest—their associates and affiliates.

I think the other people it's so important to talk to are the parents, because I've been getting messages all day from the hundreds of parents who are watching this—overjoyed, gushing, and elated that a federal agency has organized this day-long seminar—because they've felt so unseen and hidden. They've lived in a straitjacket of silence. And so, the fact that there are federal lawyers who are willing—I mean, they're literally probably dancing in their closets, watching this. Some of them live inside a cone of silence, even within their own homes and neighborhoods. They haven't had a voice. They can tell you firsthand how they were deceived and misled. They haven't been heard.
Dr. Grossman has been an excellent advocate for them. But the voices of the families that have been shattered into a thousand little pieces—you want to talk about how they were misled, deceived, and

torn apart. Talk to the parents and zero in on the predatory doctors who have been named today. That will get you started.

Mark Meador:

Thank you.

Jay Richards:

Yeah, what Brandon said—essentially the same thing. I mean, obviously, everyone who has attended this event, everyone who has been on this stage today—starting with them—and everyone who has attended. But I can tell you, as someone who spent several years working on this in the policy arena and elsewhere, that in some ways I feel like some of us here are probably reaping what others sowed years ago.

This was a very tough issue at first, and it felt like there was absolutely no way to win. Now, I just happened to be convinced that no, there's no way this can ultimately be sustained because it contradicts what we can observe with our own senses and things that everyone knows. This isn't some abstract concept—it's simply stating, "There are males and females, and we can tell the difference." That's what we were dealing with. Nevertheless, it was really hard at first to get people to believe that this was happening.

It was hard to get Republican members of Congress and their staff to think, "Okay, yeah, this is something—maybe, okay, maybe it happens in California or somewhere, but it's not widespread." I mean, that was the prevailing view. I recall a state hearing in Nebraska with Luke Hein, a detransitioner who had undergone a double mastectomy, and someone else was testifying and insisting that it never happened in her state—that it didn't happen there—even though there was a victim right there in the room. That's the level of denial regarding the reality of the situation.

And so, as awful as it was at first when detransitioners started deciding, "Okay, we're going to talk about this," that changed the game entirely because you can have 12 people making interesting scientific and philosophical arguments, and one detransitioner just kind of wipes them out. And so, having parents and children—who are the primary victims of this ideology as it manifests in medicine—at the forefront is crucial for demonstrating just how fundamental and real this issue is and why it matters.

But then also, the experts themselves—the specific specialists, including many of the medical scientists here, alongside competent generalists and translators. It's kind of hard to describe this, but sometimes a medical specialist, despite all their expertise, can also be subject to confirmation bias and a narrowing of perspective. But the generalist often lacks a grasp of the details. And so, a combination of people who've studied this as generalists—who've translated it into what matters—and the specialists is absolutely crucial.

And then, just to reiterate what Brandon said, you should talk to the members of the committees and medical associations that developed their respective guidelines—such as the American Academy of Pediatrics, the Endocrine Society, and the American Psychiatric Association. Ask them not just in general terms, but specifically how they developed those guidelines and what scientific procedures they followed to do so, and find out what they have to say. And then—

Brandon Showalter:

Just a quick add-on. I'd like to add that, in my view, the biggest stronghold—to put it that way—is that the medical societies and the courts are the main forces keeping things rooted in insanity here in America. Because if you have court systems that have been ideologically co-opted—as the FTC takes action and tries to adjudicate these matters—and if they defer to these medical organizations, what was so ingenious about what the state of Alabama did was that they challenged WPATH's much-touted guidelines, and

they correctly identified that as the source of the problem. Because once they dismantled that, they were able to show the judges that all of this was just nonsense. Yeah, put the screws on those who are writing these junk guidelines because they're just based on lies, and I think that will open the floodgates.

Mark Meador:

Thank you. Thank you both. And Jay, one of the things you said reminds me—someone Brandon and I both know likes to say that bad ideas can only withstand the weight of reality for so long. And it seems like that's what we're approaching here. And so, I appreciate all of your comments today from the entire panel. It's been incredibly insightful, and I think it gives us a lot to consider as we move forward as a commission.

I'm sure we could discuss this all day long, but unfortunately, that brings us to the end of our time for today's panel. I'd like to take this opportunity to once again thank our distinguished guests for their time and their thoughtful reflections.

To wrap up the day, we've had a remarkable and groundbreaking workshop. We repeatedly heard from parents and individuals gravely impacted by youth gender medicine gone wrong, who suffered the harms of misrepresentations about the effects of these medical interventions. We heard from critics of the politicization of scientific debate in this area, who explained the various pressures that prevent researchers from speaking openly about their findings and how all of this ultimately results in medical decisions being made without the best available data. Parents and young people deserve better.

We heard from scientific experts and ethicists who addressed the state of research in this area—experts willing to examine the data rather than merely parrot the slogans of activist organizations—and what they had to say was deeply concerning, or at least it should be to anyone concerned with the well-being of American children. We heard from whistleblowers who risked everything to reveal the truth about what has been done in the name of so-called gender-affirming care. All too often, we learned that medical decisions have not been guided by the science. Shortcuts have been taken, ethical boundaries have been crossed, and young people have suffered the most.

At this most recent panel, we heard from experts who are helping us chart a course forward as we continue to address this issue as a commission. These conversations have been so important because, for too long, those in power have only given a voice to one side of this debate. Sadly, it was the side that is perpetrating the very fraud that needs to be exposed and stopped. That changed today as those of us with the power to effect change finally gave a voice to the powerless. I am very grateful for our panel's insights and the contributions of everyone who joined us today. We will need them in the months and years ahead. No child should suffer from dangerous, unproven, and unwarranted medical interventions, especially if those interventions are unfair and deceptive.

This workshop may be drawing to a close, but the commission's work has only just begun. To that end, I'd like to thank the chairman and my colleague, Commissioner Holyoak, for their leadership and commitment to the issues of youth, gender medicine, and the related consumer protection concerns. Together, we look forward to fighting even harder for the best available science and for the rights of children and families. And I'd like to thank all the distinguished and courageous guests who have spoken to us throughout the day. Let's please give them another round of applause.

And then, last but not least, I do want to give special thanks to Johan Schweppe in the chairman's office for all the great work he put into ensuring this workshop was a success. Thank you all, and Godspeed.

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Genspect

January 2025

Resource for Gender Dysphoria

Survey for family and friends

Survey for parents

Based on DSM-5-TR criteria,
to promote awareness and understanding



Submitted on March 5 by an anonymous father; name known to Genspect

Tip:

It only takes 5 minutes!

Filling out the entire survey takes a lot of time and requires detailed insight. Want quick results? Then just fill out page 22—it takes only 5 minutes. Next, send the complete 27-page document to the clinic, your primary care physician, and your insurance provider. If this doesn't yield the desired result, you can always fill out the entire survey later.

Gender-related issues are complex. You or the people around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Reach out to organizations that specialize in gender-critical topics.

Dear Parents,

We regularly receive desperate messages from parents whose voices are ignored during their child's gender clinic evaluations. Although they are invited to participate in the diagnostic process, their crucial insights are routinely dismissed in favor of immediate confirmation.

The current system is deeply troubling: *although clinics seek parental input, the child's statement regarding his or her desired identity overrides the family's years of knowledge and observations. As a result, these consultations are effectively nothing more than administrative formalities—"checking boxes on insurance forms" rather than meaningful clinical evaluation. (Specialists at VUmc even suggest that the patient's wishes should take precedence, regardless of whether the treatment works or not, ed.[39])*

This practice fundamentally undermines the quality of health care. ***Parents and family members possess important knowledge that is not adequately captured through brief clinical consultations alone.*** *A meta-analytic review by Dowell and Ogles (2010)[1] and a meta-analysis by Sun et al. (2019)[2] demonstrated that parental involvement in their child's treatment has a positive effect on its overall effectiveness. Parents are familiar with their child's patterns, struggles, and changes in personality. They are often the first to notice underlying issues that may contribute to their child's distress. Yet these essential insights are often overlooked.*

Gender-related stress can arise in many different ways, which means there are also multiple paths to a solution. When clinics automatically prioritize the desire to transition and rely entirely on a young person's self-report, they miss opportunities to explore other, less invasive approaches to alleviating the stress.

To help families advocate for thorough, evidence-based care, we have developed two complementary tools:

1. The Family and Friends Survey—*This questionnaire gathers observations from family members and others who have known your child for a long time. When multiple observers share the same perspective, their collective insight becomes harder to ignore.*

2. The Family Questionnaire—*This detailed questionnaire helps identify underlying factors that need to be examined before irreversible interventions are considered.*

We recommend completing these questionnaires regardless of whether the family currently supports direct transmedicalization. Together, they provide a complete picture, ensuring your child receives the careful and thorough assessment they deserve—one that examines all contributing factors rather than rushing to medicalization. When multiple surveys have been completed by family members, we recommend printing them out and handing them in person to your child's healthcare provider. Also send electronic copies and keep them for future reference. This ensures that the family's opinion cannot be easily ignored—it is now officially documented and can be consulted in the future. ***We also recommend sending the completed survey to your primary care physician and insurance company (or, in Belgium, the health insurance fund)****, so that all parties involved are informed about the complexity and concerning aspects of cross-sex medication and surgery.*

The survey also offers an additional benefit in that it gives the extended family the opportunity to engage with this topic in a thoughtful way. It invites them to remain or become a supportive presence in the life of your vulnerable child. Concerned parents often avoid discussing gender, but this is not always helpful. Ignoring the "problem" is a common reaction to mental health issues within the family, but it is often less effective than it seems. Although parents and young people may avoid conflicts over trans issues this way, the young person often holds onto a carefully constructed identity, which can hinder the recovery process.

Remember: ***Questioning the current approach does not mean rejection.*** *The goal is for young people to receive appropriate care that, above all, does no harm. Your knowledge of your child matters, and these tools will help you effectively advocate for a thoughtful and comprehensive assessment.*

By working together and using these tools, you can ensure that your voice is not only heard but also documented. Your insights are invaluable, and advocating for thorough, evidence-based care is essential to your child's well-being.

Sincerely,
Stella O'Malley/Genspect, January 2025

1 Dowell K. A., Ogles B. M. (2010) **The Effects of Parent Participation on Child Psychotherapy Outcome: A Meta-analytic Review.** https://www.tandfonline.com/doi/abs/10.1080/15374410903532585
2 Sun M., Rith-Najarian L. R., Williamson T. J., Chorpita B. F. (2019) **Treatment Features Associated with Youth Cognitive Behavioral Therapy Follow-up Effects for Internalizing Disorders: a Meta-analysis.** https://pubmed.ncbi.nlm.nih.gov/29677451/
39 Annelou L.C. de Vries et al. (2024) **Gender-affirming medical treatment for adolescents: a critical reflection on "effective" treatment outcomes** https://bmcme-dethics.biomedcentral.com/articles/10.1186/s12910-024-01143-8

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General information

Information for Parents

Panic Within the Family

Your child has told you that he or she is questioning their gender and wants to visit a gender clinic at the hospital. How do you respond to this situation with the hospital? Many families are caught off guard by this topic, leading to years of emotional turmoil and discussions, often with mounting pressure. The self-identified gender identity of the child or young adult may not be immediately recognized by family members, and when it is, there are often legitimate concerns about pursuing irreversible medical interventions.

Understanding Self-Reported Identity

The core problem in clinical assessment is that the experienced "gender identity" is not physically measurable. Invasive, irreversible healthcare decisions must be based on objective evidence, not solely on the patient's subjective experience. To quantify observable patterns, we designed a survey not only for immediate family members but also for the broader circle of people who know the individual well, preferably from birth: friends, neighbors, and teachers. The survey follows the criteria described in the DSM-5-TR (the standard handbook on mental disorders).

Clinical specialists often dismiss parental observations, explaining that the child did not feel safe expressing themselves to their parents. Although this may be true in some cases, especially in highly conservative or religious families, it becomes less credible if no one in the extended family or social circle has ever noticed any signs. A cousin, childhood friend, neighbor, teacher, aunt, or grandparent—someone would likely have noticed something over the years. "Gender expression" is crucial to the diagnosis. **If no one has ever noticed anything, the story simply doesn't add up.**

The Gender-Affirming Model

A fundamental principle of the gender-affirming model is that the patient's feelings are central to the care process. This raises a troubling issue: it is not limited to the patient's wishes; rather, the patient's self-diagnosis is the determining factor in the diagnostic process, which is automatically followed by clinical psychologists or psychiatrists.

Discussing these concerns with friends and acquaintances can quickly lead to debate. A common defense is that the care provided is of high quality and carried out by highly skilled experts. Parents or partners who question this process receive little understanding or support and are dismissed as overly suspicious. Hospitals tell the press that they conduct very thorough diagnostic evaluations before taking any significant steps.

How does a diagnosis work?

We now know from experience that the diagnostic process differs from how it is often portrayed in the media. The hospital makes a diagnosis based on a method that is entirely focused on the person's self-diagnosis. We will describe the procedure in Dutch clinics; it is likely that Belgium follows a similar approach.

As soon as a person is admitted to the gender clinic, a questionnaire is administered. The person must then write a letter explaining their feelings. The letter corroborates the questionnaire, and vice versa. These self-diagnostic documents are considered evidence of "gender incongruence." The letter and the questionnaire corroborate each other but share the same source. **An additional problem often cited is that the person is following a learned script.** The clichéd language suggests that the ideas do not stem from personal experience but are rather imposed or instilled—learned from the internet. "Gender incongruence" is not the same as "gender dysphoria," although the terms are often used interchangeably. This can be very confusing. "Gender incongruence" refers to a discrepancy between one's experienced "gender identity" and biological sex, whereas "gender dysphoria" involves significant distress associated with this experienced discrepancy. This is an important distinction. **It remains a mystery why insurance companies (in Belgium: health insurance funds) cover a treatment process based on incongruence, yet one in which psychological distress need not be a necessary component.**

Current Clinical Practice

In the Netherlands today, no comprehensive differential analyses are conducted. Although clinics assess whether someone has psychosis, autism, narcissism, or other mental disorders, these additional conditions are noted and taken into account in the care process, but not used to substantiate the "gender incongruence" diagnosis. The question simply becomes: Is the person mentally and physically fit enough? This is not a differential approach, but **an assessment of readiness for medical treatment**.

With the exception of psychosis, severe depression, and related extremes, there is no rejection based on traumatic experiences, a history of bullying, autism, or other mental health issues, and the insurance (in Belgium: the health insurance fund) covers the process (with the exception of a small copayment). **In the Netherlands, even people with intellectual disabilities receive gender-affirming care.**[3]

Insurance companies (in Belgium: health insurance funds) trust that the care provided is adequate. On paper, the questionnaire and motivation letter appear thorough. However, this perception was challenged when Dutch parents introduced a rigorous, systematic intervention in the form of a family questionnaire, which revealed something entirely different and exposed the limitations of self-diagnosis. This questionnaire is based on that approach, and it gives you, as a concerned parent, significant influence over the process.

Perception of the Environment

The gender teams claim to be committed to maintaining peace within the family. Because the care file must give the impression that a broad perspective is being considered, they actively encourage conversations with parents, partners, and others directly involved. Anyone familiar with gender-critical literature—such as the books by Abigail Shrier and Hannah Barnes and the testimonies of whistleblower Jamie Reed—knows that the reality is much darker. Parents are formally invited to share their perspective. The healthcare provider nods politely, takes notes as accurately as possible on the family's impressions, and reassures them that he understands. While many parents do not support their child's self-diagnosis, some go along with their child's perspective, while others remain critical.

In follow-up meetings, the family's concerns are acknowledged, but the diagnosis is still considered final, and the treatment plan proceeds as planned. The family's impressions are noted but do not influence the final decision. In fact, their concerns are even used against them in a counterproductive way to make the investigation appear more thorough on paper in order to meet insurance requirements (in Belgium: reimbursement requirements). Parents who give their consent despite their doubts often do not realize the implications until later. A well-known example of this dynamic was revealed in Elon Musk's interview with Jordan Peterson in July 2024.[4]

3 **Genderpoli / They and Them (Nov 2023).** Dutch documentary about YOUZ https://www.npodoc.nl/documentaires/2023/11/genderpoli-they-and-them.html

4 **Elon Musk interviewed by Jordan Peterson (July 2024)** https://www.youtube.com/watch?v=Q20Nbq3EJsc

Explanation of the Family and Friends Survey Information for Parents

Purpose of the Family and Friends Survey

Based on the key findings of Shrier, Barnes, Reed, and other concerning publications about clinics, we have developed an assessment method that goes beyond parental input alone and also incorporates broader family observations.
The survey, based on the DSM-5-TR criteria for "Gender Dysphoria," is designed for adults who have known the individual for a long time and have detailed knowledge of his or her development. These may include family members, neighbors, cousins, childhood friends, former teachers, and work supervisors. Through this comprehensive approach, we aim to support healthcare providers and families in making well-informed, evidence-based decisions.

Systematic Documentation and Clinical Validation

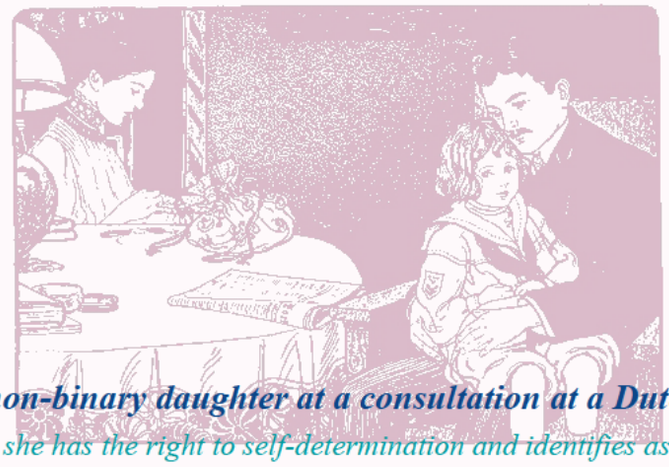
The primary value of the family and friends survey lies in its ability to objectify parental observations. Patients may claim that their "gender incongruence" has always been present but hidden, or that parental resistance stems from conservative views, but these assertions require careful clinical evaluation.
Research by Abigail Shrier shows that parents seeking a thorough assessment are often open-minded, accepting of sexual diversity, politically progressive, and frequently successful and highly educated individuals with a deep understanding of their children's development.
The survey results consistently show that family members and acquaintances often share the same observations as the parents. This becomes particularly relevant when multiple observers from different contexts report no prior signs of gender incongruence. Early developmental patterns are typically observed by at least some members of a child's social network. **Therefore, this systematic documentation constitutes a crucial clinical tool that deserves serious consideration.**

Gender-critical perspectives are not far-right politics

It is important to note that Shrier, Barnes, and especially Reed (a lesbian healthcare professional who was married to a transgender person when she made her whistleblower statement) are **progressive intellectuals**. This demonstrates that the critical analysis of current gender clinic protocols stems from diverse intellectual backgrounds, rather than from a specific ideological political position.

Impact on the Diagnosis

The survey results provide the specialist with insight into how the entire family perceives the patient and give greater weight to the aspect of family issues in cases of differing opinions. Official guidelines for transgender care offer little information on family matters, but **ignoring family dynamics when considering irreversible medical interventions raises serious ethical concerns.**
If there is a social divide, relationship therapy should take place first. **Disrupting the family through a care process involving a high degree of family friction raises serious ethical concerns regarding patient care and the well-being of the family.**



Father of a 21-year-old non-binary daughter at a consultation at a Dutch clinic

"My daughter is 21, so she has the right to self-determination and identifies as non-binary. She didn't want hormones, but she did want a double mastectomy. To my great surprise, that's actually possible in the Netherlands! I wanted to speak with the clinic and was invited. The psychiatrist began by saying, 'If your daughter wants to end the conversation, it's over immediately. She's completely in control.' Later, he said, 'I actually don't think a psychiatrist needs to be involved at all. Unless, for example, there's severe depression or psychosis; then we'll take a different approach. If you say what you are, then that's what you are—that's enough for me.' The psychologist compared the situation to getting a tattoo or emigrating: "Sometimes children make choices you're not happy with, but as a parent, you'll still have to accept them."
"My daughter and I haven't been in contact since the surgery a few months ago because of our difference of opinion."

Explanation of the Family Survey

Information for Parents

Clinical considerations regarding coexisting conditions

Due to growing scientific skepticism regarding the gender-affirming model and emerging research findings, we have developed this survey to assist clinicians in thoroughly evaluating potential coexisting conditions. When a young person has experienced trauma, exhibits self-hatred, or has a neurodevelopmental disorder such as autism, careful consideration must be given to how these factors may influence their self-reported "gender dysphoria." This thorough evaluation is essential before considering irreversible medical or surgical interventions, in line with the fundamental principle of medicine: **"Primum non nocere" (first, do no harm).**

Diagnostic overshadowing

The **Cass Review** warns against **"diagnostic overshadowing**." The specialist may attribute the problem to the wrong cause. Patients may attribute their discomfort to medical conditions rather than linking it to other underlying factors and addressing those. This pattern has been observed more frequently in previously suddenly prevalent conditions such as RSI (repetitive strain injury), false memory syndrome, and dissociative identity disorder. These conditions often share characteristics such as recent widespread recognition of the phenomenon, difficulty in objective measurement, and a primary reliance on patient self-reporting. Although the discomfort is real, potential nocebo effects (negative expectations that trigger the symptoms) warrant attention. Because gender-affirming treatments often involve irreversible medical interventions, the implications of diagnostic overshadowing are significant. Recent data indicating a 30% dropout rate at follow-up raise concerning questions. Therefore, thorough documentation and a comprehensive evaluation are essential before proceeding with medical interventions.

SOC-8 and the Dutch Protocol in Conflict with the Cass Review

Shortly after the publication of the Cass Review, Dutch clinics issued a statement claiming that the practices described in the report were already standard practice in the Netherlands. **This is incorrect.** The original Dutch protocol was based on **patients who, from a young age, exhibited clear gender-nonconforming behavior** and expressed a desire to be of the opposite sex. In addition, a strict requirement was that the children had **no other problems** and that they had **family support.**

The so-called **"real-life test"** was also part of the protocol. This was a two-year phase during which individuals had to live as the opposite sex. This allowed them to experience the practical consequences of their transition and to demonstrate to the clinic that their desire was sincere and well-considered. This procedure was eliminated in 2014. Today, individuals diagnosed with "gender dysphoria"—based entirely on their own self-report—can begin hormone therapy immediately after receiving a formal diagnosis. Although this approach increases accessibility, it can lead to challenges, such as unrealistic expectations or unexpected problems that were not apparent before the transition. The practice in the Netherlands (and Belgium) corresponds to what is described in Barnes's book and represents precisely the core of the criticism Cass voices in her report.

Impact on Family Dynamics

The lack of evidence-based explanations creates significant concerns for families. Parents often experience severe stress during this process, and poor communication from the clinic can exacerbate the family's distress. When clinics fail to address the family's concerns or provide clear clinical justification, **this can cause iatrogenic* harm to the family.**

Conducting the Family Survey

The family survey contains a comprehensive list of conditions often associated with transgender self-identification. Parents are asked to indicate which of these conditions they have observed. **When submitting the survey, explicitly ask the clinic for feedback on:**

- Whether the specialists have observed the same patterns
- If not, what the clinical basis is for their different observations
- How Identified Disorders May Affect Self-Reported "Gender Dysphoria"
- What specialists believe to be the proposed mechanism of interaction between the conditions

The clinic's responsibility and family rights

Although respecting patient privacy is important, open communication remains essential, particularly in cases of gender dysphoria, given the far-reaching implications of irreversible medical interventions and their impact on long-term health. Decisions affect the entire family and can cause significant stress-related health risks. **Therefore, the family has the right to receive sufficient information to understand and process clinical decisions.** When clinics refuse to address these concerns, they risk causing iatrogenic harm, not only to the patient but also to the family**. Healthcare providers must uphold ethical standards that take into account both the individual's well-being and that of the family.** They must not "create" patients.

Parent of a daughter with multiple conditions

> *"Our adult daughter developed a non-binary identity during high school,* ***partly due to social and online influences.*** *She decided to have her breasts removed to prove that she was 'transmasc.' Despite a letter* ***detailing her additional mental health conditions—such as eating disorders, autism, trauma from bullying, and obsessive-compulsive disorder (OCD)****—our healthcare provider removed our daughter's healthy breasts. The medical organization never contacted us to discuss our daughter's mental health issues. We can thank the incompetent therapists for enabling this self-hatred and self-harming behavior."*

5 H. Postma (Oct 2024) **The Dutch Leaks: Trans Regret is Possibly 33%** https://genspect.org/trans-regret-is-possibly-33/

* "Iatrogenic" means: harm caused by the treatment itself.

Early and Late Onset of Gender Dysphoria

Information for Parents

Characteristics According to the DSM-5-TR

The DSM-5-TR provides two sets of criteria for identifying gender dysphoria (GD): early-onset and late-onset.[6]

Early-Onset Gender Dysphoria (EOGD)

Children are typically diagnosed with gender dysphoria if they have experienced **significant distress** for at least six months and exhibit **at least six of the following characteristics**:

- A strong desire to be of the opposite sex or a persistent belief that they belong to the opposite sex.
- A strong preference for wearing clothing typical of the opposite sex
- A strong preference for roles associated with the opposite sex during pretend play or fantasy play
- A strong preference for toys, games, or activities stereotypically associated with the opposite sex
- A strong preference for playmates of the opposite sex
- Strong aversion to toys, games, and activities typical of one's own sex
- Strong aversion to one's own physical sex characteristics
- Strong desire for the physical sex characteristics of the opposite sex

Late-Onset Gender Dysphoria (LOGD)

To be diagnosed with gender dysphoria as a teenager or adult, there must be at least six months of significant distress due to at least two of the following characteristics:

- A clear incongruence between the primary or secondary sex characteristics of one's own sex and the experienced and expressed other sex
- A strong desire to rid oneself of the primary or secondary sex characteristics of one's assigned sex
- A strong desire for the primary or secondary sex characteristics of the other sex
- A strong desire to be of the other gender
- A strong desire to be treated as the other gender
- A strong conviction that you have the typical feelings and reactions of the other gender



Parent of a teenage daughter who has paused her transition

"From age 11 to 15, my daughter struggled with anxiety, PTSD, and possibly ADHD. She learned about 'transgender' from ***spending too much time online, school counselors who discussed it with her behind our backs, and her peers at school.*** *It was incredibly disappointing and confusing that every professional I trusted to help our daughter achieve a more holistic self-understanding focused solely on 'gender identity.' Our concerns that our daughter's stress was a maladaptive coping mechanism and that she was being influenced by others were dismissed. Her private therapist called us* ***"non-accepting parents."*** *The school counselor encouraged "identity exploration" and supported the idea that my daughter "might actually be a boy," and changed her name and pronouns at school. When she became withdrawn and depressed, I realized that our daughter, at age 14, had been secretly speaking with a trans-ideological licensed social worker about the medical aspects of "her gender," hormone injections, and surgeries. All of this happened without our knowledge or consent. Surprisingly, even our pediatrician—despite all the issues our daughter was struggling with—promoted the "options" of puberty blockers and binders.* ***These adults placed their blind trust in a child,*** *without understanding the process of identity development and without realizing that my daughter's focus on gender identity was fueled by those who spoke to her about it as if it were a real possibility. My daughter decided to stop just before her 16th birthday, and is now incredibly grateful that I did not give in to her constant demands to see her as the other gender and to allow medical interventions.* ***Our family will carry the aftermath, the trauma, and the anger from this experience with us for the rest of our lives, and we consider ourselves victims of a terrible medical-ethical scandal."***

6 **DSM-V-TR online:** https://archive.org/details/dsm-5-tr/page/n1/mode/2up

The Illogicality of the DSM-5-TR Criteria

Information for Parents

The illogical nature of the DSM-5-TR criteria for "gender dysphoria"

Share with family and friends

Feminism and Gender Role Patterns and Expression

Feminism rightly criticizes the stereotyping of male and female role patterns. After all, every person should be free to express themselves without being constrained by social norms such as "girls play with dolls" or "boys have to be tough." A person exhibits certain behavior because he or she finds it enjoyable or interesting. **That should remain free from speculation about supposed "gender identity."**

The DSM-5-TR and Outdated Gender Stereotyping

However, in the DSM-5-TR criteria, the vaguely defined term "gender expression" and gender role patterns are indeed used as indicators of experienced "gender dysphoria." For example: A boy with a strong preference for "girls' toys" or girlish behavior may meet the criteria for "gender dysphoria." **This approach is a regression to outdated stereotypes** and contradicts the feminist idea that behavior is independent of sex. Feminism rightly emphasizes that breaking gender stereotypes is precisely not an indication of so-called "gender incongruence" and should have no medical or diagnostic significance whatsoever.

Context of "gender dysphoria"

The DSM-5-TR attempts to identify "gender dysphoria" in individuals who experience psychological distress due to a perceived incongruence between their gender identity (based on outdated stereotypes) and their sex. It is therefore not purely about behavior, but about behavior combined with significant distress. The inclusion of gender stereotypes as a criterion is problematic, as it can lead to **the unnecessary pathologization** of individuals who simply do not conform to traditional gender role patterns.

Homosexual individuals, artistic people, and people with autistic traits or mental health issues often exhibit atypical behavior. The person's self-assessed conclusion must be examined. Why does the person come to the conclusion that he or she belongs to the opposite sex or to no sex (non-binary), even though this is not a biological reality? A better solution is to make the diagnosis independent of gender stereotypes. Freedom in "gender expression" renders transmedicalization unnecessary. After all, why damage a body when someone can simply express themselves in any form they choose?

What does the DSM-5-TR analyze?

The DSM-5-TR criteria thus analyze whether a person behaves in a gender-conforming or gender-nonconforming manner based on outdated gender stereotypes. **This is fundamentally flawed**, but if a person clearly behaves in a gender-conforming manner according to their social environment, this should be a major red flag for the clinic, and no transmedicalization should take place. After all, the DSM-5-TR criteria state that there must be gender-nonconforming expression, and that is precisely what is not visible in this group.

Even if gender-nonconforming behavior is present, that is **still not a legitimate reason** to proceed with transmedicalization, because the atypical behavior may stem from entirely different causes, and this cannot be determined using the overly simplistic and incorrectly formulated DSM-5-TR criteria. The clinic will have to demonstrate how it actually arrived at its diagnosis. It is to be expected that they will be unable to do so, as there are no measurement methods for this. **"Primum non nocere" (first, do no harm) takes precedence over the medicalization of what cannot be determined.**

Is the family and friends survey then unnecessary?

It is common for family and friends to go along with the person's narrative out of compassion. Part 1 of the survey, which is based on the DSM-5-TR, prompts friends and family to reflect on how illogical the diagnostic criteria actually are and that they should never serve as the basis for consenting to highly invasive, body-damaging transmedicalization. The subsequent sections of the survey provide the clinic with additional insight into what is going on with the person.



Rapid-Onset Gender Dysphoria (ROGD) Information for Parents

Characteristics of Rapid-Onset Gender Dysphoria (ROGD)

ROGD, or Rapid Onset Gender Dysphoria, is a hypothesis proposed by Dr. Lisa Littman that describes **the sudden onset of gender-related distress**, particularly among adolescents and young adults with no prior signs of "gender dysphoria" during childhood.[7]

The ROGD hypothesis suggests that gender-related distress may be influenced by social and environmental factors, including:

- social isolation (e.g., during the COVID-19 pandemic)
- the influence of the internet (due to increased online activity on social media)
- underlying anxiety
- misinterpretation of other mental health issues
- dynamics within the group of friends

The Family and Friends Survey as an Indicator of ROGD

An unexpected finding emerged during the development of the family and friends survey: The tool confirms the likelihood of the ROGD hypothesis. Littman's hypothesis sparked significant clinical debate worldwide, as it directly conflicts with the gender-affirming model, which views gender identity claims as innate and immutable.

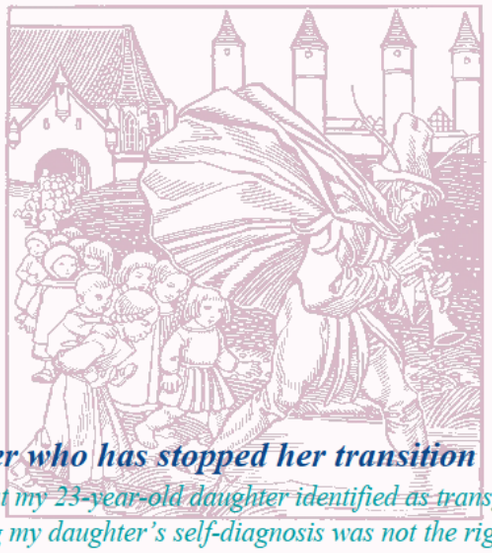
A common criticism of Littman's research—that it was based on parent interviews rather than direct patient accounts—ignores important methodological considerations regarding self-report bias in clinical assessment. **The family and friends survey helps to objectify parents' observations** by providing systematic documentation of when and how gender-related stress developed.

The scientific consensus is shifting

A rapidly growing group of experts, including **Hilary Cass, Jonathan Haidt, Gordon Guyatt (EBM), Richard Dawkins, Ray Blanchard, Stephen Levine, Michael Bailey, Ken Zucker, Marcus Evans, Michael Biggs, Riittakerttu Kaltiala**, and many other leading researchers, supports Littman's analysis. Partly because of these experts' academic credentials, ROGD should be taken more seriously than gender clinics would have us believe. Their view no longer aligns with the growing awareness in 2025 that social contagion very likely plays a major role in the extreme increase.

Important to Know

The existence of ROGD is often ignored by clinics that offer "gender-affirming care" because it directly conflicts with the provision of medication and surgery, since this type of gender-related distress is not innate but socially induced. The clinic must prove why someone does not have ROGD. We, as parents, do not have to prove that ROGD exists. **This is a reversal of the burden of proof imposed on parents who are not specialists and do not have research resources at their disposal.**



Parent of a 23-year-old daughter who has stopped her transition

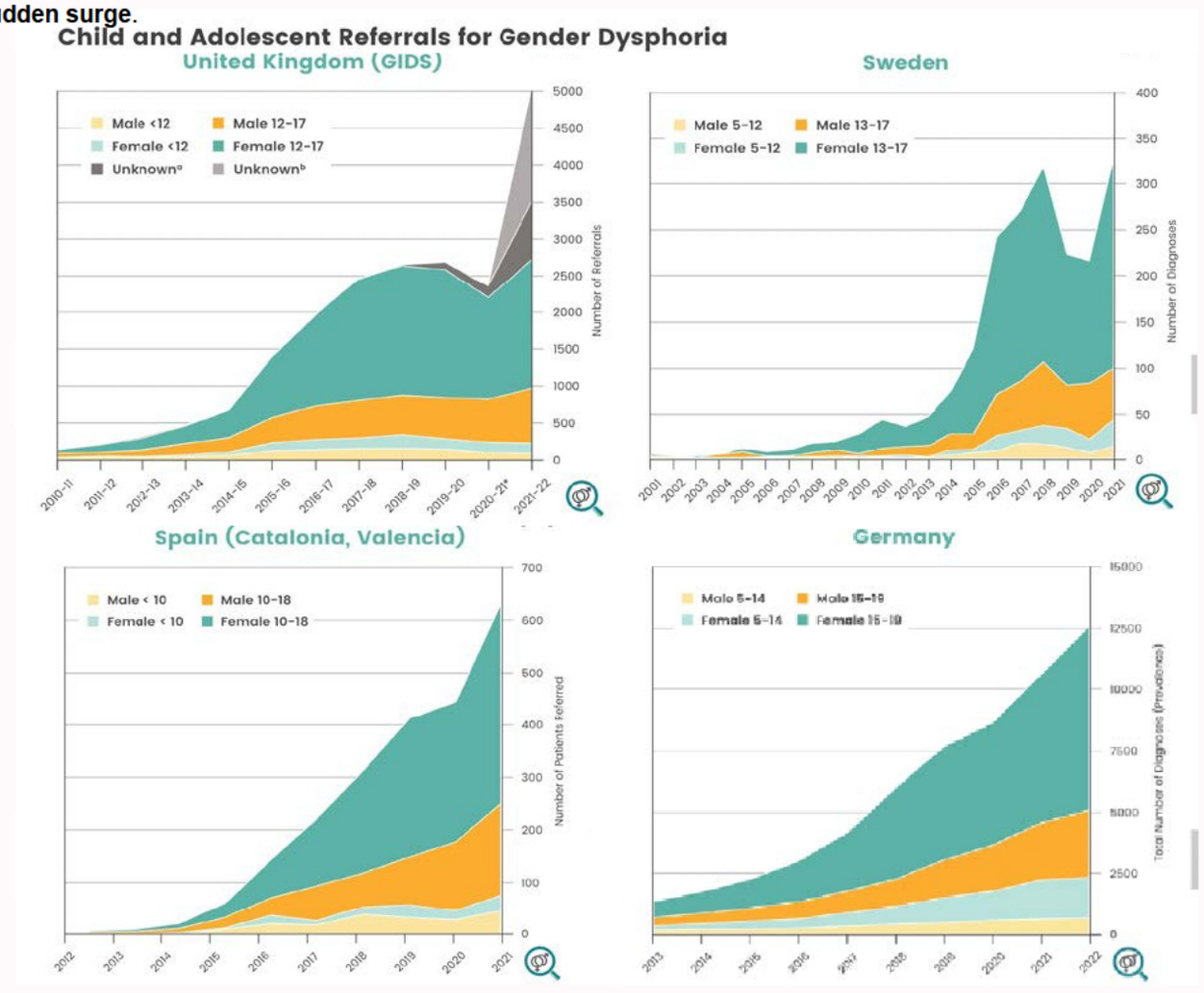
"When I told our family doctor that my 23-year-old daughter identified as transgender, she immediately referred us to the gender clinic. I felt that confirming my daughter's self-diagnosis was not the right course of action. I wanted to talk to the doctor about the phenomenon of ***'Rapid Onset Gender Dysphoria,'*** *which accurately described the symptoms of my daughter's behavior. The doctor wouldn't listen to me.* ***When I tried to give her a printed article about ROGD, she threw her hands up in the air and refused to take it.*** *She said she sees many transgender patients and already knew enough. I lost trust in that doctor and never went back. My daughter has since stopped her transition. I'm still angry at that doctor for not taking me seriously, and I'm immensely relieved that we didn't follow her ill-informed and misleading advice."*

7 Lisa Littman (2018) **Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria**
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330

Rapid-Onset Gender Dysphoria (ROGD) Information for Parents

Epidemic

After the term "gender identity disorder" was replaced by "gender dysphoria" in the DSM in 2014 and there was extensive media coverage of transgender youth, the number of referrals to clinics in all Western countries rose by **2,000% to 5,000%**. The Netherlands has not published any charts since 2016, but the numbers are identical here as well. From a few dozen (±50) per year to approximately 2,000 patients in 2024—that is **an increase of ±4,000%**. Belgium **does not** publish **any data** at all **on this sudden surge**.



Wertherism

Wertherism, or the Werther effect—a term derived from Goethe's novel **The Sorrows of Young Werther** (1774)—refers to the phenomenon in which people are influenced by media or stories, **particularly regarding self-destructive behavior**. In the book, the main character, Werther, commits suicide with a pistol after his love for an unattainable woman goes unrequited. Following its publication, there was an observed increase in the number of young men who committed suicide in a similar manner, sometimes even wearing the same style of clothing as Werther. In other words: A very firm, collective belief arose that happiness could be achieved exclusively through **"true love"; without that prospect, suicide seemed the only way out.** This led to the term "Werther effect," which refers to the risk of imitative behavior following media coverage of suicide.

Detransitioner Charlie Bentley-Astor *(interviewed by Andrew Gold)*

> *"Queer Destiny is, in essence, the rather harmful idea that if you're born gay, bi, trans, or queer — whatever label you choose — this is the most important thing about you. It becomes the defining characteristic of your existence and determines the course of your life. You have only two choices: You either embrace it fully, or you commit suicide. Because if you don't accept it, it festers and you become so trapped within yourself, in such a horrific way, that your only escape is suicide. But ultimately, it's just an idea."*

Detransitioner Christina Hineman

> *"A kind of punk behavior, but instead of sex, drugs, and rock 'n' roll, it was just drugs. And surgeries. It's a medicalized version of normal teenage rebellion. And I got completely sucked into it."*

Mia Hughes*—author of *The WPATH Files**

> *"Rapid-onset gender dysphoria is the most obvious case of social contagion that has ever occurred."*

The Falsehoods of Gender-Affirming Care Information for Parents

On February 21, 2023, the **Florida House Health & Human Services Committee** heard testimony from board-certified psychiatrist **Dr. Stephen Levine,** clinical professor of psychiatry at Case Western Reserve University. He outlined thirteen scientifically inaccurate assumptions that form the basis of gender-affirming care for "gender dysphoria" in children.*

"I have identified thirteen ideas in the literature put forward by those who support medicalization for children, adolescents, and adults experiencing the transgender phenomenon. In my view, each of these thirteen points is scientifically incorrect. Nevertheless, they are firmly held. When they are refuted in discussions—or even merely touched upon—it leads to passionate outrage that they are supposedly untrue. However, as far as I can tell, these thirteen ideas are not scientifically verifiable and are clearly clinically incorrect. Yet they are repeatedly cited in the writings and conversations of therapists who support affirmative care.
Before I present these thirteen points, I want to offer a different perspective on this major question regarding transgender care for young people: Is this an example of therapeutic progress to help those affected, or is it yet another medical misstep? In the medical world, we have ***a history of many medical missteps.*** *The most recent—and also one of the most harmful—is the opioid crisis. We began prescribing opioids liberally without scientific evidence of their benefits or harms. Now, in every state in the United States—and elsewhere—people are suffering from premature death due to opioid abuse.*

Here are the thirteen points that, in my opinion, are not true:
1. "Once established, a trans identity is unchangeable and always remains the same." This is clearly not true.

2. "Trans identities are primarily caused by prenatal biological factors." This claim suggests that treatment simply corrects a biological or embryological error.

3. "Sexual orientation is completely independent of gender identity." Sexual orientation is a preference for romantic and sexual relationships with members of a particular group (men or women). However, as children develop—from childhood through puberty and into adolescence—gender dysphoria often co-occurs with same-sex attraction, indicating that they are not entirely separate phenomena.

4. "No form of gender identity is a deviation or a symptom of another problem." This is not a psychologically tenable concept, but it is often claimed in the literature.

5. "Gender dysphoria is a serious medical condition that requires medical intervention, but only if the patient wants it." This idea contains an inherent paradox: if it is a serious medical condition, that implies the need for treatment, but only if the patient desires it.

6. "The associated emotional problems are primarily caused by living in a discriminatory world." Many children diagnosed with gender dysphoria had already received other psychological diagnoses.

7. "There are no effective alternatives to affirmative care." Doctors often claim that this is the only solution for children, but alternative psychiatric approaches, as discussed by Dr. Laidlaw, do indeed exist.

8. "Attempts to provide psychotherapy are unethical forms of conversion therapy and should be banned." Any attempt to help the child and the family is often labeled as conversion therapy, with calls to ban it in various jurisdictions (instead of psychotherapy to address the underlying psychological problems, ed.).

9. "Affirmative care permanently improves mental health and social functioning." This is often used as justification, but long-term studies demonstrating this are lacking. In fact, data point to increased mortality rates among transgender adults.

10. "Affirmative care reduces suicidal thoughts and prevents suicide." This is a powerful, compelling message conveyed to parents of teenagers. However, studies—such as those from Sweden—show significantly increased suicide rates among adults who have undergone gender-reassignment surgery.

11. "Young teenagers know best what will make them happy in the future." This claim assumes that a teenager fully understands his or her "true self," which is not necessarily the case.

12. "Meeting the diagnostic criteria for gender dysphoria predicts a positive outcome with affirmative care." This is demonstrably false.

13. "Regret and detransitioning are rare among these patients." Recent years have shown that detransitioning is being recognized with increasing frequency. The reporting of "regret" is too limited, because detransitioners usually do not inform their practitioners about it, and it does not do justice to the complexity of this phenomenon.

These thirteen ideas form the core of the claims about affirmative care. ***If the ideas themselves are not true or scientifically substantiated, how can we trust the treatments based on them?****"*

To supplement this, in line with Levine's list:
The German version of this Genspect survey cites the German critical thinker Alexander Korte, stating that every DSM diagnosis is **always** a snapshot in time and **should never be a reason for permanent, irreversible bodily modifications**.[39]

8 **Dr. Stephen Levine: 13 Untruths Behind Gender-Affirmative Therapies for Kids** (Feb 2023) https://www.youtube.com/watch?v=OflbCjj_hVc 39 **Hinter dem Regenbogen, A. Korte, page 210** (2024) https://shop.kohlhammer.de/hinter-dem-regenbogen

Recommendations for Further Research

The more you know, the better you can protect your child.

Books and Literature on Gender

- *Trans* - **Helen Joyce,** ISBN-13 978-9463833547 (2024). On the issues surrounding gender ideology from the broadest sociological perspective. **The Dutch edition** is available through Bruna.
- **End of Gender: Debunking the Myths About Sex and Identity in Our Society*—**Debra Soh,** ISBN-13 978-1982132521 (2023). An essential critique of the inaccuracies in gender studies as a field of scholarship.
- **Irreversible Damage* - **Abigail Shrier** ISBN-13 978-1800750364 (2021). On ROGD.
- **Time to Think*—**Hannah Barnes,** ISBN-13 978-1800751118 (2023). About the Tavistock scandal and the disturbing science and history of gender-affirming care as a flawed treatment model.
- **Detrans*—**Dr. Az Hakeem** ISBN-13 979-8862184549 (2023). About the psychology of cross-dressing and transsexual behavior and their serious consequences.
- *When Kids Say They're Trans* - **Lisa Marchiano, Stella O'Malley & Sasha Ayad** ISBN-13 978-1800752641 (2023). A guide for parents.
- **Lost in Trans Nation: A Child Psychiatrist's Guide Out of the Madness*—**Miriam Grossman** (2023) ISBN-13: 978-1510777743. Main theme of this book: Parents know their child best.
- *The WPATH Files* - **Mia Hughes** (2024). Exposes the corruption within WPATH and how it has influenced gender-affirming care worldwide.
- *The Cass Review, Final Report* - **Hilary Cass** (2024). The most comprehensive systematic review of the gender-affirming care model. This report is fully in line with the issues Barnes also highlighted in her book.

Books Offering a Broader Perspective

- **Bodies under Siege* - **Armando R. Favazza** ISBN-13 978-0801899669 (2011). On self-mutilation, non-suicidal self-harm, and body modification in culture and psychiatry.
- *Mass and Power* - **Elias Canetti** ISBN-13 978-9025315696 (2022). On collective behavior, mass delusions, cults, and extreme (self-harm) rituals.
- *The Rape of the Mind* - **Joost A. M. Meerloo** ISBN-13 978-1-61577-376-3 (2009). On the psychology of mind control, menticide, and brainwashing.

Don't have a reader? No problem!

- **Watch interviews on YouTube** with the experts mentioned above. Listen to **the "Gender: A Wider Lens"** podcast.
- Join Facebook groups. There are many English-language groups. For Dutch and Flemish parents, there's the group **"Concerned Parents of Children with Gender Dysphoria**." This is a critical group. There's also **"Parents of Transgender Children**." The latter is a parent group whose members believe their child is trans. The two groups differ significantly in tone, so choose what feels best for you and avoid conflict.
- **Go to X** (and other social media platforms) and follow Dutch-language gender-critical organizations such as Voorzij, Genderpunt, Cry for Recognition, and MeMoMa, as well as English-language organizations like Genspect, Stats
  for Gender, PITT, Parents of Desisters, Do No Harm, Therapy First, CAN-SG, and many others.
- Get in touch with parent groups and gender-critical organizations: **Voorzij, Cry for Recognition, Genderpunt, MeMoMa, NPV Zorg.** You can't resolve a disagreement with a clinic on your own.
- **Write letters** to the media and politicians and ask for help.
- **Attend conferences** to network.

***Eliza Mondegreen**—a journalist at the European Professional Association for Transgender Health conference* [8]

*"In an alarming update on the link between autism and transgender identity among patients at the Dutch clinic, researchers reported that—of the 30 patients who were potentially eligible to participate in a 17-year follow-up study — **four had refused** to participate, **two had de-transitioned**, one who had not de-transitioned expressed **deep regret** about the vaginoplasty, and **two had 'died**.' Only at the end of the presentation did the researchers admit that these two patients had, in fact, committed **suicide**. According to the researchers, the suicides demonstrated that there are "two sides to every story," that there is "no crystal ball," and that the subject "should not be treated without nuance." However, exactly what a "nuanced" approach entails remained unclear. Does "nuance" sometimes mean glossing over negative outcomes to avoid undesirable conclusions? The presenters preferred to focus on the "diversity" of their "trans-autistic" patients, with their varied self-identifications 17 years after they began their transition journey: "fairy," "elf," "non-binary," "friendly, non-intimidating woman," "cis" (read: detransitioned). "Every referral," according to the presenters—including patients who died, had detransitioned, or experienced regret—"followed their own unique path regarding their gender identity and mental health journey."*

*Time and again, researchers and clinicians presented alarming findings suggesting that something is seriously going wrong in the world of "gender-affirming care," only to fail to apply their conclusions to their practice. **Despite the tragic consequences, this care continues to be regarded as "essential" and "life-saving"—even when patients die**."*

9 Eliza Mondegreen (May 4, 2023) **Part I: Three days at the European Professional Association for Transgender Health** https://genspect.org/dont-stop-be-lievin-three-days-at-the-european-professional-association-for-transgender-health/ 12

Genspect

Submit to clinic

Family and Friends Survey

An Objectification of the Parental Perspective

For clinical assessment prior to the start of gender-affirming interventions

Gender-related issues are complex. You or the people around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Contact organizations that specialize in gender-critical topics.



Family and Friends Survey - 1

Submit to the clinic

Sixteen questions based on DSM-5-TR criteria

To develop this survey, the DSM-5-TR criteria were rewritten into questions suitable for family members and friends. We included two criteria from the section on children and also applied them to the behavior of adolescents (Questions 7 and 8).

All family members provided the same answers.

Present

1. Is there a clear, visible discrepancy between the desired gender (gender expression) and the biological sex?
   No

2. Does the person express a strong desire to be rid of his or her sexual characteristics?
   No

3. Does the person clearly present themselves as the opposite sex in terms of clothing and behavior?
   No

4. Does the person express a strong desire to become the opposite sex?
   No

5. Does the person express a strong desire to be treated as the opposite sex?
   No

6. Does the person exhibit typical feelings and reactions normally associated with the opposite sex?
   No

7. Do you see expressions in their music preferences, movies, anime, or hobbies that are stereotypical of the opposite sex? **No**

8. Does the person seek social interaction with groups of the opposite sex?
   No

Past

9. As a child, did the person show a strong desire to be of the opposite sex?
   No

10. As a child, did the person wear clothing typical of the opposite sex?
    No

11. As a child, did the person show a strong preference for roles of the opposite sex in fantasy or “pretend play”?
    No

12. As a child, did the person show a strong preference for toys, games, or activities stereotypically associated with the opposite sex?
    No

13. As a child, did the person have a strong preference for playmates of the opposite sex?
    No preference
    (plays with her younger sister and a female friend. The friend is now a lesbian; she was a tomboy-like child at the time)

14. As a child, did the person have a strong aversion to toys, games, and activities typical of his or her gender? **No**

15. Did the person have a strong aversion to his or her own sexual anatomy as a child?
    No

16. As a child, did the person have a strong desire for physical sexual characteristics that correspond to their gender identity? **No**

Family and Friends

Submit to the clinic

Questions about the person's background and social influence

All family members gave the same answers.

1. Did the transgender identity emerge suddenly during or after puberty without any prior signs in childhood?
   Yes

2. Do you think the person might be influenced by friends?
   Yes

3. Are there transgender/non-binary/"queer" people in the class or group of friends?
   Yes

4. Do you think online information plays a role in the person's self-diagnosis?
   Yes

5. Do you think this person might have other mental health issues, such as anxiety, depression, or autism spectrum disorder?
   Yes
   If yes, what notable behaviors does the person exhibit?
   Self-hatred, a huge ego regarding their own creativity, autism, childhood depression/melancholy—which is very typical for the family. Angry at the world (the "patriarchy," whatever that may be in an open Western society with full respect for feminism, especially in our community), adolescent rebels/punk/immature.

6. Did the person behave differently as a child or before expressing their self-diagnosis compared to now?
   Yes
   If yes, can you describe what that change looks like?
   Very sweet and calm. Now obstinate, headstrong, reclusive, gloomy, irritable, and prone to lying.

7. Did the person distance themselves from family and/or former friends shortly before or after "coming out as trans/non-binary"?
   Yes

8. Are most of their friendships and activities now related to their trans identity?
   Yes

9. Do you get the impression that the person is confused about their identity and has misdiagnosed themselves?
   Yes

10. Do you think that, for this person, a trans identity might simply be a temporary phase of interest?
    Yes



Family and Friends Survey - 3

Submit to the clinic

Additional questions

All family members gave the same answers.

1. Should the family's perspective be given significant weight in the diagnosis?
   Yes
   Why do you think so?
   He resembles his father in every way. His behavior also resembles that of his uncle, grandfather, and great-grandfather. The family resemblance is extremely evident. The family has known him since birth and knows him best, so they are the ones who notice the sudden change most clearly.

2. Should the opinions of the primary care physician and other healthcare providers also be sought and taken into consideration?
   Yes

3. Do you think the person might be gay, bisexual, or asexual?
   No

4. Could the person be experiencing inner shame about possible homosexuality?
   No

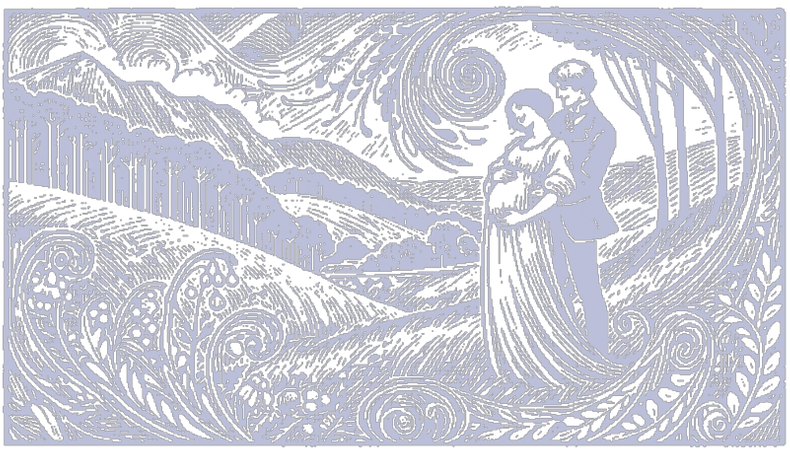
5. Does the family have issues with gay people?
   No

6. Does any religious community, workplace, or sports club the person may be involved with have issues with gay people?
   No

7. Do you understand what makes the person unhappy with his or her body?
   Yes
   If yes, can you explain why?
   We believe he is projecting his issues onto his transgender identity.

8. Have you ever experienced serious gender-related distress yourself, either when you were younger or now?
   Yes
   If yes, can you explain why?
   Father: "During puberty (probably due to hormonal fluctuations), I experienced brief bouts of gender-related delusions, but that was mainly teenage daydreaming about sex and a longing for first love.

9. Is there anything else you'd like to add regarding the person's diagnosis or this questionnaire?
   No



Family and Friends

Submit to the clinic

1ua. Question regarding informed consent (for men)

The medical literature documents the following serious potential side effects:*

Puberty blockers

- Permanent impairment of sexual function, including fertility and failure to develop the ability to experience orgasm [32,33]
- Long-term effects on bone density (osteoporosis) and growth [10]
- Negative impact on neuropsychological functioning [10]
- Underdeveloped genital tissue (micropenis), which may limit future surgical options [11]

Estrogen therapy (in combination with antiandrogens)

- Increased risk of mortality [12]
- Insulin resistance (33% of patients) with an increased risk of diabetes [13]
- Increased risk of cancer (breast and liver cancer, meningioma (brain tumor)) and liver damage
- 26 times higher risk of testicular cancer (1 in 100 patients) [14]
- Thrombosis (5% of trans women, 22 times higher than in cis men) [15]
- Significant weight gain and redistribution of body fat
- Cardiovascular complications, mortality rate 2.6 times higher [12]
- Severe loss of muscle mass
- Permanent infertility (very common) [16]
- Changes in sexual function, decreased libido, impotence [17]
- Progressive decrease in bone density
- Severe shrinkage of the testicles



Postsurgical complications (following vaginoplasty)

- Organ prolapse (up to 7.5%) [18]
- Incontinence (up to 15%) [18]
- Chronic urinary tract symptoms (up to 20%) [18]
- Death from infections; mortality rate 9 times higher [12]
- Sexual dysfunction (up to 75%) [18]
- Inability to achieve orgasm (studies are extremely flawed and present distorted figures due to poor methodology)

General considerations

- **11% of men (trans women), average age 23, died after 11 years** [12]
- Permanent dependence on hormone therapy and medical supervision [19,20]
- Substantial risks of serious medical complications [11–16, 18, 21–27, 32, 33, 26]
- High likelihood of permanent loss of fertility and sexual function [16]
- Persistently elevated risk of suicide after transition; mortality rate 7 times higher among men [12]
- Irreversible changes with limited long-term studies; effects not fully understood [28]
- All of the above medications are used off-label
- Very limited dating pool, leading to loneliness, lack of intimacy, relationship stress, and depression
- **No proven mental health benefits (puberty blockers and estrogen, surgery)** [7]

Question for the clinic

Have you thoroughly assessed these medical implications, informed the patient about them, and are you convinced that this is the optimal treatment?

0 Yes 0 No If yes, why is this the optimal treatment?

Question for a family member

Now that you have thoroughly assessed these medical consequences, with an understanding of the potential lifelong effects, do you understand the impact and believe that this is **not** the optimal treatment path?

Yes, please do not medicalize this

Dr. Stephen Levine *- The Reality of Trans Youth Evaluations (Denver, USA, 2023)*

"Before patients start hormone therapy, I ask them if, when they feel depressed, they'll consider the possibility that it's due to their transition and not something else. And I want them to have the strength and courage to acknowledge that. Like so many of us, you may have made a mistake in your life.

Endocrinologists almost never stop hormone treatment for the people they started it with. All the detransitioners I speak with stopped their hormones on their own; it wasn't the doctor. ***Even if they're depressed or have attempted suicide, treatment often continues****."*

*Sources on page 19

Family and Friends Survey - 3

Submit to the clinic

10b. Question regarding informed consent (about women)

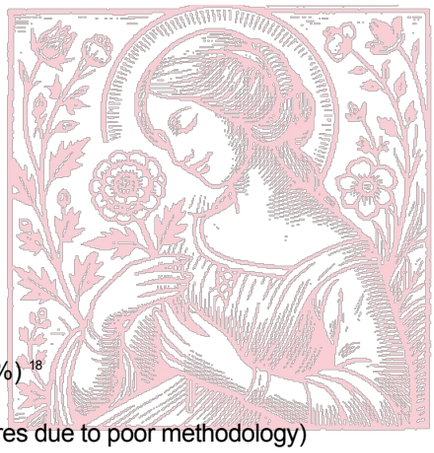
The medical literature documents the following serious potential side effects:*

Puberty blockers

- Permanent impairment of sexual function, including fertility and failure to develop the ability to experience orgasm [34–36]
- Long-term effects on bone density (osteoporosis) and growth [10]
- Negative impact on neuropsychological functioning [10]

Testosterone therapy

- Increased risk of mortality [12]
- Progressive decline in bone density (14% develop osteoporosis, 22% develop osteopenia) [29]
- Atrophy of vaginal tissue [21]and urinary complications (87%) [22, 30]
- Removal of the uterus and ovaries (hysterectomy and oophorectomy) is usually required after 3–5 years of treatment due to chronic symptoms [22]
- Chronic pelvic and genital pain [23]
- High likelihood of permanent infertility [22]
- Ovarian cysts and endometrial complications [23]
- Metabolic disturbances [24]and weight gain and changes in appetite [26]
- Significant mood and emotional changes [10]
- Severe liver complications [25]
- Pelvic floor dysfunction (94%) [30]
- Sexual dysfunction (53%) [30]
- Problems with the anus and rectum (45%) [30]



Post-surgical complications (following double mastectomy and phalloplasty)

- Organ prolapse (up to 4%) [18]
- Incontinence (up to 50%) [18]and chronic urinary tract symptoms (up to 37%) [18]
- Sexual dysfunction (up to 54%) [18]
- Absence of orgasm (studies are extremely flawed and present distorted figures due to poor methodology)

General considerations

- **3% of women (trans men), average age 30, died after 5 years** [12]
- Permanent dependence on hormone therapy and medical supervision [19,20]
- Substantial risks of serious medical complications [11–16, 18, 21–27, 32, 33, 26]
- High likelihood of permanent loss of fertility and sexual function [16]
- Persistently elevated risk of suicide after transition; mortality rate 3.3 times higher among women [12]
- Irreversible changes with limited long-term studies; effects not fully understood [28]
- All of the above medications are used off-label
- Very limited dating pool, leading to loneliness, lack of intimacy, relationship stress, and depression.
- **No proven mental health benefits (puberty blockers and testosterone, surgery)** [7]

Testosterone is a substance with a high potential for addiction that falls under Schedule III

A simplified overview; for a more detailed explanation, consult the DEA drug schedules [31] .

Schedule I:	Heroin, LSD, marijuana, MDMA (ecstasy), peyote
Schedule II:	Cocaine, methamphetamine, methadone, fentanyl, Dexedrine, Ritalin
Schedule III:	Ketamine, codeine (in certain formulations), anabolic steroids, **testosterone**
Schedule IV:	Valium, Xanax, tramadol
Schedule V:	Cough syrups containing small amounts of codeine

It is often noted that girls who use testosterone initially view it as a positive experience. This is not surprising, since testosterone has a mentally stimulating effect similar to that of other drugs. While the first few years may feel like a **"honeymoon phase**," over time the mental and serious physical side effects often emerge, which can be described as the "hangover years."

Question for the clinic: Have you thoroughly assessed these medical implications, informed the patient about them, and are you convinced that this is the optimal treatment? 0 Yes 0 No If yes, why is this the most optimal treatment?

Question for the family member: Now that you have thoroughly assessed these medical consequences and understand the potential lifelong effects, do you believe this is the optimal treatment plan? **N/A because the patient is a boy**

***Dr. Stephen Levine** - The Reality of Trans Youth Evaluations (Denver, USA, 2023)*

"Before patients start hormone therapy, I ask them if, when they feel depressed, they'll consider the possibility that it's due to their transition and not something else. And I want them to have the strength and courage to acknowledge that. Like so many of us, you may have made a mistake in your life.

*Endocrinologists almost never stop hormone treatment for the people they started it with. All the detransitioners I speak with stopped their hormones on their own; it wasn't the doctor. **Even if they're depressed or have attempted suicide, treatment is often continued**."*

*Sources on page 19

Family and Friends Survey - 4

Submit to clinic

A few personal questions

1. How old are you? **52**
2. What is your level of education? **Vocational**
3. What was your most recent job? **Freelance artist, part-time professor of cultural philosophy and art education**
4. Are you religious? **No**
5. What are your political views? **Left**
6. What is your stance on issues such as same-sex marriage, euthanasia, abortion, and gender transition (if properly researched)?

	Same-sex marriage	Euthanasia	Abortion	Gender Transition
It's fantastic that this is possible in our country	**This**	**This**	**This**	0
No problem with it	0	0	0	0
I don't care what others do	0	0	0	0
Worrying	0	0	0	**This**
Strong against	0	0	0	0

Further explanation regarding concerns about gender transition: **After reading extensively on the subject, I now have serious concerns about this form of medical care. In and of itself, I am not opposed to transition, provided it involves cosmetic procedures (similar to breast augmentation, Botox, or gastric bypass surgery) or serves as a form of extreme body modification art (there are people who take this very far, and if it's self-funded, I think this art form is justified as a personal choice. I do believe, however, that the performing physician must be extremely vigilant not to lose their license due to the illegality of apotemnophilia affirmation). I wouldn't dare do it myself as a doctor; it seems like a minefield to me. I don't think it's right that body-affirming gender transition is labeled as necessary care that is largely reimbursed by public funds. This opens the door far too easily for gender-confused children and young adults.**

The family is a mix of highly educated and less educated members, mostly left-leaning, with a few on the right. No one is religious or narrow-minded conservative. We have two gay people in the family. We all consider abortion, euthanasia, and same-sex marriage to be a fantastic set of freedoms. Before trans issues entered our lives, we also had great compassion for "people born in the wrong body." However, I have always wondered whether this isn't a far too premature form of care, based on Valentijn de Hingh and similar examples. The data and numerous reports now seem to increasingly confirm this; Valentijn himself stated in an interview that he shouldn't have had the surgery.

Sources for the questions regarding informed consent on pages 17 and 18:
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11 Zinnia Jones (December 2018) **Use of puberty blockers in transgender girls, effects on genital tissue development, and vaginoplasty options** https://genderanalysis.net/2018/12/use-of-puberty-blockers-in-transgender-girls-effects-on-genital-tissue-development-and-vaginoplasty-options/
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19 M. Fradd **How the Medical World Is Creating Lifelong Patients** https://pintswithaquinas.com/how-the-medical-world-is-creating-lifelong-patients
20 M. den Heijer **Long-term hormonal treatment for transgender people** https://www.bmj.com/content/bmj/359/bmj.j5027.full.pdf
21 P. J. Cheng et al. (June 2019) **Fertility Concerns of the Transgender Patient** https://pmc.ncbi.nlm.nih.gov/articles/PMC6626312/
22 **Information on the Cleveland Clinic website** https://my.clevelandclinic.org/health/diseases/15500-vaginal-atrophy
23 Juno Obedin-Maliver (June 2016) **Pelvic pain and persistent menstruation in transgender men** https://transcare.ucsf.edu/guidelines/pain-transmen
24 Leila Hashemiet et al. (June 2024) **Gender-Affirming Hormone Treatment and Metabolic Syndrome Among Transgender Veterans** https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820670
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Results of the family and friends

Submit to the clinic

	Name of family member or friend	Relationship to the person:
A:	Anonymized	**Father**
B :	Anonymized	**Mother**
C :	Anonymized	**Sister**
D :	Anonymized	**Grandmother**
E :	Anonymized	**Grandma**
F :	Anonymized	**Aunt**
G :	Anonymous	**Uncle**
H :	.....	.....
I :	.....	.....
J :	.....	.....
K :	.....	.....
L:	.....	.....

Use the following color codes to indicate your answers: **Yes:** Green **No:** Red **Both/Unclear:** Orange

Part 1 - Based on DSM-5-TR

Present	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**
Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Past												
Question 9	0	0	0		0	0	0	0	0	0	0	0
Question 10	0	0	0	0	0	0	0	0	0	0	0	0
Question 11	0	0	0	0	0	0	0	0	0	0	0	0
Question 12	0	0	0	0	0	0	0	0	0	0	0	0
Question 13	0	0	0	0	0	0	0	0	0	0	0	0
Question 14	0	0	0	0	0	0	0	0	0	0	0	0
Question 15	0	0	0	0	0	0	0	0	0	0	0	0
Question 16	0	0	0	0	0	0	0	0	0	0	0	0
				0								

Part 2 - ROGD Indication

Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Question 9	0	0	0	0	0	0	0	0	0	0	0	0
Question 10	0	0	0	0	0	0	0	0	0	0	0	0

Part 3 - Additional Questions

Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Question 9	N/A											
Question regarding informed consent												
Question 10: Transition?	0	0	0	0	0	0	0	0	0	0	0	0
	No, please don't											

Parents' Signature:

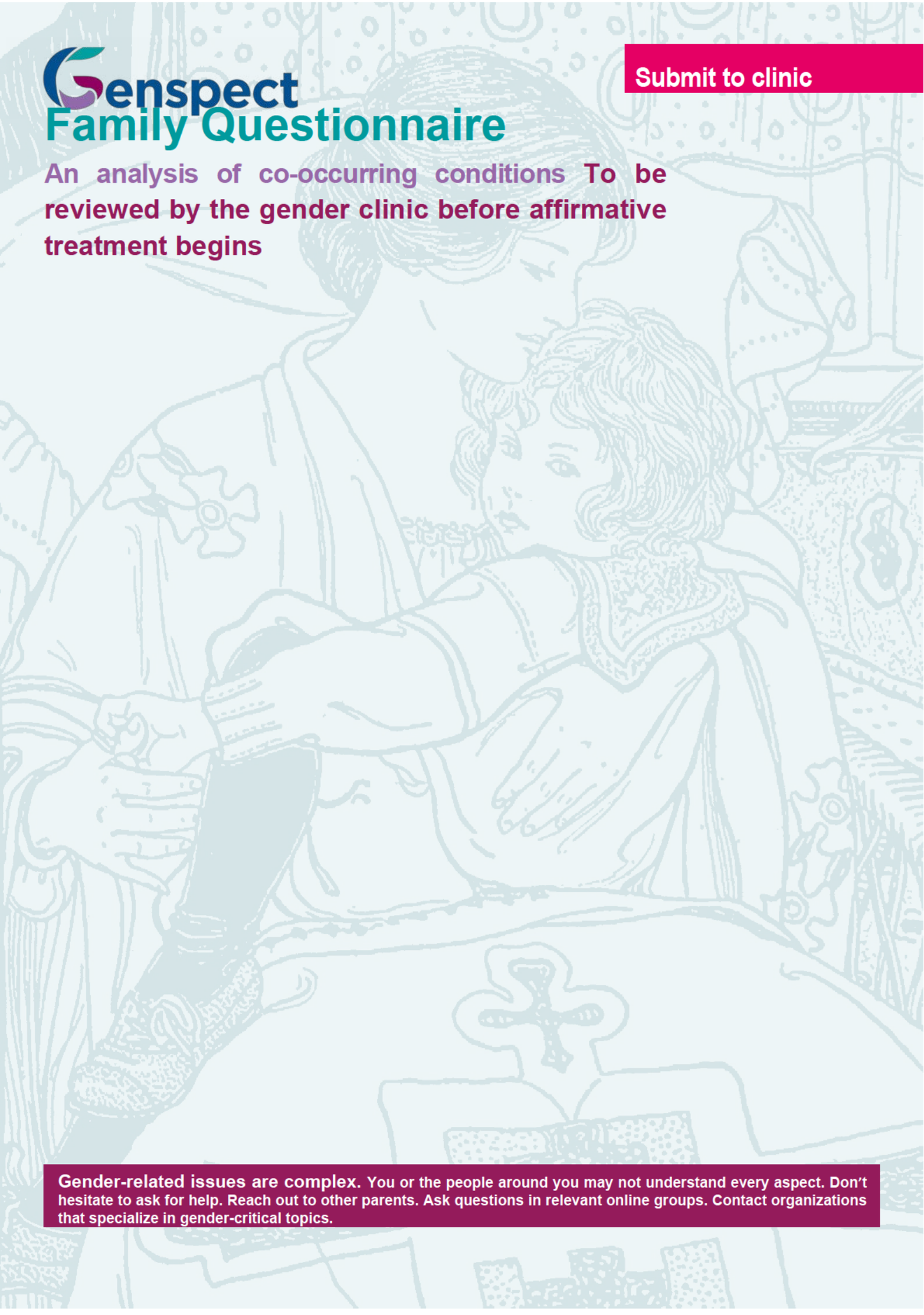
Date: Previous version submitted to the clinic on **March 4, 2024**

Genspect

Family Questionnaire

Submit to clinic

An analysis of co-occurring conditions To be reviewed by the gender clinic before affirmative treatment begins



Gender-related issues are complex. You or the people around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Contact organizations that specialize in gender-critical topics.

Family Survey

Submit to the clinic

Possible Comorbidities

As a parent, please indicate (in the green "yes/no" row) whether you observe any of the following characteristics that may be relevant to your child's self-reported gender incongruence (check all that apply).

For each characteristic you observe, ask the clinic whether they also recognize it in their assessment.

		Family	Clinic
Most important and most common co-occurring conditions			
Internalized homophobia (not acknowledging/feeling ashamed of being gay or lesbian)		no	yes / no
Self-hatred		yes	yes / no
Autism		yes	yes / no
Loneliness		yes	yes / no
Symptoms of ROGD (sudden-onset gender dysphoria)			
Coming out as trans was completely unexpected		yes	yes / no
The "coming out" does not match the expected image of a "trans person"		yes	yes / no
Social influence from friends		yes	yes / no
Social influence via the internet		yes	yes / no
Mental decline after "coming out"		yes	yes / no
Sudden increase in lying		yes	yes / no
Sudden changes in behavior after "coming out"		yes	yes / no
Shame or reluctance to express oneself as the opposite gender (for example, toward family)		yes	yes / no
Creating two separate worlds (home/family vs. friends or school, triangulation)		yes	yes / no
Seeking (negative) attention (hence claiming to be "trans" or "non-binary")		yes	yes / no
Trauma			
Experiencing bullying now or in the past	**According to the father, no; according to the mother, yes**	yes / no	yes / no
Problems caused by divorced parents		no	yes / no
Childhood fears		no	yes / no
History of sexual abuse		no	yes / no
Experience of physical violence		no	yes / no
Immaturity, social and relationship problems			
Immature or childish behavior		yes	yes / no
Little or no experience with boyfriends or girlfriends		yes	yes / no
Reluctance to touch people (and potential partners)		yes	yes / no
Hatred of heteronormativity (or, for example, "the patriarchy")		yes	yes / no
Extreme political beliefs		yes	yes / no
Fear of contamination		**yes**	yes / no
Psychological problems			
Any previous diagnosis of a disorder (based on the DSM)		no	yes / no
ADHD or ADD		no	yes / no
Body Dysmorphic Disorder (BDD) (dissatisfaction with body parts)		yes	yes / no
Self-harm (**cutting, but very mild**)		yes	yes / no
Fear of commitment		yes	yes / no
Sexual fears		yes	yes / no
Signs of narcissistic traits (inflated self-image, Peter Pan syndrome)		yes	yes / no
Signs of borderline personality disorder (splitting, conflicts, self-harm, threatening to leave)		yes	yes / no
Suspected factitious disorder (ICD 6D50, DSM-5-TR 300.19) (other problem)		yes	yes / no
As a man: Expressed hostility toward conventionally feminine women		yes	yes / no
Transmaxxing [37]		yes	yes / no
Autogynephilia [38], transvestic fetishism (a paraphilia, classified as 302.3 (F65.1) in the DSM-5-TR)		no	yes / no
Other unspecified characteristics 1: **Fear of the future**		yes	yes / no
Other unspecified characteristics 2: **Fear that he will not become special**		yes	yes / no
Other unspecified characteristics 3: **Nihilism**		yes	yes / no
Other unspecified characteristics 4: **Experiences great suffering because life imposes responsibility.**			
Believes they can escape this through trans (=transmaxxing)		yes	yes / no

Question for the treating physician

For each item marked differently from the parental perspective above, please provide your clinical rationale for why your assessment differs from the family's observations.

37 **Transmaxxing** is a controversial phenomenon in which men, primarily from "incel" (involuntarily single) online communities, undergo trans medicalization for perceived social benefits rather than gender-related stress, such as being treated better socially or escaping male social pressures. 38 **Autogynephilia (AGP)** is a paraphilia characterized by sexual arousal at the thought of being a woman. This condition can have problematic consequences if surgical interventions are undertaken, as procedures such as castration can lead to reduced libido, which

may result in significant regret. AGP represents a paraphilic disorder rather than a “gender identity,” and gender-affirming treatment is not recommended (Dr. Az Hakeem - DE-TRANS: When Transition Is Not the Solution, ISBN 979-8862184549).

Questions for the Clinic

Submit to the clinic

Questions for the specialist regarding ethical issues and responsibility

Current protocols for gender-affirming care reveal a notable lack of clinical guidelines and attention regarding the long-term implications for **intimate relationships** and **healthy sexual functioning**. This critical omission requires urgent attention, especially since the procedures involve permanent physical alterations.

1. What documented protocol does the clinic use to distinguish gender-related stress from other conditions based on objective clinical criteria?

2. How does the clinic prevent the body modification from impairing long-term function in intimate relationships or other crucial aspects of life?

3. What clinical criteria validate a patient's self-reported gender-related distress, and what evidence-based support justifies these interventions, given that self-reported distress is subjective and not measurable?

4. Can you provide your protocol authorizing permanent interventions for gender-related stress, especially when comparable interventions (such as FGM or voluntary amputation) are prohibited for other body-related conditions? What is the evidence-based justification for this distinction?

5. What protocols govern medical necessity and informed consent, particularly in the absence of long-term outcomes?

6. "In dubio abstine" is a fundamental principle in medical ethics. Is gender-affirming care consistent with this principle?

7. Please read the anecdote about the father below. Are we dealing here with a variation on Hannah Arendt's "banality of evil"?

8. Plastic surgery generally follows the principle of preserving the natural form. For example, tails are not added, nor are eyes removed to create a cyclops. Does this ethical standard apply within your protocol? We ask this specifically with regard to the gender identities non-binary*, nullo*, and eunuch*. Is it ethical and legal to surgically treat these identities?

9. Is it ethical to help individuals fulfill their desires if this leads to social disruption, such as family breakdown or the infringement of women's rights?

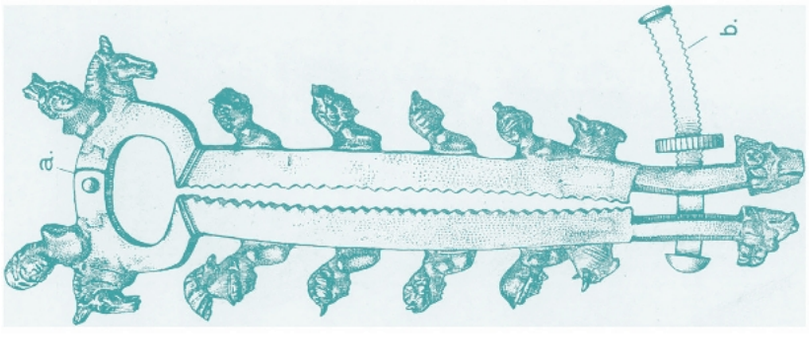
10. Given the significant limitations in evidence-based validation of the gender-affirming model, is it ethical to ask family members to place their trust in this process?

Please respond with logical reasoning

11. If "gender identity" is both innate and immutable, as gender theory suggests, yet also encompasses fluid identities, how can medical interventions be deemed necessary without violating "primum non nocere" (first, do no harm) and "in dubio abstine" (when in doubt, do nothing), given this inherent paradox?

12. If genitalia do not define gender, how does their removal affirm gender (in the context of gender-affirming care)?

These questions are intended to clarify the clinical reasoning process and the documentation supporting current treatment protocols.



Father Asks Questions at the Dutch Clinic

"The conversation with the clinical psychologist went beyond just my question about what percentage of people who transition experience regret. That question is incomplete. The real question should be whether people have a better quality of life after gender-affirming procedures. And here came the most remarkable statement from the clinical psychologist: ***'Transitioning doesn't make you happy.'***

Our reaction was: ***'Huh? Then why are we doing it?!'*** *The clinical psychologist repeated this baffling statement several times during our conversation. We were shocked that he admitted this so openly.* ***We still don't understand it****."*

*A "nullo" is someone who has all sexual characteristics removed: breasts, internal and external genitalia, but also, for example, nipples and the navel. In the most extreme case, only the urethral opening remains. Surgical affirmation of non-binary identity also involves partial nullification. The eunuch identity is mentioned in the Dutch Somatic Transgender Care Model 2024, pages 23–29. This is a sadomasochistic fetish of "cutters" and "wannabes," not a "gender."

Questions for the Clinic

Submit to the clinic

Fifteen scientific questions

The remarkable list by Dr. Stephen Levine that we cited in the introduction raises **fifteen crucial scientific questions**. These questions can help parents engage in a critical and constructive dialogue with specialists about the assumptions underlying the gender-affirming care model.

1. Is it really true that, once established, a trans identity remains fixed forever?

2. Can you prove that trans identities are primarily caused by prenatal biological factors?

3. How can you explain that sexual orientation is completely independent of “gender identity,” when the development of both often appears to be interconnected? Doesn’t early medicalization hinder the discovery of homosexuality?

4. Is it really true that no form of “gender identity” can be a symptom of an underlying psychological problem?

5. How can you say that “gender dysphoria” is a serious medical condition that justifies trans medicalization, but that treatment is only necessary if the patient wants it?

6. Are the emotional problems of children with “gender dysphoria” solely due to discrimination, or are there other, underlying factors at play?

7. Why is it often claimed that there are no effective alternatives to gender-affirming care, when other approaches do exist?

8. Is every attempt at psychotherapy really comparable to conversion therapy, and why should it be banned? Isn’t medical transition a conversion of the biological body?

9. What scientific evidence is there to show that gender-affirming care leads to lasting improvements in mental health and social functioning?

10. Do you have evidence that gender-affirming care actually reduces suicidal thoughts and suicide rates in the long term?

11. How certain are you that young teenagers and adolescents know what will make them happy in the future?

12. Can meeting the diagnostic criteria for “gender dysphoria” truly guarantee a positive outcome from gender-affirming care?

13. If regret and detransitioning are rare, how do you explain the growing recognition of detransitioning in recent years?

14. How can the clinic justify using a DSM diagnosis—which, by definition, is a snapshot in time—as a basis for permanent, irreversible bodily modifications?

15. The preceding fourteen questions form the core of the claims regarding affirmative care. If the ideas themselves are not true or scientifically substantiated, how can we trust the interventions based on them?



Some Important Steps

Write down the history and your views on the situation

We recommend organizing your thoughts by writing a detailed letter. Describe how the situation began, provide an overview of your child's behavioral characteristics, and share your perspective on what you think is going on. Submit this letter to both the gender clinic and your primary care physician. **Send a printed copy via certified mail with return receipt requested for official documentation, and also send a copy via email for faster communication.**

Report signs of shame, problematic behavior, and unrealistic expectations

If the survey indicates that there is shame surrounding "gender expression" (or other problematic behavioral indicators), the gender clinic must address this issue. Any concerns expressed by you or other family members should lead to a clear and logical follow-up, including an explanation of the clinic's approach. **Shame is fundamentally incompatible with medical treatment**, as it can exacerbate iatrogenic* harm when physical changes resulting from medical interventions become visible. It is essential that the patient overcomes feelings of shame before any further steps are taken.

Your primary care physician is your ally

Share your concerns with your primary care physician in a written document, supported by reliable sources that substantiate your concerns. The ongoing medical controversy surrounding the gender-affirming care model is rapidly evolving, and many primary care physicians may not yet be fully informed. They often rely on the clinics—a phenomenon known as the "chain of trust." It is your responsibility to raise the issues with gender-affirming care that you have identified in the literature.
In addition, let your primary care physician know how you feel about the way you, as a parent, are treated at the clinic—especially if your views are dismissed, not taken seriously, or if you are excluded from discussions about your child's care.

What is the specialist's level of knowledge and experience?

Make a list of questions and ask for written answers. Ask the specialist about the sources you have read. Has the specialist also read this literature? If not, what qualifies him as an expert? What is the specialist's level of knowledge and experience? A specialist has a professional obligation to stay as broadly informed as possible. In particular, the bestsellers on the recommended reading list are well-documented and directly contradict what the affirmative clinics claim. If they are unfamiliar with this professional literature, that constitutes a culpable deficiency, and they are unqualified as specialists.

Request to the gender clinic to consult with the primary care physician

It is wise to ask the clinic to consult with the primary care physician to incorporate their perspective. **If the primary care physician's opinion differs from that of the gender clinic, it should not be dismissed without a clear and logical explanation.** This request encourages the clinic to act transparently and responsibly, which helps limit potential legal issues in the future.

Send copies of the questionnaire to your primary care physician and your insurance company (in Belgium: the health insurance fund)

We recommend sharing the completed questionnaire with **your primary care physician** and the **insurance company (in Belgium: the health insurance fund)** so that all parties involved are well-informed about the complex issues surrounding medical transition. Because a diagnosis of "gender dysphoria" cannot be objectively measured, it is crucial to communicate the results of the questionnaire to the insurance company (in Belgium: the health insurance fund), especially if the outcome differs from your child's self-diagnosis. This ensures that the clinic is held accountable and must explain why the self-diagnosis carries more weight than the family's perspective and why medical interventions—which carry significant health risks—are viewed as the only viable solution. **Send a printed copy of the letter by certified mail with return receipt requested to all parties, and also send a copy via email for faster communication.**



* "Iatrogenic" means: harm caused specifically by the treatme

Parental Statement

Submit to the clinic

Entering a legal minefield

Once a diagnosis has been made, the clinical report must clearly address the concerns mentioned above. It is essential that all possible contributing factors to the patient's reported "gender dysphoria" be thoroughly investigated. Addressing these factors may resolve the presented problems and potentially eliminate the need for irreversible medical interventions.
In addition, it must be demonstrated to what extent coexisting conditions are present and why they do not give rise to diagnostic overshadowing.
A carefully documented investigation into coexisting conditions is crucial, especially given the drastic and irreversible procedures performed by clinics. **We have clear indications that such documentation is currently lacking, which could lead to significant legal problems.** Insurance companies (in Belgium: health insurance funds) do not appear to be aware of these issues. Once they are made aware of this, fundamental questions will likely be raised to avoid legal and financial risks. Sending the results of our survey to insurance companies (in Belgium: health insurance funds) helps raise awareness.
Furthermore, we must not forget that parents' long-term knowledge of and closeness to their child are not recognized in the decision-making process. This systematic disregard for parental input raises significant medical-legal concerns. **How is it possible that gender clinics systematically ignore this crucial source of clinical information?** Now that this survey is available, the question arises as to when parental insights will be taken into account. Can clinics demonstrate that this has been done adequately in previous cases? And how do historical clinical decisions align with the findings of families who have completed our systematic assessment?
It is to be expected that this survey will pose significant challenges for gender clinics, especially now that it is becoming clear that parental perspectives have been systematically ignored. It can no longer be argued that parental input is irrelevant, especially now that there is concrete evidence of the value and impact of our information through this survey and your collective responses to these questions.

If the clinic wishes to proceed with further treatment involving medication and surgery, we, as parents, request that you answer each of our questions point by point and send your responses to the address below.

Parental Statement

With this statement, we, as parents, issue a clear warning that we believe "gender-affirming treatment" should not be continued.
Should the clinic invoke patient privacy, we will forward this document to our family doctor and the insurance company (in Belgium: the health insurance fund). In this way, these parties can work together with the clinic to make an informed decision. This means that all parties will share responsibility if complications arise after treatment, unless they also advise against providing medical treatment to the patient.
It is reasonable that, in the event of harm, compensation and/or reconstructive medical care be provided in accordance with the patient's wishes.

Name of parent/relative:

Anonymized

Date:
Previous version submitted to clinic on **March 4, 2024**

Parent/family member's address:

Anonymized

Signature of parent/family member:

Supported by



Stephanie Davies-Arai—Director of Transgender Trend

"In those first few years, I spoke with ***parents who found themselves in the terrible situation of not only having a serious problem with their teenager, but also feeling like the whole world was against them and viewed them as bigots****.*

Normally, when you're dealing with teenage problems—your child getting involved with the wrong crowd, drugs, alcohol, sex... You know all these teenage problems—at least you have the support of the community around you. There are people who sympathize with you; some might blame you, but you get support. You can talk about it with your friends. But I spoke with parents who didn't even dare to talk to their friends because they were afraid they'd be accused of being narrow-minded or transphobic."

Dr. Stephen B. Levine—Clinical Professor of Psychiatry, Cleveland, Ohio

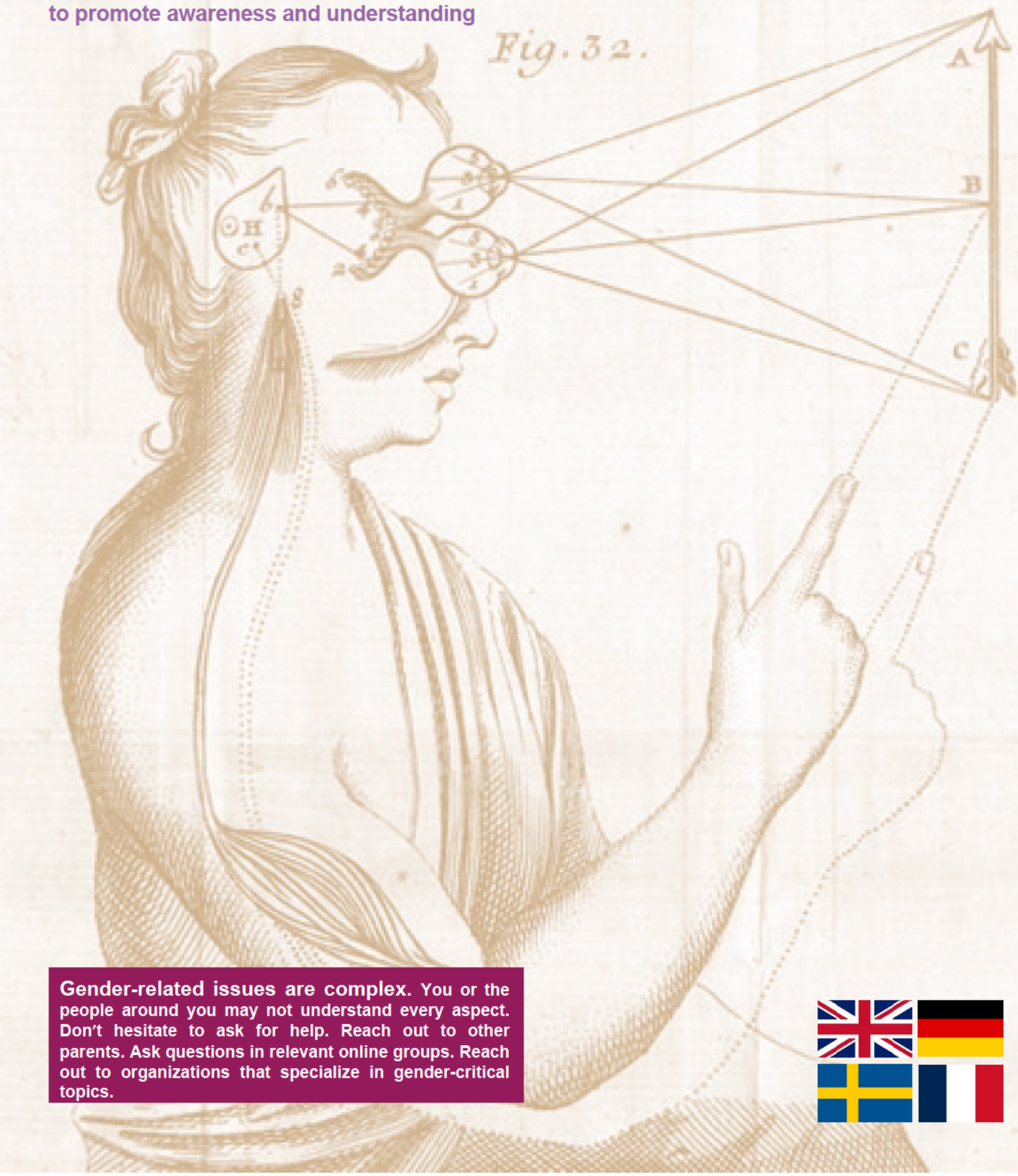
"Parents (of children who identify as trans) simply need to be given the opportunity to speak*, to share their perspectives. Mental health professionals must help their young patients to speak up. Even highly intelligent* ***patients often lack a deep understanding of themselves****. And, of course, they also lack a deep understanding of others. They lack sufficient vocabulary to describe psychological phenomena and, naturally, have limited life experience to assess their own experiences.*

The vast majority of parents I have worked with over the past 50 years love their child dearly. They are not their child's enemy. ***The fact that adolescents view their parents as enemies reflects their limited, immature understanding****."*

Genspect

January
2025

Resource for Gender Dysphoria
Survey for Family and Friends
Survey for Parents
Based on DSM-5-TR criteria,
to promote awareness and understanding



Gender-related issues are complex. You or the people around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Reach out to organizations that specialize in gender-critical topics.

Dear Parents,

We regularly receive desperate messages from parents whose voices are ignored during their child's gender clinic evaluations. Although they are invited to participate in the diagnostic process, their crucial insights are routinely dismissed in favor of immediate affirmation.

The current system is deeply troubling: *although clinics request parental input, the child's statement regarding his or her desired identity overrides the family's years of knowledge and observations. As a result, these consultations are effectively nothing more than administrative formalities—"checking boxes on insurance forms" rather than meaningful clinical evaluation. (Specialists at VUmc even suggest that the patient's wishes should take precedence, regardless of whether the treatment works or not, ed.[39])*

This practice fundamentally undermines the quality of health care. ***Parents and family members possess important knowledge that is not adequately captured through brief clinical consultations alone.*** *A meta-analytic review by Dowell and Ogles (2010)[1] and a meta-analysis by Sun et al. (2019)[2] demonstrated that parental involvement in their child's treatment has a positive effect on its overall effectiveness. Parents are familiar with their child's patterns, struggles, and changes in personality. They are often the first to notice underlying issues that may contribute to their child's distress. Yet these essential insights are often overlooked.*

Gender-related stress can arise in many different ways, which means there are also multiple paths to a solution. When clinics automatically prioritize the desire to transition and rely entirely on a young person's self-report, they miss opportunities to explore other, less invasive approaches to alleviating the stress.

To help families advocate for thorough, evidence-based care, we have developed two complementary tools:

1. The Family and Friends Survey—*This questionnaire gathers observations from family members and others who have known your child for a long time. When multiple observers share the same perspective, their collective insight becomes harder to ignore.*

2. The Family Questionnaire—*This detailed questionnaire helps identify underlying factors that need to be examined before irreversible interventions are considered.*

We recommend completing these questionnaires regardless of whether the family currently supports direct transmedicalization. Together, they provide a complete picture, ensuring your child receives the careful and thorough assessment they deserve—one that examines all contributing factors rather than rushing to medicalization. When multiple surveys have been completed by family members, we recommend printing them out and handing them in person to your child's healthcare provider. Also send electronic copies and keep them for future reference. This ensures that the family's opinion cannot be easily ignored—it is now officially documented and can be consulted in the future. ***We also recommend sending the completed survey to your primary care physician and insurance company (or, in Belgium, the health insurance fund)****, so that all parties involved are informed about the complexity and concerning aspects of cross-sex medication and surgery.*

The survey also offers an additional benefit in that it gives the extended family the opportunity to engage with this topic in a thoughtful way. It invites them to remain or become a supportive presence in the life of your vulnerable child. Concerned parents often avoid discussing gender, but this is not always helpful. Ignoring the "problem" is a common reaction to mental health issues within the family, but it is often less effective than it seems. Although parents and young people may avoid conflicts over trans issues this way, the young person often holds onto a carefully constructed identity, which can hinder the recovery process.

Remember: ***Questioning the current approach does not mean rejecting it.*** *The goal is for young people to receive the right care—care that, above all, does no harm. Your knowledge of your child matters, and these tools will help you effectively advocate for a thorough and comprehensive assessment.*

By working together and using these tools, you can ensure that your voice is not only heard but also documented. Your insights are invaluable, and advocating for thorough, evidence-based care is essential to your child's well-being.

Sincerely,
Stella O'Malley/Genspect, January 2025

1 Dowell K. A., Ogles B. M. (2010) **The Effects of Parent Participation on Child Psychotherapy Outcome: A Meta-analytic Review.** https://www.tandfonline.com/doi/abs/10.1080/15374410903532585
2 Sun M., Rith-Najarian L. R., Williamson T. J., Chorpita B. F. (2019) **Treatment Features Associated with Youth Cognitive Behavioral Therapy Follow-up Effects for Internalizing Disorders: a Meta-analysis.** https://pubmed.ncbi.nlm.nih.gov/29677451/
39 Annelou L.C. de Vries et al. (2024) **Gender-affirming medical treatment for adolescents: a critical reflection on "effective" treatment outcomes** https://bmcme-dethics.biomedcentral.com/articles/10.1186/s12910-024-01143-8

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Submit to the clinic

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General information

Information for Parents

Panic Within the Family

Your child has told you that he or she is questioning their gender and wants to visit a gender clinic at the hospital. How do you respond to this situation with the hospital? Many families are caught off guard by this topic, leading to years of emotional turmoil and discussions, often with mounting pressure. The self-identified gender identity of the child or young adult may not be immediately recognized by family members, and when it is, there are often legitimate concerns about pursuing irreversible medical interventions.

Understanding Self-Reported Identity

The core problem in clinical assessment is that the experienced "gender identity" is not physically measurable. Invasive, irreversible healthcare decisions must be based on objective evidence, not solely on the patient's subjective experience. To quantify observable patterns, we designed a survey not only for immediate family members but also for the broader circle of people who know the individual well, preferably from birth: friends, neighbors, and teachers. The survey follows the criteria described in the DSM-5-TR (the standard manual on mental disorders).

Clinical specialists often dismiss parental observations, explaining that the child did not feel safe expressing themselves to their parents. Although this may be true in some cases, especially in highly conservative or religious families, it becomes less credible if no one in the extended family or social circle has ever noticed any signs. A cousin, childhood friend, neighbor, teacher, aunt, or grandparent—someone would likely have noticed something over the years. "Gender expression" is crucial to the diagnosis. **If no one has ever noticed anything, the story simply doesn't add up.**

The Gender-Affirming Model

A fundamental principle of the gender-affirming model is that the patient's feelings are central to the care process. This raises a troubling issue: it is not limited to the patient's wishes; rather, the patient's self-diagnosis is the determining factor in the diagnostic process, which is automatically followed by clinical psychologists or psychiatrists.

Discussing these concerns with friends and acquaintances can quickly lead to a debate. A common defense is that the care provided is of high quality and is delivered by highly skilled experts. Parents or partners who question this process receive little understanding or support and are dismissed as overly suspicious. Hospitals tell the press that they conduct very thorough diagnostics before taking any major steps.

How does a diagnosis work?

We now know from experience that the diagnostic process differs from how it is often portrayed in the media. The hospital makes a diagnosis based on a method that is entirely focused on the person's self-diagnosis. We will describe the procedure in Dutch clinics; it is likely that Belgium follows a similar approach.

As soon as a person is admitted to the gender clinic, a questionnaire is administered. The person must then write a letter explaining their feelings. The letter corroborates the questionnaire, and vice versa. These self-diagnostic documents are considered evidence of "gender incongruence." The letter and the questionnaire corroborate each other but share the same source. **An additional problem often cited is that the person is following a learned script.** The clichéd language suggests that the ideas do not stem from personal experience but are rather imposed or instilled—learned from the internet. "Gender incongruence" is not the same as "gender dysphoria," although the terms are often used interchangeably. This can be very confusing. "Gender incongruence" refers to a discrepancy between one's experienced "gender identity" and biological sex, whereas "gender dysphoria" involves significant distress associated with this experienced discrepancy. This is an important distinction. **It remains a mystery why insurance companies (in Belgium: health insurance funds) cover a treatment process based on incongruence, yet one in which psychological distress need not be a necessary component.**

Current Clinical Practice

In the Netherlands today, no comprehensive differential analyses are conducted. Although clinics assess whether someone has psychosis, autism, narcissism, or other mental disorders, these additional conditions are noted and taken into account in the care process, but not used to substantiate the "gender incongruence" diagnosis. The question simply becomes: Is the person mentally and physically fit enough? This is not a differential approach, but **an assessment of readiness for medical treatment**.

With the exception of psychosis, severe depression, and related extremes, there is no rejection based on traumatic experiences, a history of bullying, autism, or other mental health issues, and the insurance (in Belgium: the health insurance fund) covers the process (with the exception of a small copayment). **In the Netherlands, even people with intellectual disabilities receive gender-affirming care.**[3]

Insurance companies (in Belgium: health insurance funds) trust that the care provided is adequate. On paper, the questionnaire and motivation letter appear thorough. However, this perception was challenged when Dutch parents introduced a rigorous, systematic intervention in the form of a family questionnaire, which revealed something entirely different and exposed the limitations of self-diagnosis. This questionnaire is based on that approach, and it gives you, as a concerned parent, significant influence over the process.

Perception of the Environment

The gender teams claim to be committed to maintaining peace within the family. Because the care file must give the impression that a broad perspective is being considered, they actively encourage conversations with parents, partners, and others directly involved. Anyone familiar with gender-critical literature—such as the books by Abigail Shrier and Hannah Barnes and the testimonies of whistleblower Jamie Reed—knows that the reality is much darker. Parents are formally invited to share their perspective. The healthcare provider nods politely, takes notes as accurately as possible on the family's impressions, and reassures them that he understands. While many parents do not support their child's self-diagnosis, some go along with their child's perspective, while others remain critical.

In follow-up meetings, the family's concerns are acknowledged, but the diagnosis is still considered final, and the treatment plan proceeds as planned. The family's impressions are noted but do not influence the final decision. In fact, their concerns are even used against them in a counterproductive way to make the investigation appear more thorough on paper in order to meet insurance requirements (in Belgium: reimbursement requirements). Parents who give their consent despite their doubts often do not realize the implications until later. A well-known example of this dynamic was revealed in Elon Musk's interview with Jordan Peterson in July 2024.[4]

3 **Genderpoli / They and Them (Nov 2023).** Dutch documentary about YOUZ https://www.npodoc.nl/documentaires/2023/11/genderpoli-they-and-them.html

4 **Elon Musk interviewed by Jordan Peterson (July 2024)** https://www.youtube.com/watch?v=Q20Nbq3EJsc

Explanation of the Family and Friends Survey Information for Parents

Purpose of the Family and Friends Survey

Based on the key findings of Shrier, Barnes, Reed, and other concerning publications about clinics, we have developed an assessment method that goes beyond parental input alone and also includes broader family observations.
The survey, based on the DSM-5-TR criteria for "Gender Dysphoria," is designed for adults who have known the individual for a long time and have detailed knowledge of his or her development. These may include family members, neighbors, cousins, childhood friends, former teachers, and work supervisors. Through this comprehensive approach, we aim to support healthcare providers and families in making well-informed, evidence-based decisions.

Systematic Documentation and Clinical Validation

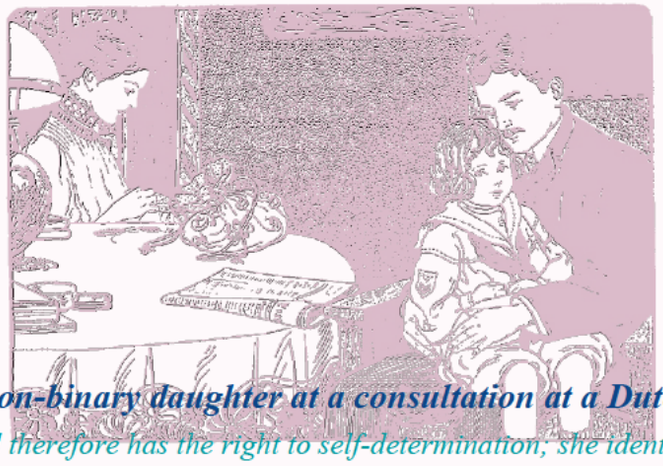
The primary value of the family and friends survey lies in its ability to objectify parental observations. Patients may claim that their "gender incongruence" has always been present but hidden, or that parental resistance stems from conservative views, but these claims require careful clinical evaluation.
Research by Abigail Shrier shows that parents seeking a thorough assessment are often open-minded, accepting of sexual diversity, politically progressive, and frequently successful and highly educated individuals with a deep understanding of their children's development.
Survey results consistently show that family members and acquaintances often share the same observations as the parents. This becomes particularly relevant when multiple observers from different contexts report no prior signs of gender incongruence. Early developmental patterns are typically observed by at least some members of a child's social network. **Therefore, this systematic documentation constitutes a crucial clinical tool that deserves serious consideration.**

Gender-critical perspectives are not far-right politics

It is important to note that Shrier, Barnes, and especially Reed (a lesbian healthcare professional who was married to a transgender person when she made her whistleblower statement) are **progressive intellectuals**. This demonstrates that the critical analysis of current gender clinic protocols stems from diverse intellectual backgrounds, rather than from a specific ideological political position.

Impact on the Diagnosis

The survey results provide the specialist with insight into how the entire family perceives the patient and give greater weight to the aspect of family issues in cases of differing opinions. Official guidelines for transgender care offer little information on family matters, but **ignoring family dynamics when considering irreversible medical interventions raises serious ethical concerns.**
If there is a social divide, relationship therapy should take place first. **Disrupting the family through a care process involving a high degree of family friction raises serious ethical concerns regarding patient care and the well-being of the family.**



Father of a 21-year-old non-binary daughter at a consultation at a Dutch clinic

"My daughter is 21 and therefore has the right to self-determination; she identifies as non-binary. Her wish was not to take hormones, but to undergo a double mastectomy. To my great surprise, that is actually possible in the Netherlands!"
I wanted to speak with the clinic and was invited to do so. The psychiatrist began by saying, "If your daughter wants to end the conversation, it's over right away. She's completely in control." Later, he said, "I actually don't think a psychiatrist needs to be involved at all. Unless, for example, there's severe depression or psychosis; then we'll take a different approach. If you say what you are, then that's what you are—that's enough for me." The psychologist compared the situation to getting a tattoo or emigrating: "Sometimes children make choices you're not happy with, but as a parent, you'll still have to accept them."
"My daughter and I haven't been in contact since the surgery a few months ago because of our difference of opinion."

Explanation of the Family Survey

Information for Parents

Clinical considerations regarding coexisting conditions

Due to growing scientific skepticism regarding the gender-affirming model and emerging research findings, we have developed this survey to assist clinicians in thoroughly evaluating potential coexisting conditions. When a young person has experienced trauma, exhibits self-hatred, or has a neurodevelopmental disorder such as autism, careful consideration must be given to how these factors may influence their self-reported "gender dysphoria." This thorough evaluation is essential before considering irreversible medical or surgical interventions, in line with the fundamental principle of medicine: **"Primum non nocere" (first, do no harm).**

Diagnostic overshadowing

The **Cass Review** warns against **"diagnostic overshadowing**." The specialist may attribute the problem to the wrong cause. Patients may attribute their discomfort to medical conditions rather than linking it to other underlying factors and addressing those. This pattern has been observed more frequently in previously suddenly prevalent conditions such as RSI (repetitive strain injury), false memory syndrome, and dissociative identity disorder. These conditions often share characteristics such as recent widespread recognition of the phenomenon, difficulty in objective measurement, and a primary reliance on patient self-reporting. Although the discomfort is real, potential nocebo effects (negative expectations that trigger the symptoms) warrant attention. Because gender-affirming treatments often involve irreversible medical interventions, the implications of diagnostic overshadowing are significant. Recent data indicating a 30% dropout rate at follow-up raise concerning questions. Therefore, thorough documentation and a comprehensive evaluation are essential before proceeding with medical interventions.

SOC-8 and the Dutch Protocol in Conflict with the Cass Review

Shortly after the publication of the Cass Review, Dutch clinics issued a statement claiming that the practices described in the report were already standard practice in the Netherlands. **This is incorrect.** The original Dutch protocol was based on **patients who, from a young age, exhibited clear gender-nonconforming behavior** and expressed a desire to be of the opposite sex. In addition, a strict condition was that the children had **no other problems** and that they had **family support.**

The so-called **"real-life test"** was also part of the protocol. This was a two-year phase during which individuals had to live as the opposite sex. This allowed them to experience the practical consequences of their transition and to demonstrate to the clinic that their desire was sincere and well-considered. This procedure was eliminated in 2014. Today, individuals diagnosed with "gender dysphoria"—based entirely on their own self-report—can begin hormone therapy immediately after receiving a formal diagnosis. Although this approach increases accessibility, it can lead to challenges, such as unrealistic expectations or unexpected problems that were not apparent before the transition. The practice in the Netherlands (and Belgium) corresponds to what is described in Barnes's book and represents precisely the core of the criticism Cass voices in her report.

Impact on Family Dynamics

The lack of evidence-based explanations creates significant concerns for families. Parents often experience severe stress during this process, and poor communication from the clinic can exacerbate the family's distress. When clinics fail to address the family's concerns or provide clear clinical justification, **this can cause iatrogenic* harm to the family.**

Conducting the Family Survey

The family survey contains a comprehensive list of conditions often associated with transgender self-identification. Parents are asked to indicate which of these conditions they have observed. **When submitting the survey, explicitly ask the clinic for feedback on:**

- Whether the specialists have observed the same patterns
- If not, what the clinical basis is for other observations
- How identified conditions may influence self-reported "gender dysphoria"
- What the specialists believe to be the proposed mechanism of interaction between the conditions

The clinic's responsibility and family rights

Although respecting patient privacy is important, open communication remains essential, particularly in cases of gender dysphoria, given the far-reaching implications of irreversible medical interventions and their impact on long-term health. Decisions affect the entire family and can cause significant stress-related health risks. **Therefore, the family has the right to receive sufficient information to understand and process clinical decisions.** When clinics refuse to address these concerns, they risk causing iatrogenic harm, not only to the patient but also to the family**. Healthcare providers must uphold ethical standards that take into account both the individual's well-being and that of the family.** They must not "create" patients.

Parent of a daughter with multiple conditions

> *"Our adult daughter developed a non-binary identity during high school,* ***partly due to social and online influences.*** *She decided to have her breasts removed to prove that she was 'transmasc.' Despite a letter* ***detailing her additional mental health conditions—such as eating disorders, autism, trauma from bullying, and obsessive-compulsive disorder (OCD)****—our healthcare provider removed our daughter's healthy breasts. The medical organization never contacted us to discuss our daughter's mental health issues. We can thank the incompetent therapists for enabling this self-hatred and self-harming behavior."*

5 H. Postma (Oct 2024) **The Dutch Leaks: Trans Regret is Possibly 33%** https://genspect.org/trans-regret-is-possibly-33/

* "Iatrogenic" means: harm caused by the treatment itself.

Early and Late Onset of Gender Dysphoria

Information for Parents

Characteristics According to the DSM-5-TR

The DSM-5-TR provides two sets of criteria for identifying gender dysphoria (GD): early-onset and late-onset.[6]

Early-Onset Gender Dysphoria (EOGD)

Children are usually diagnosed with gender dysphoria if they have experienced **significant distress** for at least six months and exhibit **at least six of the following characteristics**:

- A strong desire to be of the opposite sex or a persistent belief that they belong to the opposite sex.
- A strong preference for wearing clothing typical of the opposite sex
- A strong preference for roles associated with the opposite sex during pretend play or fantasy play
- A strong preference for toys, games, or activities stereotypically associated with the opposite sex
- A strong preference for playmates of the opposite sex
- Strong aversion to toys, games, and activities typical of one's own sex
- Strong aversion to one's own physical sex characteristics
- Strong desire for the physical sex characteristics of the opposite sex

Late-Onset Gender Dysphoria (LOGD)

To be diagnosed with gender dysphoria as a teenager or adult, there must be at least six months of significant distress due to at least two of the following characteristics:

- A clear incongruence between the primary or secondary sex characteristics of one's own sex and the experienced and expressed other sex
- A strong desire to rid oneself of the primary or secondary sex characteristics of one's assigned sex
- A strong desire for the primary or secondary sex characteristics of the other sex
- A strong desire to be of the other gender
- A strong desire to be treated as the other gender
- A strong conviction that you have the typical feelings and reactions of the other gender



Parent of a teenage daughter who has paused her transition

"From age 11 to 15, my daughter struggled with anxiety, PTSD, and possibly ADHD. She learned about 'transgender' from ***spending too much time online, school counselors who discussed it with her behind our backs, and her peers at school.*** *It was incredibly disappointing and confusing that every professional I trusted to help our daughter achieve a more holistic self-understanding focused solely on 'gender identity.' Our concerns that our daughter's stress was a maladaptive coping mechanism and that she was being influenced by others were dismissed. Her private therapist called us* ***"non-accepting parents."*** *The school counselor encouraged "identity exploration" and supported the idea that my daughter "might actually be a boy," and changed her name and pronouns at school. When she became withdrawn and depressed, I realized that our daughter, at the age of 14, had been secretly speaking with a trans-ideological licensed social worker about the medical aspects of "her gender," hormone injections, and surgeries. All of this happened without our knowledge or consent. Surprisingly, even our pediatrician—despite all the issues our daughter was struggling with—promoted the "options" of puberty blockers and binders.* ***These adults placed their blind trust in a child,*** *without understanding the process of identity development and without realizing that my daughter's focus on gender identity was fueled by those who spoke to her about it as if it were a real possibility. My daughter decided to stop just before her 16th birthday, and is now incredibly grateful that I did not give in to her constant demands to see her as the opposite sex and to allow medical interventions.* ***Our family will carry the aftermath, the trauma, and the anger from this experience with us for the rest of our lives, and we consider ourselves victims of a terrible medical-ethical scandal."***

6 **DSM-V-TR online:** https://archive.org/details/dsm-5-tr/page/n1/mode/2up

The Illogicality of the DSM-5-TR Criteria

Information for Parents

The illogical nature of the DSM-5-TR criteria for "gender dysphoria"

Share with family and friends

Feminism and Gender Role Patterns and Expression

Feminism rightly criticizes the stereotyping of male and female role patterns. After all, every person should be free to express themselves without being constrained by social norms such as "girls play with dolls" or "boys have to be tough." A person exhibits certain behavior because they find it enjoyable or interesting. **That should remain free from speculation about supposed "gender identity."**

The DSM-5-TR and Outdated Gender Stereotyping

However, in the DSM-5-TR criteria, the vaguely defined term "gender expression" and gender role patterns are indeed used as indicators of experienced "gender dysphoria." For example: A boy with a strong preference for "girls' toys" or girlish behavior may meet the criteria for "gender dysphoria." **This approach is a regression to outdated stereotypes** and contradicts the feminist idea that behavior is independent of sex. Feminism rightly emphasizes that breaking gender stereotypes is precisely not an indication of so-called "gender incongruence" and should have no medical or diagnostic significance whatsoever.

Context of "gender dysphoria"

The DSM-5-TR attempts to identify "gender dysphoria" in individuals who experience psychological distress due to a perceived incongruence between their gender identity (based on outdated stereotypes) and their sex. It is therefore not purely about behavior, but about behavior combined with significant distress. The inclusion of gender stereotypes as a criterion is problematic, as it can lead to **the unnecessary pathologization** of individuals who simply do not conform to traditional gender role patterns.

Homosexual individuals, artistic people, and people with autistic traits or mental health issues often exhibit atypical behavior. The person's self-assessed conclusion must be examined. Why does the person come to the conclusion that he or she belongs to the opposite sex or to no sex (non-binary), even though this is not a biological reality? A better solution is to make the diagnosis independent of gender stereotypes. Freedom in "gender expression" renders transmedicalization unnecessary. After all, why damage a body when someone can simply express themselves in any form they choose?

What does the DSM-5-TR analyze?

The DSM-5-TR criteria thus analyze whether a person behaves in a gender-conforming or gender-nonconforming manner based on outdated gender stereotypes. **This is fundamentally flawed**, but if a person clearly behaves in a gender-conforming manner according to their social environment, this should be a major red flag for the clinic, and no transmedicalization should take place. After all, the DSM-5-TR criteria state that there must be gender-nonconforming expression, and that is precisely what is not visible in this group.

Even if gender-nonconforming behavior is present, that is **still not a legitimate reason** to proceed with transmedicalization, because the atypical behavior may stem from entirely different causes, and this cannot be determined using the overly simplistic and incorrectly formulated DSM-5-TR criteria. The clinic will have to demonstrate how it actually arrived at its diagnosis. It is to be expected that they will be unable to do so, as there are no measurement methods for this. **"Primum non nocere" (first, do no harm) takes precedence over the medicalization of what cannot be determined.**

Is the family and friends survey then unnecessary?

It is common for family and friends to go along with the person's story out of compassion. Part 1 of the survey, which is based on the DSM-5-TR, encourages friends and family to reflect on how illogical the diagnostic criteria actually are and that they should never serve as the basis for consenting to highly invasive, body-damaging transmedicalization. The subsequent sections of the survey provide the clinic with additional insight into what is going on with the person.



Rapid-Onset Gender Dysphoria (ROGD) Information for Parents

Characteristics of Rapid-Onset Gender Dysphoria (ROGD)

ROGD, or Rapid Onset Gender Dysphoria, is a hypothesis proposed by Dr. Lisa Littman that describes **the sudden onset of gender-related distress**, particularly among adolescents and young adults with no prior signs of "gender dysphoria" in childhood.[7]

The ROGD hypothesis suggests that gender-related distress may be influenced by social and environmental factors, including:

- social isolation (e.g., during the COVID-19 pandemic)
- the influence of the internet (due to increased online activity on social media)
- underlying anxiety
- misinterpretation of other mental health issues
- dynamics within the group of friends

The Family and Friends Survey as an Indicator of ROGD

An unexpected finding emerged during the development of the family and friends survey: The tool confirms the likelihood of the ROGD hypothesis. Littman's hypothesis sparked significant clinical debate worldwide, as it directly conflicts with the gender-affirming model, which views gender identity claims as innate and immutable.

A common criticism of Littman's research—that it was based on parent interviews rather than direct patient accounts—ignores important methodological considerations regarding self-report bias in clinical assessment. **The family and friends survey helps to objectify parents' observations** by providing systematic documentation of when and how gender-related stress developed.

The scientific consensus is shifting

A rapidly growing group of experts, including **Hilary Cass, Jonathan Haidt, Gordon Guyatt (EBM), Richard Dawkins, Ray Blanchard, Stephen Levine, Michael Bailey, Ken Zucker, Marcus Evans, Michael Biggs, Riittakerttu Kaltiala**, and many other leading researchers, supports Littman's analysis. Partly because of these experts' academic credentials, ROGD should be taken more seriously than gender clinics would have us believe. Their view no longer aligns with the growing awareness in 2025 that social contagion very likely plays a major role in the extreme increase.

Important to Know

The existence of ROGD is often ignored by clinics that offer "gender-affirming care" because it directly conflicts with the provision of medication and surgery, since this type of gender-related distress is not innate but socially induced. The clinic must prove why someone does not have ROGD. We, as parents, do not have to prove that ROGD exists. **This is a reversal of the burden of proof imposed on parents who are not specialists and do not have research resources at their disposal.**



Parent of a 23-year-old daughter who has stopped her transition

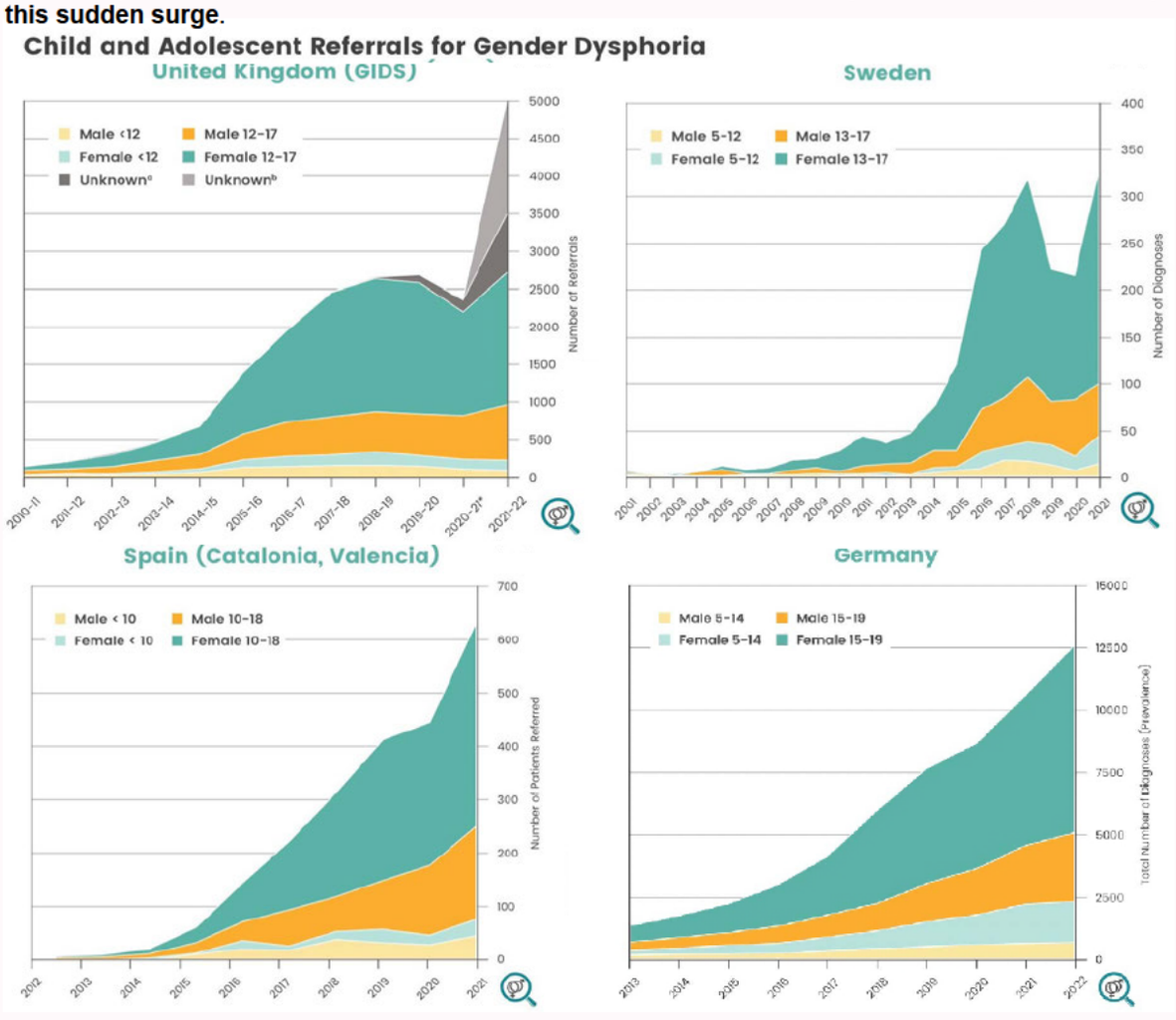
"When I told our family doctor that my 23-year-old daughter identified as transgender, she immediately referred us to the gender clinic. I felt that confirming my daughter's self-diagnosis was not the right course of action. I wanted to talk to the doctor about the phenomenon of ***'Rapid Onset Gender Dysphoria,'*** *which accurately described the symptoms of my daughter's behavior. The doctor wouldn't listen to me.* ***When I tried to give her a printed article about ROGD, she threw her hands up in the air and refused to take it.*** *She said she sees many transgender patients and already knew enough. I lost trust in that doctor and never went back. My daughter has since stopped her transition. I'm still angry at that doctor for not taking me seriously, and I'm immensely relieved that we didn't follow her ill-informed and misleading advice."*

7 Lisa Littman (2018) **Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria**
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330

Rapid-Onset Gender Dysphoria (ROGD) Information for Parents

Epidemic

After the term "gender identity disorder" was replaced by "gender dysphoria" in the DSM in 2014 and there was extensive media coverage of transgender youth, the number of referrals to clinics in all Western countries rose by **2,000% to 5,000%**. The Netherlands has not published any charts since 2016, but the numbers here are identical as well. From a few dozen (±50) per year to approximately 2,000 patients in 2024—that is **an increase of ±4,000%**. Belgium **does not** publish **any data** at all **regarding this sudden surge**.



Wertherism

Wertherism, or the Werther effect—a term derived from Goethe's novel **The Sorrows of Young Werther** (1774)—refers to the phenomenon in which people are influenced by media or stories, **particularly regarding self-destructive behavior**. In the book, the main character, Werther, commits suicide with a pistol after his love for an unattainable woman goes unrequited. Following its publication, there was an observed increase in the number of young men who committed suicide in a similar manner, sometimes even wearing the same style of clothing as Werther. In other words: A very firm, collective belief arose that happiness could be achieved exclusively through **"true love"; without that prospect, suicide seemed the only way out.** This led to the term "Werther effect," which refers to the risk of imitative behavior following media coverage of suicide.

Detransitioner Charlie Bentley-Astor *(interviewed by Andrew Gold)*

> *"Queer Destiny is, in essence, the rather harmful idea that if you're born gay, bi, trans, or queer — whatever label you choose — this is the most important thing about you. It becomes the defining characteristic of your existence and determines the course of your life. You have only two choices: You either embrace it fully, or you commit suicide. Because if you don't accept it, it festers and you become so trapped within yourself, in such a horrific way, that your only escape is suicide. But ultimately, it's just an idea."*

Detransitioner Christina Hineman

> *"A kind of punk behavior, but instead of sex, drugs, and rock 'n' roll, it was just drugs. And surgeries. It's a medicalized version of normal teenage rebellion. And I got completely sucked into it."*

Mia Hughes*—author of *The WPATH Files**

> *"Rapid-onset gender dysphoria is the most obvious case of social contagion that has ever occurred."*

The Falsehoods of Gender-Affirming Care Information for Parents

On February 21, 2023, the **Florida House Health & Human Services Committee** heard testimony from board-certified psychiatrist **Dr. Stephen Levine,** clinical professor of psychiatry at Case Western Reserve University. He outlined thirteen scientifically inaccurate assumptions that form the basis of gender-affirming care for "gender dysphoria" in children.*

"I have identified thirteen ideas in the literature put forward by those who support medicalization for children, adolescents, and adults experiencing the transgender phenomenon. In my view, each of these thirteen points is scientifically incorrect. Nevertheless, they are held with firm conviction. When they are refuted in discussions—or even merely touched upon—it leads to passionate outrage that they are supposedly untrue. However, as far as I can tell, these thirteen ideas are not scientifically verifiable and are clearly clinically incorrect. Yet they are repeatedly cited in the writings and conversations of therapists who support affirmative care.
Before I present these thirteen points, I want to offer a different perspective on this major question regarding transgender care for young people: Is this an example of therapeutic progress to help those affected, or is it yet another medical misstep? In the medical world, we have ***a history of many medical missteps.*** *The most recent—and also one of the most harmful—is the opioid crisis. We began prescribing opioids liberally without scientific evidence of their benefits or harms. Now, in every state in the United States—and elsewhere—people are suffering from premature death due to opioid abuse.*

Here are the thirteen points that, in my opinion, are not true:
1. "Once established, a trans identity is unchangeable and always remains the same." This is clearly not true.

2. "Trans identities are primarily caused by prenatal biological factors." This claim suggests that treatment simply corrects a biological or embryological error.

3. "Sexual orientation is completely independent of gender identity." Sexual orientation is a preference for romantic and sexual relationships with members of a particular group (men or women). However, as children develop—from childhood through puberty and into adolescence—gender dysphoria often co-occurs with same-sex attraction, indicating that they are not entirely separate phenomena.

4. "No form of gender identity is a deviation or a symptom of another problem." This is not a psychologically tenable concept, but it is often claimed in the literature.

5. "Gender dysphoria is a serious medical condition that requires medical intervention, but only if the patient wants it." This idea contains an inherent paradox: if it is a serious medical condition, that implies the need for treatment, but only if the patient desires it.

6. "The associated emotional problems are primarily caused by living in a discriminatory world." Many children diagnosed with gender dysphoria had already received other psychological diagnoses.

7. "There are no effective alternatives to affirmative care." Doctors often claim that this is the only solution for children, but alternative psychiatric approaches, as discussed by Dr. Laidlaw, do indeed exist.

8. "Attempts to provide psychotherapy are unethical forms of conversion therapy and should be banned." Any attempt to help the child and the family is often labeled as conversion therapy, with calls to ban it in various jurisdictions (instead of psychotherapy to address the underlying psychological problems, ed.).

9. "Affirmative care permanently improves mental health and social functioning." This is often used as justification, but long-term studies demonstrating this are lacking. In fact, data point to increased mortality rates among transgender adults.

10. "Affirmative care reduces suicidal thoughts and prevents suicide." This is a powerful, compelling message conveyed to parents of teenagers. However, studies—such as those from Sweden—show significantly increased suicide rates among adults who have undergone gender-reassignment surgery.

11. "Young teenagers know best what will make them happy in the future." This claim assumes that a teenager fully understands his or her "true self," which is not necessarily the case.

12. "Meeting the diagnostic criteria for gender dysphoria predicts a good outcome with affirmative care." This is demonstrably false.

13. "Regret and detransition are rare among these patients." Recent years have shown that detransition is being recognized with increasing frequency. The reporting of "regret" is too limited, because detransitioners usually do not inform their practitioners about it, and it does not do justice to the complexity of this phenomenon.

These thirteen ideas form the core of the claims regarding affirmative care. ***If the ideas themselves are not true or scientifically substantiated, how can we trust the treatments based on them?****"*

To supplement this, in line with Levine's list:
The German version of this Genspect survey cites the German critical thinker Alexander Korte, stating that every DSM diagnosis is **always** a snapshot in time and **should never be a reason for permanent, irreversible bodily modifications**.[39]

8 **Dr. Stephen Levine: 13 Untruths Behind Gender-Affirmative Therapies for Kids** (Feb 2023) https://www.youtube.com/watch?v=OflbCjj_hVc 39 **Hinter dem Regenbogen, A. Korte, page 210** (2024) https://shop.kohlhammer.de/hinter-dem-regenbogen

Recommendations for Further Research

The more you know, the better you can protect your child.

Books and Literature on Gender

- *Trans* - **Helen Joyce,** ISBN-13 978-9463833547 (2024). Explores the issues surrounding gender ideology from the broadest sociological perspective. **The Dutch edition** is available through Bruna.
- *End of Gender: Debunking the Myths About Sex and Identity in Our Society* - **Debra Soh** ISBN-13 978-1982132521 (2023). An essential critique of the inaccuracies in gender studies as a discipline.
- *Irreversible Damage* - **Abigail Shrier** ISBN-13 978-1800750364 (2021). About ROGD.
- **Time to Think**—**Hannah Barnes,** ISBN-13 978-1800751118 (2023). About the Tavistock scandal and the disturbing science and history of gender-affirming care as a flawed treatment model.
- **Detrans**—**Dr. Az Hakeem** ISBN-13 979-8862184549 (2023). About the psychology of cross-dressing and transsexual behavior and their serious consequences.
- *When Kids Say They're Trans* - **Lisa Marchiano, Stella O'Malley & Sasha Ayad** ISBN-13 978-1800752641 (2023). A guide for parents.
- *Lost in Trans Nation: A Child Psychiatrist's Guide Out of the Madness* - **Miriam Grossman** (2023) ISBN-13: 978-1510777743 Main theme of this book: Parents know their child best.
- *The WPATH Files* - **Mia Hughes** (2024). Exposes the corruption within WPATH and how it has influenced gender-affirming care worldwide.
- *The Cass Review, Final Report* - **Hilary Cass** (2024). The most comprehensive systematic review of the gender-affirming care model. This report is fully in line with the issues Barnes also highlighted in her book.

Books Offering a Broader Perspective

- *Bodies under Siege* - **Armando R. Favazza** ISBN-13 978-0801899669 (2011). On self-mutilation, non-suicidal self-harm, and body modification in culture and psychiatry.
- *Mass and Power* - **Elias Canetti** ISBN-13 978-9025315696 (2022). On collective behavior, mass delusions, cults, and extreme (self-harm) rituals.
- *The Rape of the Mind* - **Joost A. M. Meerloo** ISBN-13 978-1-61577-376-3 (2009). On the psychology of mind control, menticide, and brainwashing.

Don't have a reader? No problem!

- **Watch interviews on YouTube** with the experts mentioned above. Listen to **the "Gender: A Wider Lens"** podcast.
- Join Facebook groups. There are many English-language groups. For Dutch and Flemish parents, there's the group **"Concerned Parents of Children with Gender Dysphoria**." This is a critical group. There's also **"Parents of Transgender Children**." The latter is a parent group whose members believe their child is trans. The two groups differ significantly in tone, so choose what feels best for you and avoid conflict.
- **Go to X** (and other social media platforms) and follow Dutch-language gender-critical organizations such as Voorzij, Genderpunt, Cry for Recognition, and MeMoMa, as well as English-language organizations like Genspect, Stats
  for Gender, PITT, Parents of Desisters, Do No Harm, Therapy First, CAN-SG, and many others.
- Get in touch with parent groups and gender-critical organizations: **Voorzij, Cry for Recognition, Genderpunt, MeMoMa, NPV Zorg.** You can't resolve a disagreement with a clinic on your own.
- **Write letters** to the media and politicians and ask for help.
- **Attend conferences** to network.

***Eliza Mondegreen**—journalist at the European Professional Association for Transgender Health conference* [8]

*"In a disturbing update on the link between autism and transgender identity among patients at the Dutch clinic, researchers reported that—of the 30 patients who were potentially eligible to participate in a 17-year follow-up study — **four had refused** to participate, **two had de-transitioned**, one who had not de-transitioned expressed **deep regret** about the vaginoplasty, and **two were 'deceased**.' Only at the end of the presentation did the researchers admit that these two patients had, in fact, committed **suicide**. According to the researchers, the suicides demonstrated that there are "two sides to every story," that there is "no crystal ball," and that the subject "should not be treated without nuance." However, exactly what a "nuanced" approach entails remained unclear. Does "nuance" sometimes mean glossing over negative outcomes to avoid undesirable conclusions?*

The presenters preferred to focus on the "diversity" of their "trans-autistic" patients, with their varied self-identifications 17 years after they began their transition journey: "fairy," "elf," "non-binary," "friendly, non-intimidating woman," "cis" (read: detransitioned). "Every referral," according to the presenters—including patients who died, had detransitioned, or experienced regret—"followed their own unique path regarding their gender identity and mental health journey."

*Time and again, researchers and clinicians presented alarming findings suggesting that something is seriously going wrong in the world of "gender-affirming care," only to fail to apply their conclusions to their practice. **Despite the tragic consequences, this care continues to be regarded as "essential" and "life-saving"—even when patients die**."*

9 Eliza Mondegreen (May 4, 2023) **Part I: Three days at the European Professional Association for Transgender Health** https://genspect.org/dont-stop-be-lievin-three-days-at-the-european-professional-association-for-transgender-health/

Genspect

Submit to clinic

Family and Friends Survey

An Objective Assessment of the Parental Perspective for Clinical Evaluation Prior to Initiating Gender-Affirming Interventions

Gender-related issues are complex. You or the people around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Contact organizations that specialize in gender-critical topics.



Family and Friends Survey - 1

Submit to the clinic

Sixteen questions based on DSM-5-TR criteria

To develop this survey, the DSM-5-TR criteria were rewritten into questions suitable for family members and friends. We included two criteria from the section on children and also applied them to the behavior of adolescents (Questions 7 and 8).

Present

1. Is there a clearly visible discrepancy between the desired gender (gender expression) and the biological sex? 0 Yes 0 No 0 Unclear

2. Does the person express a strong desire to be rid of his or her sexual characteristics? 0 Yes 0 No 0 Unclear

3. Does the person clearly present themselves as the opposite sex in terms of clothing and behavior? 0 Yes 0 No 0 Unclear

4. Does the person express a strong desire to become the opposite sex? 0 Yes 0 No 0 Unclear

5. Does the person express a strong desire to be treated as the opposite sex? 0 Yes 0 No 0 Unclear

6. Does the person exhibit typical feelings and reactions normally associated with the opposite sex? 0 Yes 0 No 0 Unclear

7. Do you see expressions in their music preferences, movies, anime, or hobbies that are stereotypical of the opposite gender? 0 Yes 0 No 0 Unclear

8. Does the person seek social interaction with groups of the same sex or the opposite sex? 0 Yes 0 No 0 Both

Past

9. As a child, did the person show a strong desire to be of the opposite sex? 0 Yes 0 No 0 Unclear

10. As a child, did the person wear clothing typical of the opposite sex? 0 Yes 0 No 0 Unclear

11. As a child, did the person show a strong preference for roles of the opposite gender in fantasy or “pretend play”? 0 Yes 0 No 0 Unclear

12. As a child, did the person show a strong preference for toys, games, or activities stereotypically associated with the opposite sex? 0 Yes 0 No 0 Both

13. As a child, did the person have a strong preference for playmates of the opposite sex? 0 Yes 0 No 0 No preference

14. As a child, did the person have a strong aversion to toys, games, and activities typical of his or her gender? 0 Yes 0 No 0 Unclear

15. As a child, did the person have a strong aversion to his or her own sexual anatomy? 0 Yes 0 No 0 Unclear

16. As a child, did the person have a strong desire for physical sexual characteristics that corresponded to their gender identity? 0 Yes 0 No 0 Unclear

Family and Friends

Submit to the clinic

Questions about the person's background and social influences

1. Did the transgender identity emerge suddenly during or after puberty without any prior signs in childhood? 0 Yes 0 No 0 I don't know

2. Do you think the person might be influenced by friends? 0 Yes 0 No 0 I don't know

3. Are there transgender/non-binary/"queer" people in the class or group of friends? 0 Yes 0 No 0 I don't know

4. Do you think online information plays a role in the person's self-diagnosis? 0 Yes 0 No 0 I don't know

5. Do you think this person might have other mental health issues, such as anxiety, depression, or autism spectrum disorder? 0 Yes 0 No 0 I don't know
If yes, what notable behaviors does the person exhibit?

6. Did the person behave differently as a child or before disclosing their self-diagnosis compared to now? 0 Yes 0 No
If yes, can you describe what that change looks like?

7. Did the person distance themselves from family and/or former friends shortly before or after "coming out as trans/non-binary"? 0 Yes 0 No

8. Are most of their friendships and activities now related to their trans identity? 0 Yes 0 No 0 I don't know

9. Do you get the impression that the person is confused about his or her identity and has misdiagnosed themselves? 0 Yes 0 No

10. Do you think that, for this person, a trans identity might simply be a temporary phase of interest? 0 Yes 0 No 0 I don't know



Family and Friends Survey - 3

Submit to the clinic

Additional questions

1. Should the family's impression be given significant weight in the diagnosis? 0 Yes 0 No
   Why do you think so?

2. Should the opinions of the primary care physician and other healthcare providers also be sought and taken into consideration? 0 Yes 0 No

3. Do you think the person might be gay, bisexual, or asexual? 0 Yes 0 No

4. Could the person be experiencing inner shame about possible homosexuality? 0 Yes 0 No 0 I don't know

5. Does the family have issues with gay people? 0 Yes 0 No
   0 I don't know If yes, can you explain why?

6. Does any religious community, workplace, or sports club you may be part of have issues with gay people? 0 Yes 0 No 0 I don't know

7. Do you understand what makes the person unhappy with his or her body? 0 Yes
   0 No
   If yes, can you explain why?

8. Have you ever experienced serious gender-related distress yourself, either when you were younger or now? 0 Yes 0 No
   If yes, can you explain why?

9. Is there anything else you'd like to add regarding the person's diagnosis or this questionnaire?



Family and Friends Survey - 3

Submit to the clinic

10a. Question regarding informed consent (for men)

The medical literature documents the following serious potential side effects:*

Puberty blockers

- Permanent impairment of sexual function, including fertility and failure to develop the ability to experience orgasm [32,33]
- Long-term effects on bone density (osteoporosis) and growth [10]
- Negative impact on neuropsychological functioning [10]
- Underdeveloped genital tissue (micropenis), which may limit future surgical options [11]

Estrogen therapy (in combination with antiandrogens)

- Increased risk of mortality [12]
- Insulin resistance (33% of patients) with an increased risk of diabetes [13]
- Increased risk of cancer (breast and liver cancer, meningioma (brain tumor)) and liver damage
- 26 times higher risk of testicular cancer (1 in 100 patients) [14]
- Thrombosis (5% of trans women, 22 times higher than in cis men) [15]
- Significant weight gain and redistribution of body fat
- Cardiovascular complications, mortality rate 2.6 times higher [12]
- Severe loss of muscle mass
- Permanent infertility (very common) [16]
- Changes in sexual function, decreased libido, impotence [17]
- Progressive decrease in bone density
- Severe shrinkage of the testicles



Postsurgical complications (following vaginoplasty)

- Organ prolapse (up to 7.5%) [18]
- Incontinence (up to 15%) [18]
- Chronic urinary tract symptoms (up to 20%) [18]
- Death from infections; mortality rate 9 times higher [12]
- Sexual dysfunction (up to 75%) [18]
- Inability to achieve orgasm (studies are extremely flawed and present distorted figures due to poor methodology)

General considerations

- **11% of men (trans women), average age 23, died after 11 years** [12]
- Permanent dependence on hormone therapy and medical supervision [19,20]
- Substantial risks of serious medical complications [11–16, 18, 21–27, 32, 33, 26]
- High likelihood of permanent loss of fertility and sexual function [16]
- Persistently elevated risk of suicide after transition; mortality rate 7 times higher among men [12]
- Irreversible changes with limited long-term studies; effects not fully understood [28]
- All of the above medications are used off-label
- Very limited dating pool, leading to loneliness, lack of intimacy, relationship stress, and depression
- **No proven mental health benefits (puberty blockers and estrogen, surgery)** [7]

Question for the clinic

Have you thoroughly assessed these medical implications, informed the patient about them, and determined that this is the optimal treatment?

0 Yes 0 No

Question for a family member

Have you thoroughly assessed these medical consequences and determined that this is the optimal treatment plan, with an understanding of the potential lifelong consequences?

0 Yes 0 No

***Dr. Stephen Levine** - The Reality of Trans Youth Evaluations (Denver, USA, 2023)*

"Before patients start hormone therapy, I ask them if, when they feel depressed, they'll consider the possibility that it's due to their transition and not something else. And I want them to have the strength and courage to acknowledge that. Like so many of us, you may have made a mistake in your life.

*Endocrinologists almost never stop hormone treatment for the people they started it with. All the detransitioners I speak with stopped their hormones on their own; it wasn't the doctor. **Even if they're depressed or have attempted suicide, treatment is often continued**."*

*Sources on page 19

Family and Friends Survey - 3

Submit to the clinic

10b. Question regarding informed consent (about women)

The medical literature documents the following serious potential side effects:*

Puberty blockers

- Permanent impairment of sexual function, including fertility and failure to develop the ability to experience orgasm [34–36]
- Long-term effects on bone density (osteoporosis) and growth [10]
- Negative impact on neuropsychological functioning [10]

Testosterone therapy

- Increased risk of mortality [12]
- Progressive decline in bone density (14% develop osteoporosis, 22% develop osteopenia) [29]
- Atrophy of vaginal tissue [21]and urinary complications (87%) [22, 30]
- Removal of the uterus and ovaries (hysterectomy and oophorectomy) is usually required after 3–5 years of treatment due to chronic symptoms [22]
- Chronic pelvic and genital pain [23]
- High likelihood of permanent infertility [22]
- Ovarian cysts and endometrial complications [23]
- Metabolic disturbances [24]and weight gain and changes in appetite [26]
- Significant mood and emotional changes [10]
- Severe liver complications [25]
- Pelvic floor dysfunction (94%) [30]
- Sexual dysfunction (53%) [30]
- Problems with the anus and rectum (45%) [30]



Post-surgical complications (following double mastectomy and phalloplasty)

- Organ prolapse (up to 4%) [18]
- Incontinence (up to 50%) [18]and chronic urinary tract symptoms (up to 37%) [18]
- Sexual dysfunction (up to 54%) [18]
- Absence of orgasm (studies are extremely flawed and present distorted figures due to poor methodology)

General considerations

- **3% of women (trans men), average age 30, died after 5 years** [12]
- Permanent dependence on hormone therapy and medical supervision [19,20]
- Substantial risks of serious medical complications [11–16, 18, 21–27, 32, 33, 26]
- High likelihood of permanent loss of fertility and sexual function [16]
- Persistently elevated risk of suicide after transition; mortality rate 3.3 times higher among women [12]
- Irreversible changes with limited long-term studies; effects not fully understood [28]
- All of the above medications are used off-label
- Very limited dating pool, leading to loneliness, lack of intimacy, relationship stress, and depression.
- **No proven mental health benefits (puberty blockers and testosterone, surgery)** [7]

Testosterone is a substance with a high potential for addiction that falls under Schedule III

A simplified overview; for a more detailed explanation, consult the DEA drug schedules [31] .

Schedule I:	Heroin, LSD, marijuana, MDMA (ecstasy), peyote
Schedule II:	Cocaine, methamphetamine, methadone, fentanyl, Dexedrine, Ritalin
Schedule III:	Ketamine, codeine (in certain formulations), anabolic steroids, **testosterone**
Schedule IV:	Valium, Xanax, tramadol
Schedule V:	Cough syrups containing small amounts of codeine

It is often noted that girls who use testosterone initially view it as a positive experience. This is not surprising, since testosterone has a mentally stimulating effect similar to that of other drugs. While the first few years may feel like a **"honeymoon phase**," over time the mental and serious physical side effects often emerge, which can be described as the "hangover years."

Question for the clinic: Have you thoroughly assessed these medical implications, informed the patient about them, and determined that this is the optimal treatment? 0 Yes 0 No

Question for the family member: Have you thoroughly evaluated these medical implications and determined that this is the optimal course of treatment, with an understanding of the potential lifelong consequences? 0 Yes 0 No

***Dr. Stephen Levine** - The Reality of Trans Youth Evaluations (Denver, USA, 2023)*

"Before patients start hormone therapy, I ask them if, when they feel depressed, they'll consider the possibility that it's due to their transition and not something else. And I want them to have the strength and courage to acknowledge that. Like so many of us, you may have made a mistake in your life.

*Endocrinologists almost never stop hormone treatment for the people they started it with. All the detransitioners I speak with stopped their hormones on their own; it wasn't the doctor. **Even if they're depressed or have attempted suicide, treatment is often continued**."*

*Sources on page 19

Family and Friends Survey - 4

Submit to clinic

A few personal questions

1. How old are you?

2. What is your level of education?

3. What was your most recent job?

4. Are you religious?
   0 Very 0 Moderate 0 Slightly 0 I believe there is something 0 Not

5. What is your political preference?
   Left / Right / Center / I'd rather not say

6. What is your stance on civil liberties such as same-sex marriage, euthanasia, abortion, and gender transition (if well-researched)?

	Same-sex marriage	Euthanasia	Abortion	Gender transition
It's fantastic that this is possible in our country	0	0	0	0
No problem with it	0	0	0	0
I don't care what others do	0	0	0	0
Worrying	0	0	0	0
Strongly against	0	0	0	0

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Results of the Family and Friends

Submit to clinic

	Name of family member or friend	Relationship to the person:
A :	.....	.....
B :	.....	.....
C :	.....	.....
D:	.....	.....
E:	.....	.....
F :	.....	.....
G :	.....	.....
H :	.....	.....
I :	.....	.....
J :	.....	.....
K:	.....	.....
L:	.....	.....

Use the following color codes to indicate your answers: **Yes:** Green **No:** Red **Both/Unclear:** Orange

Part 1 - Based on DSM-5-TR

Present	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**
Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Past												
Question 9	0	0	0	0	0	0	0	0	0	0	0	0
Question 10	0	0	0	0	0	0	0	0	0	0	0	0
Question 11	0	0	0	0	0	0	0	0	0	0	0	0
Question 12	0	0	0	0	0	0	0	0	0	0	0	0
Question 13	0	0	0	0	0	0	0	0	0	0	0	0
Question 14	0	0	0	0	0	0	0	0	0	0	0	0
Question 15	0	0	0	0	0	0	0	0	0	0	0	0
Question 16	0	0	0	0	0	0	0	0	0	0	0	0

Part 2 - ROGD Indication

Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Question 9	0	0	0	0	0	0	0	0	0	0	0	0
Question 10	0	0	0	0	0	0	0	0	0	0	0	0

Part 3 - Additional Questions

Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Question 9	0	0	0	0	0	0	0	0	0	0	0	0
Question regarding informed consent												
Question 10: Transition?	0	0	0	0	0	0	0	0	0	0	0	0

Parents' Signature: Date:

Genspect

Family Questionnaire

Submit to the clinic

An analysis of co-occurring conditions To be evaluated by the gender clinic before affirmative treatment begins

Gender-related issues are complex. You or the people around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Contact organizations that specialize in gender-critical topics.

Family Survey

Submit to the clinic

Possible Comorbidities

As a parent, please indicate (in the green "yes/no" row) whether you observe any of the following characteristics that may be relevant to your child's self-reported gender incongruence (check all that apply).

For each characteristic you observe, ask the clinic whether they also recognize it in their assessment.

Most important and most common co-occurring conditions	**Family**	**Clinic**
Internalized homophobia (not acknowledging/feeling ashamed of being gay or lesbian)	yes / no	yes / no
Self-hatred	yes / no	yes / no
Autism	yes / no	yes / no
Loneliness	yes / no	yes / no
Symptoms of ROGD (rapid-onset gender dysphoria)		
Coming out as trans was completely unexpected	yes / no	yes /
no The "coming out" does not match the expected image of a "trans person" yes / no	yes / no	Social influence
from friends	yes / no	yes /
no		
Social influence via the internet	yes / no	yes / no
Mental decline after "coming out"	yes / no	yes / no
Sudden increase in lying	yes / no	yes / no
Sudden changes in behavior after "coming out"	yes / no	yes /
no Shame or reluctance to express oneself as the opposite		
gender (for example, toward family)	yes / no	yes /
no Creating two separate worlds (home/family vs. friends or school, triangulation) yes / no	yes /	no Seeking
(negative) attention (therefore claiming to be "trans" or "non-binary")	yes / no	yes /
no		
Trauma		
Experiencing bullying now or in the past	yes / no	yes / no
Problems due to divorced parents	yes / no	yes / no
Childhood fears	yes / no	yes / no
History of sexual abuse	yes / no	yes / no
Experience of physical violence	yes / no	yes / no
Immaturity, social and relationship problems		
Immature or childish behavior	yes / no	yes / no
Little or no experience with boyfriends or girlfriends	yes / no	yes / no
Reluctance to touch people (and potential partners)	yes / no	yes / no
Hatred of heteronormativity (or, for example, "the patriarchy")	yes / no	yes / no
Extreme political beliefs	yes / no	yes / no
Psychological problems		
Any previous diagnosis of a disorder (based on the DSM)	yes / no	yes / no
ADHD or ADD	yes / no	yes / no
Body Dysmorphic Disorder (BDD) (dissatisfaction with body parts)	yes / no	yes / no
Self-harm (such as cutting, scratching, anorexia, bulimia)	yes / no	yes / no
Fear of commitment	yes / no	yes / no
Sexual fears	yes / no	yes / no
Signs of narcissistic traits (inflated self-image, Peter Pan syndrome)	yes / no	yes / no
Signs of borderline personality disorder (splitting, conflicts, self-harm, threatening to leave)	yes / no	yes / no
Suspected factitious disorder (ICD 6D50, DSM-5-TR 300.19) (other problem)	yes / no	yes / no
If female: Expressed hostility toward conventionally masculine men	yes / no	yes / no
As a man: Expressed hostility toward conventionally feminine women	yes / no	yes / no
Transmaxxing [37]	yes / no	yes / no
Autogynephilia [38], transvestic fetishism (a paraphilia, classified as 302.3 (F65.1) in the DSM-5-TR)	yes / no	yes / no
Other unspecified characteristics 1:	yes / no	yes / no
Other unspecified characteristics 2:	yes / no	yes / no
Other unspecified characteristics 3:	yes / no	yes / no

Question for the treating physician

For each item marked differently from the parental perspective above, please provide your clinical rationale for why your assessment differs from the family's observations.

37 **Transmaxxing** is a controversial phenomenon in which men, primarily from "incel" (involuntarily single) online communities, undergo trans medicalization for perceived social benefits rather than gender-related stress, such as being treated better socially or escaping male social pressures. 38 **Autogynephilia (AGP)** is a paraphilia characterized by sexual arousal at the thought of being a woman. This condition can have problematic consequences if surgical interventions are undertaken, as procedures such as castration can lead to reduced libido, which may result in significant regret. AGP represents a paraphilic disorder rather than a "gender identity," and gender-affirming treatment is not recommended (Dr. Az Hakeem - DE-TRANS:

When Transition Is Not the Solution, ISBN 979-8862184549).

Questions for the Clinic

Submit to the clinic

Questions for the specialist regarding ethical issues and responsibility

Current protocols for gender-affirming care reveal a notable lack of clinical guidelines and attention regarding the long-term implications for **intimate relationships** and **healthy sexual functioning**. This critical omission requires urgent attention, especially since the procedures involve permanent physical alterations.

1. What documented protocol does the clinic use to distinguish gender-related stress from other conditions based on objective clinical criteria?

2. How does the clinic prevent the body modification from impairing long-term function in intimate relationships or other crucial aspects of life?

3. What clinical criteria validate a patient's self-reported gender-related distress, and what evidence-based support justifies these interventions, given that self-reported distress is subjective and not measurable?

4. Can you provide your protocol authorizing permanent interventions for gender-related stress, especially when comparable interventions (such as FGM or voluntary amputation) are prohibited for other body-related conditions? What is the evidence-based justification for this distinction?

5. What protocols govern medical necessity and informed consent, particularly in the absence of long-term outcomes?

6. "In dubio abstine" is a fundamental principle in medical ethics. Is gender-affirming care consistent with this principle?

7. Please read the anecdote about the father below. Are we dealing here with a variation on Hannah Arendt's "banality of evil"?

8. Plastic surgery generally follows the principle of preserving the natural form. For example, tails are not added, nor are eyes removed to create a cyclops. Does this ethical standard apply within your protocol? We ask this specifically with regard to the gender identities non-binary*, nullo*, and eunuch*. Is it ethical and legal to surgically treat these identities?

9. Is it ethical to help individuals fulfill their desires if this leads to social disruption, such as family breakdown or the infringement of women's rights?

10. Given the significant limitations in evidence-based validation of the gender-affirming model, is it ethical to ask family members to place their trust in this process?

Please respond with logical reasoning

11. If "gender identity" is both innate and immutable, as gender theory suggests, yet also encompasses fluid identities, how can medical interventions be deemed necessary without violating "primum non nocere" (first, do no harm) and "in dubio abstine" (when in doubt, do nothing), given this inherent paradox?

12. If genitalia do not define gender, how does their removal affirm gender (in the context of gender-affirming care)?

These questions are intended to clarify the clinical reasoning process and the documentation supporting current treatment protocols.



Father Asks Questions at the Dutch Clinic

"The conversation with the clinical psychologist went beyond just my question about what percentage of people who transition experience regret. That question is incomplete. The real question should be whether people have a better quality of life after gender-affirming procedures. And here came the most remarkable statement from the clinical psychologist: ***'Transitioning doesn't make you happy.'***

Our reaction was: ***'Huh? Then why are we doing it?!'*** *The clinical psychologist repeated this baffling statement several times during our conversation. We were shocked that he admitted this so openly.* ***We still don't understand it****."*

*A "nullo" is someone who has all sexual characteristics removed: breasts, internal and external genitalia, but also, for example, nipples and the navel. In the most extreme case, only the urethral opening remains. Surgical affirmation of non-binary identity also constitutes partial nullification. The eunuch identity is mentioned in the Dutch Somatic Transgender Care Model 2024, pages 23–29. This is a sadomasochistic fetish of "cutters" and "wannabes," not a "gender."

Questions for the Clinic

Submit to the clinic

Fifteen scientific questions

The remarkable list by Dr. Stephen Levine that we cited in the introduction raises **fifteen crucial scientific questions**. These questions can help parents engage in a critical and constructive dialogue with specialists about the assumptions underlying the gender-affirming care model.

1. Is it really true that, once established, a trans identity remains fixed forever?

2. Can you prove that trans identities are primarily caused by prenatal biological factors?

3. How can you explain that sexual orientation is completely independent of “gender identity,” when the development of both often appears to be interconnected? Doesn’t early medicalization hinder the discovery of homosexuality?

4. Is it really true that no form of “gender identity” can be a symptom of an underlying psychological problem?

5. How can you say that “gender dysphoria” is a serious medical condition that justifies trans medicalization, but that treatment is only necessary if the patient wants it?

6. Are the emotional problems of children with “gender dysphoria” solely due to discrimination, or are there other, underlying factors at play?

7. Why is it often claimed that there are no effective alternatives to gender-affirming care, when other approaches do exist?

8. Is every attempt at psychotherapy really comparable to conversion therapy, and why should it be banned? Isn’t medical transition a conversion of the biological body?

9. What scientific evidence is there to show that gender-affirming care leads to lasting improvements in mental health and social functioning?

10. Do you have evidence that gender-affirming care actually reduces suicidal thoughts and suicide rates in the long term?

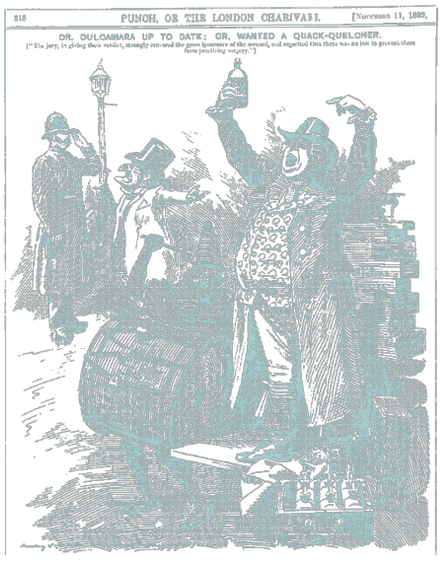
11. How certain are you that young teenagers and adolescents know what will make them happy in the future?

12. Can meeting the diagnostic criteria for “gender dysphoria” truly guarantee a positive outcome from gender-affirming care?

13. If regret and detransition are rare, how do you explain the growing recognition of detransition in recent years?

14. How can the clinic justify using a DSM diagnosis—which, by definition, is a snapshot in time—as the basis for permanent, irreversible bodily modifications?

15. The preceding fourteen questions form the core of the claims regarding affirmative care. If the ideas themselves are not true or scientifically substantiated, how can we trust the interventions based on them?



Some Important Steps

Write down the history and your views on the situation

We recommend organizing your thoughts by writing a detailed letter. Describe how the situation began, provide an overview of your child's behavioral characteristics, and share your perspective on what you think is going on. Submit this letter to both the gender clinic and your primary care physician. **Send a printed copy via certified mail with return receipt requested for official documentation, and also send a copy via email for faster communication.**

Report signs of shame, problematic behavior, and unrealistic expectations

If the survey indicates that there is shame surrounding "gender expression" (or other problematic behavioral indicators), the gender clinic must address this issue. Any concerns expressed by you or other family members should lead to a clear and logical follow-up, including an explanation of the clinic's approach. **Shame is fundamentally incompatible with medical treatment**, as it can exacerbate iatrogenic* harm when physical changes resulting from medical interventions become visible. It is essential that the patient overcomes feelings of shame before any further steps are taken.

Your primary care physician is your ally

Share your concerns with your primary care physician in a written document, supported by reliable sources that substantiate your concerns. The ongoing medical controversy surrounding the gender-affirming care model is rapidly evolving, and many primary care physicians may not yet be fully informed. They often rely on the clinics—a phenomenon known as the "chain of trust." It is your responsibility to raise the issues with gender-affirming care that you have identified in the literature.
In addition, let your primary care physician know how you feel about the way you, as a parent, are treated at the clinic—especially if your views are dismissed, not taken seriously, or if you are excluded from discussions about your child's care.

What is the specialist's level of knowledge and experience?

Make a list of questions and ask for written answers. Ask the specialist about the sources you have read. Has the specialist also read this literature? If not, what qualifies him as an expert? What is the specialist's level of knowledge and experience? A specialist has a professional obligation to inform himself as broadly as possible. In particular, the bestsellers on the recommended reading list are well-documented and directly contradict what the affirmative clinics claim. If they are unfamiliar with this professional literature, that constitutes a culpable deficiency, and they are incompetent as specialists.

Request to the gender clinic to consult with the primary care physician

It is wise to ask the clinic to consult with the primary care physician to incorporate their perspective. **If the primary care physician's opinion differs from that of the gender clinic, it should not be dismissed without a clear and logical explanation.** This request encourages the clinic to act transparently and responsibly, which helps limit potential legal issues in the future.

Send copies of the questionnaire to your primary care physician and your insurance company (in Belgium: the health insurance fund)

We recommend sharing the completed questionnaire with **your primary care physician** and the **insurance company (in Belgium: the health insurance fund)** so that all parties involved are well-informed about the complex issues surrounding medical transition. Because a diagnosis of "gender dysphoria" cannot be objectively measured, it is crucial to communicate the results of the questionnaire to the insurance company (in Belgium: the health insurance fund), especially if the results differ from your child's self-diagnosis. This ensures that the clinic is held accountable and must explain why the self-diagnosis carries more weight than the family's perspective and why medical interventions—which carry significant health risks—are viewed as the only viable solution. **Send a printed copy of the letter by certified mail with return receipt requested to all parties, and also send a copy via email for faster communication.**



* "Iatrogenic" means: harm caused specifically by the treatme

Parental Statement

Submit to the clinic

Entering a legal minefield

Once a diagnosis has been made, the clinical report must clearly refute the aforementioned concerns. It is essential that all possible contributing factors to the patient's reported "gender dysphoria" be thoroughly investigated. Addressing these factors may resolve the presented problems and potentially eliminate the need for irreversible medical interventions.
In addition, it must be demonstrated to what extent coexisting conditions are present and why they do not give rise to diagnostic overshadowing.
A carefully documented investigation into coexisting conditions is crucial, especially given the drastic and irreversible procedures performed by clinics. **We have clear indications that such documentation is currently lacking, which could lead to significant legal problems.** Insurance companies (in Belgium: health insurance funds) do not appear to be aware of these issues. Once they are made aware of this, fundamental questions will likely be raised to avoid legal and financial risks. Sending the results of our survey to insurance companies (in Belgium: health insurance funds) helps raise awareness.
Furthermore, we must not forget that parents' long-term knowledge of and closeness to their child are not recognized in the decision-making process. This systematic disregard for parental input raises significant medical-legal concerns. **How is it possible that gender clinics systematically ignore this crucial source of clinical information?** Now that this survey is available, the question arises as to when parental insights will be taken into account. Can clinics demonstrate that this has been done adequately in previous cases? And how do historical clinical decisions align with the results reported by families who completed our systematic assessment?
It is to be expected that this survey will pose significant challenges for gender clinics, especially now that it is becoming clear that parental perspectives have been systematically ignored. It can no longer be argued that parental input is irrelevant, especially now that there is concrete evidence of the value and impact of our information through this survey and your collective responses to these questions.

If the clinic wishes to proceed with further treatment involving medication and surgery, we, as parents, request that you answer each of our questions point by point and send your responses to the address below.

Parental Statement

With this statement, we, as parents, issue a clear warning that we believe "gender-affirming treatment" should not be continued.
Should the clinic invoke patient privacy, we will forward this document to our family doctor and the insurance company (in Belgium: the health insurance fund). In this way, these parties can work together with the clinic to make an informed decision. This means that all parties will share responsibility if complications arise after treatment, unless they also advise against providing medical treatment to the patient.
It is reasonable that, in the event of harm, compensation and/or reconstructive medical care be provided in accordance with the patient's wishes.

Name of parent/family member:

Date:

Address of parent/family member:

Signature of parent/family member:

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PARENTS with INCONVENIENT TRUTHS about TRANS

BEYOND TRANS

Parents of Desisters

STATS FOR GENDER.ORG

GENDERPUNT

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LGB ALLIANCE

Stephanie Davies-Arai—Director of Transgender Trend

"In those first few years, I spoke with ***parents who found themselves in the terrible situation of not only having a serious problem with their teenager, but also feeling as though the whole world was against them and viewed them as bigots****.*

Normally, when you're dealing with teenage problems—your child getting involved with the wrong crowd, drugs, alcohol, sex... You know all these teenage problems—at least you have the support of the community around you. There are people who sympathize with you; some might blame you, but you get support. You can talk about it with your friends. But I spoke with parents who didn't even dare to talk to their friends because they were afraid they'd be accused of being narrow-minded or transphobic."

Dr. Stephen B. Levine—Clinical Professor of Psychiatry, Cleveland, Ohio

"Parents (of children who identify as trans) simply need to be given the opportunity to speak*, to share their perspectives. Mental health professionals must help their young patients to speak up. Even highly intelligent* ***patients often lack a deep understanding of themselves****. And, of course, they also lack a deep understanding of others. They lack sufficient vocabulary to describe psychological phenomena and, naturally, have limited life experience to assess their own experiences.*

The vast majority of parents I have worked with over the past 50 years love their child dearly. They are not their child's enemy. ***The fact that adolescents view their parents as enemies reflects their limited, immature understanding****."*

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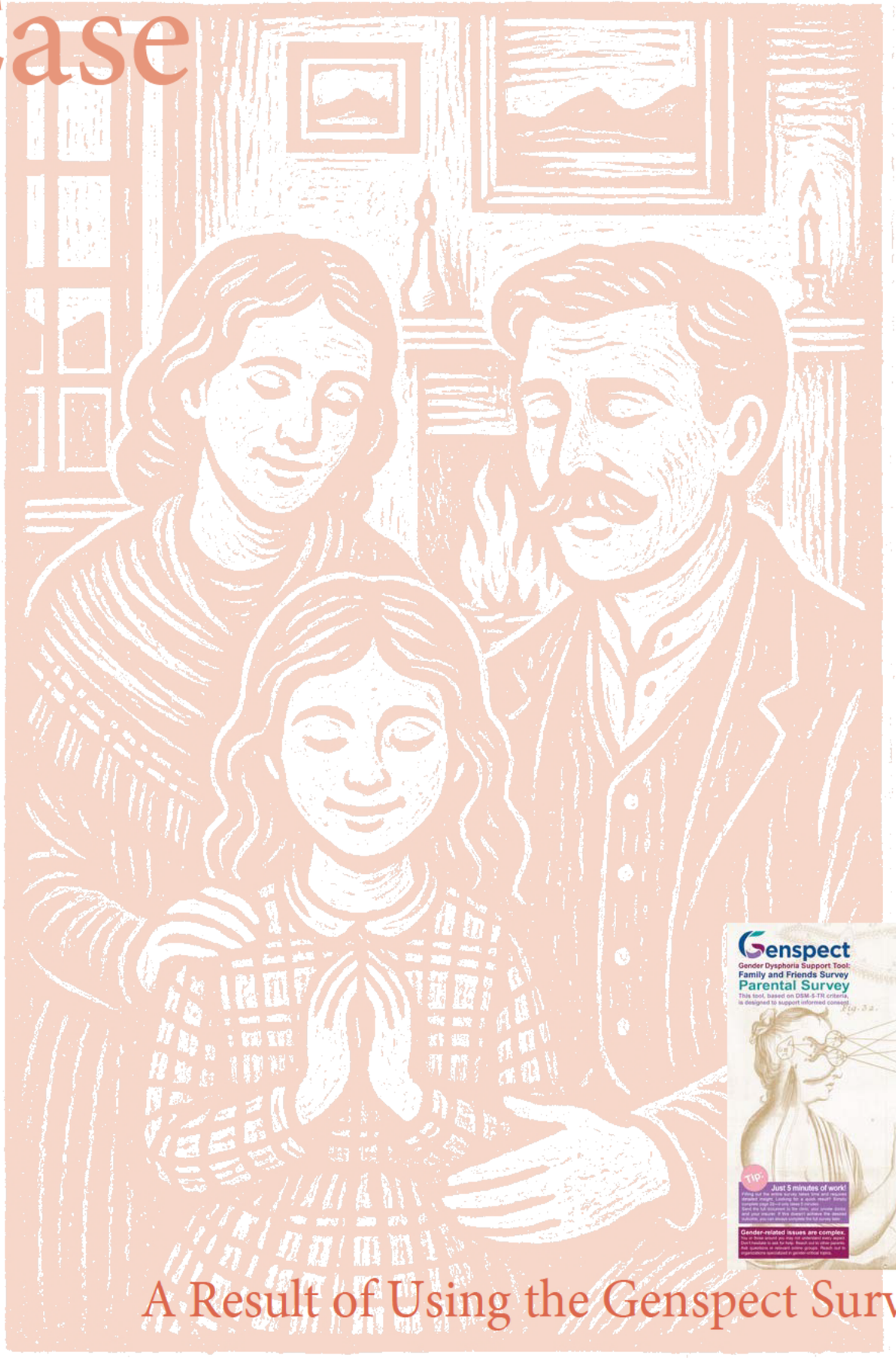
The Scottish Case

In support of parents who are not heard in clinics



A Result of Using the Genspect Survey

Article in PITT, June 2025

Our little girl, now 19 years old—so legally an adult, I suppose. A wonderful person, a kind soul, an animal lover, incredibly creative, a multi-talented musician, and very artistic—always working on something.

She is autistic; she only spoke in jargon until early elementary school, but she's now very articulate, though she still sometimes struggles to talk to people. As a child, she was incredibly outgoing, full of energy, hilarious—she loved Disney Princesses and Monster High dolls, and practically lived in a Tinkerbell dress and fairy wings. If you tried to put them in the wash, she'd fish them out of the laundry basket and put them on again. She raised butterflies, took care of animals, took ballet lessons, sang in the girls' choir, knitted, crocheted, loved everything girly, and wanted to marry David Hasselhoff because he was in the SpongeBob movie.

She was diagnosed with autism at age 9; she had a few friends at school (girls), but as her autism became more apparent, they pretty much abandoned her, and she was a lonely little soul for a long time.

As she entered her teens, she became very introverted and could barely speak to anyone; even as recently as last year, she couldn't go into a store and ask for anything, nor could she ride the bus by herself. Although she is 19 years old, she is very young for her age—we'd estimate her to be closer to 14. She has never kissed a boy or a girl and doesn't even know which she prefers yet.

She started high school. To describe it as a trans-friendly school would be an understatement. There are trans flags on the walls and in the hallways, rainbow lanyards everywhere, and as a result, a high number of students identify as trans or non-binary. She joined a band with two other girls from her class, both of whom had changed their names and presented as boys. They'd all been friends since childhood, so we let her do her own thing. She'd come back from rehearsals muttering about "straights" or "the patriarchy," but not ranting from a soapbox or anything typical of the TRAs—just little bits here and there, very subtle—but she was obviously hearing the sermons during band practice.

*Then she started crocheting trans flags for her friends and drawing pictures of Dylan Mulvaney, and began watching a female-to-male trans YouTuber named Jammie Dodger, but she kept all of this from us. She became very secretive, but that's always been a teenage thing for everyone, so we didn't pry. Until she came out to us when she was 15. I think she was expecting hearts and rainbows—like an episode of *Heartstopper*—when she told us she wanted to be a boy.*
As soon as she said she was a boy, we told her she wasn't—she was just going through puberty and all the turmoil a teenage girl goes through. But because even navigating a normal everyday experience is like climbing a mountain for her, the trials and tribulations of being in a female body—experiencing sensory overload during periods or bodily development—are amplified to the max for an autistic girl, and if she just rides it out and doesn't do anything stupid or seek medical intervention, she'll come out the other end unscathed.

She assured us she only wanted to pass as a boy; she didn't want anything like surgery or hormones—she just wanted to pass. She was already dressing in a boyish style by this time, and she's very tall, with a deep, husky voice she inherited from her mom, so we said, "Congratulations—you already pass." She was really disappointed that our reaction wasn't what she'd hoped for, so she didn't say anything more about it and just became even more withdrawn.

About six months later, she said she wanted to change her name. Mom said no because we had chosen that name for her. She didn't say anything more about it.

Then I read online about a website called Thoughtful Therapists, which is a group of medical professionals fighting against gender ideology

https://www.thoughtfultherapists.org/

They put us in touch with a lovely doctor who spent a few sessions talking with our daughter; they got along well, but after a while she decided she didn't really need to talk to anyone anymore. However, more on that wonderful doctor in a moment.

Over the next little while, she became more and more confident, started hanging out with other kids from school, playing in a new band, and was accepted to college to study Sound Design—her dream job. She started going into stores and taking buses everywhere on her own or with her friends. Everything was going great. Happy days! Until...

About a month ago, a letter arrived here from the Waterside Gender Clinic in Edinburgh, addressed to "Logan," but it was for our daughter—which is how we found out she had been seeking gender reassignment. The letter gave her the go-ahead to start taking cross-sex hormones with the intention of undergoing a double mastectomy afterward, followed by the removal of her reproductive organs and whatever other surgical procedures they might have in store for her.

She had gone there without our knowledge. They'd spoken to her without consulting us, her primary care physician, or any of the medical professionals who have been treating her since she was a baby. This gender specialist's diagnosis barely mentioned her autism; there was a brief mention that her uncles "had a history of DVT"—deep vein thrombosis. That's putting it mildly. Deep Vein Thrombosis is what killed her uncle at a young age; her other uncle nearly died from it last Christmas and is lucky to be alive today; three of my cousins tested positive for it—I didn't—but it's a huge risk factor in our family history, and I feel they downplayed that just as much as they did her autism. The brief session she spent talking with this doctor at the clinic just looked to me like a box-ticking exercise.

She'd spun them a tale about always feeling like a boy, which isn't true at all. We have plenty of pictures and videos of her as a kid, happily running around in her ratty, soup-stained Tinkerbell costume, playing with all her girly toys. She told them she played WWE wrestling with her big brother. Her brother is an LGBT ally; he supports her with her gender issues, but even he admitted the wrestling story wasn't true and acknowledges that she was very much a girly girl. She told the clinic she wore her brother's hand-me-downs. Once she became a teenager, she did start wearing his old plaid shirts—just like pretty much every other teenager does, girls and boys alike. But any hand-me-downs she wore as a child came from her female cousin or from her mom.

The rest of the letter spoke of "Logan and he/his" physical discomfort and "his" expressed desire to attain a masculine body. After briefly meeting with her, in just a few short paragraphs they recommended male hormones with a view to having her breasts and reproductive organs removed, and whatever other procedures might follow.

Reading the letter was like being hit by a train. It came completely out of the blue. We talked to her for hours. She said all her friends were going out, socializing, dating—all the things everyone wants to do as a teenager. But she refused to apply for an over-18 ID because she couldn't even write her own name; it's a constant reminder to her that she is a girl. So if she became a boy, she would feel more confident about her body and herself, and would be able to go out and experience some nightlife and maybe even meet someone. We felt so heartbroken for her and tried to explain that what she
was doing would have the opposite effect—it wouldn't give her any confidence; it would destroy her body and her life, and her dating pool would be practically nonexistent. She wouldn't listen. She was about to start hormones a couple of weeks ago; her mom talked her out of it, and we spent every minute we could trying to get her to see the reality of the situation. She was unhappy; the clinic ignored all my attempts to contact them and warn them about the dangers of her taking cross-sex hormones. I just kept telling them to leave her alone, find someone else, and leave our daughter alone. Her mom cried all the time, and none of us slept. But far more importantly, we only want health and happiness for all of our children. Going down the gender transition path would take both of those things away from our daughter. Her mom suggested speaking to our doctor friend from Thoughtful Therapists again.

Sadly, for us anyway, he had retired and was no longer practicing. But he hadn't forgotten about her, and he asked if we knew about Genspect and a survey they had that deals very thoroughly with our daughter's type of situation.

https://genspect.org/resources/gender-dysphoria-support-tool/

We downloaded it and read it. Please (if you've read this far) download it and read it. It has sections to be filled out by parents, friends, and family, as well as a couple of pages of detailed and thorough questions for the gender clinic to complete. It lists all the side effects of puberty blockers, cross-sex hormones, and all the medical procedures, then asks whether you still believe this is the right path for the patient to take. It also poses many science- and reason-based questions to the clinic and delves into the Hippocratic aspects of their profession. It asks all the questions that should have been asked during our daughter's gender diagnosis—and many more.

We printed out several copies, had family and friends fill them out, filled in the "Parents" section ourselves, and sent them all to the clinic in a big, thick envelope—LOTS of material for them to read—asking them to answer the sections on "Possible Co-Existing Conditions" and the "Questions for the Clinic" (Parts 1 and 2), and then return the completed survey to us. We sent them by certified mail and also emailed them digital scans of the survey, copying every family member who had participated, as well as Genspect.

That was last week.

After all our previous unsuccessful attempts to communicate with the gender clinic, three days after they received the Genspect survey, we received this email from them:

"Thank you for your email and letter. Unfortunately, we are unable to fulfill the third-party request. However, having obtained the necessary consent, we are able to provide a limited update on the patient in question. We can confirm that, in this case, Waterside Clinic is not proceeding with hormone treatment and will no longer be providing any medical care for the patient. Please note that this is the extent of the information we can provide. We will not be able to respond to any further communication from you or other third parties."

They were just about to put our daughter on the gender treadmill, pump her full of hormones, mutilate her body, and ruin her life—all while charging her a hefty sum for the privilege. But as soon as they realized they weren't just dealing with a vulnerable autistic girl, but that she had people on her side and in her corner—medical professionals far beyond their league and higher up the food chain than anyone at the gender clinic—that was it. They dropped our daughter like a hot potato. They told her they could no longer treat her and that if she wished to continue down the gender path, she should contact the NHS.

Anyone reading this, please—if you feel lost and helpless, bewildered, just as we've been feeling—please do what we did, no matter what stage of the gender journey your family member is at, even if they've been through everything. Send the survey to the clinic, fill it out, and get friends and family to fill it out too. Keep Genspect in the loop, and let the clinic know that Genspect is concerned about the person as well. They may not let go of your child right away, and legally they aren't required to fill out the survey, but it really comes down to "If not, why not?" And when everyone is copied on the email and the clinic knows all eyes are on them, that was all it took for them to let go of our daughter.

We knew the clinic had spoken to her to break the news, so we waited a few days. Then her mom spoke to her and simply asked what was happening with the gender clinic. She said they told her to go to the NHS, but she's been thinking it over, and she wasn't too bothered by the clinic telling her that, nor was she really too bothered about pursuing gender transition. She's been going to the gym, and she says that will help with her confidence, and she's applied for her driver's license—she even wrote her own name on the application, which is a huge deal, believe me. And she's looking forward to going out to socialize, going to concerts, and meeting people, instead of watching life pass her by.

We realize that this was a close call, and if the clinic hadn't been foolish enough to mail that letter to our house, we wouldn't have known a thing, and we'd be telling you a completely different story today. We're grateful, and we hope that if even one person reads this and does what we did, it will make a difference for their family's situation as well.

I hope PITT will let us give you an update in a few years. You never know what's around the corner, and she's not out of the woods yet, but after years of stress and heartache and wondering how it will all turn out, it's nice just to wake up and see a bit of sunshine again.

The Complete Communication

We have received all relevant information directly from the father to support other families in similar situations. If comparable cases arise and clinics respond differently, this information can be used to file complaints or presented to **private doctors, insurance companies, hospital boards, and national health inspection authorities**. Since work protocols in this healthcare sector are nearly identical across most countries, **this information can also be used internationally**. For privacy reasons, we have anonymized the family's identity. The daughter is referred to as "Xxx."

On Tue, Jun 10, 2025 at 7:14 PM, Xxx's father <dadofXxx@hotmail.com > wrote:
Dear ... (author of the Genspect Survey),

*Thank you so much for this. Please read the forwarded email from **the Waterside Gender Clinic**. And the original email I sent them, which provides a brief history of our daughter Xxx—it begins with the Waterside Gender Clinic's response to the Gender Dysphoria Support Tool request I sent them. Feel free to use any of it. I'll also send you Xxx's story—the one I'm sending to ***Parents with Inconvenient Truths About Trans***—which, of course, is anonymous and keeps her name out of the public eye. You might want to use that instead, as it also describes the outcome of sending the survey to the clinic, and you might find that useful as well.*

It's so well crafted and put together, and I think what I said before is true: those "doctors" at the clinic must have taken one look at it and realized you were out of their league and far higher up the food chain than them. It took us a good couple of days to get over our disbelief that they let her go so quickly, and it's all thanks to you. Thank you again

Love from me, my wife (Xxx's Mom), Xxx, and the whole family—but especially Xxx

From: YourGP Feedback <feedback@your.gp >
Sent: June 6, 2025, 2:40 PM
To: Dad of Xxx <<dadofXxx@hotmail.com >
Subject: Re: Genspect "Gender Dysphoria Support Tool" Attn: Dr. Michael Shaw, Dr. Sandra Vracar, Everyone else at Waterside Clinic, and Your GP Group

Thank you for your email and letter. Unfortunately, we are unable to fulfill the third-party request. However, having obtained the necessary consent, we are able to provide a limited update on the patient in question. We can confirm that, in this case, Waterside Clinic is not proceeding with hormone treatment and will no longer be providing any medical care for the patient. Please note that this is the extent of the information we can provide. We will not be able to respond to any further communication from you or other third parties.

On Tue, Jun 3, 2025 at 2:11, the father of Xxx <dadofXxx@hotmail.com > wrote:
Dear Waterside Gender Clinic, and everyone at Your GP Group, c/o Dr.

Michael Shaw and Dr. Sandra Vracar in particular

Following up on the last email I sent you regarding our daughter Xxx, whom you have been referring to as Logan and using "he/him" pronouns for, I have written to you today via regular mail, including a copy of the Genspect "Gender Dysphoria Support Tool."

You may or may not be familiar with the survey, but I would greatly appreciate it if you could answer the "Possible Co-Existing Conditions" section and complete the "Questions to Ask the Clinic" sections 1 and 2. I have enclosed a stamped, addressed envelope so you can return the completed survey to us. Also enclosed are the Family and Friends surveys, which were completed by Xxx's aunts and some close friends of the family—all of whom are practically family to Xxx as well. Everything has been sent to you via First Class Recorded Delivery and should arrive by tomorrow morning. I have addressed the letter specifically to Dr. Michael Shaw, but it is intended for everyone involved to see. Here is the Recorded Delivery tracking number for the documents: DF383110384GB.

In case you have any trouble receiving the letter, here are digital copies of all the surveys filled out by us, her parents, and her friends and family. If you're unable to open the Dropbox folder, I can email them to you individually. https://www.dropbox.com/scl/fo/sgzgk.....

Please take your time to read them to get a more complete picture of Xxx's upbringing and where she stands today. I'm sure you will find it to be very much at odds with the somewhat rushed diagnosis you gave our daughter, which led you to proceed with life-threatening hormone injections, irreversible surgery, and the removal of perfectly healthy body tissue and her reproductive organs.

I'll add some details here about Xxx's history again. Please read this very carefully as well.

Xxx, our little girl, is now 19 years old and legally an adult. She's a wonderful person, a kind soul, an animal lover, incredibly creative, a multi-talented musician, and very artistic. She is autistic; she spoke only in jargon until early elementary school, but she is now very articulate, though she still sometimes struggles to speak to others. As a child, she was incredibly outgoing, full of energy, hilarious—she loved Disney Princesses and Monster High dolls, and practically lived in a Tinkerbell dress and fairy wings. If you tried to put them in the wash, she would fish them out of the laundry basket and put them on again. She raised butterflies, took care of animals, took ballet lessons, sang in the girls' choir, knitted, crocheted, loved everything girly, and wanted to marry David Hasselhoff because he was in the SpongeBob movie.

She was diagnosed with autism at age 9; she had a few friends at school (girls), but as her autism became more apparent, they pretty much abandoned her, and she was a lonely little soul for a long time.

As she entered her teens, she became very introverted and could barely speak to anyone; even as recently as last year, she couldn't walk into a store and ask for anything, nor could she ride the bus by herself. Although she is 19 years old, she is very young for her age—we'd estimate her to be closer to 14. She has never kissed a boy or a girl and doesn't even know which she prefers yet.

She attended ... Academy in ..., Scotland—to call it a pro-trans school would be an understatement. There are trans flags on the walls and in the hallways, rainbow lanyards everywhere, and as a result, a high number of students identified as trans or non-binary. She joined a band with two other girls from her class, both of whom had changed their names and presented as boys. Xxx was still Xxx, so we left her to it. She would come back from rehearsals muttering about "straights" or "the patriarchy," but not ranting from a soapbox or anything typical of the TRAs—just very subtly.

*Then she would start crocheting trans flags for her friends and drawing pictures of Dylan Mulvaney, but she was very secretive about it—very secretive about a lot of things. Until she came out to us when she was nearly 15. I think Xxx was expecting hearts and rainbows, like an episode of *Heartstopper*, when she told us she wanted to be a boy. As soon as she said she was a boy, we told her she wasn't—she was just going through puberty and all the turmoil a teenage girl goes through. But because even navigating a normal everyday experience is like climbing a mountain for Xxx, the trials and tribulations of being in a female body—experiencing sensory overload during periods or bodily development—are amplified, turned up to 11 for her; and if she just rides it out and doesn't do anything stupid or seek medical intervention, she'll come out the other end unscathed.*

Xxx assured us she only wanted to pass as a boy; she didn't want anything like surgery or hormones—she just wanted to pass. She was already dressing like a boy by that time, and she's very tall, with the same deep, husky voice she inherited from her mom, so we said, "Congratulations—you already pass." She was really disappointed that our reaction wasn't what she'd hoped for, so she didn't say anything more about it and just became even more withdrawn.

About six months later, she said she wanted to change her name. Mom said no because we had chosen that name for her. I reminded her that her middle name, "Yyyy," came from her Aunt "Yyy," who died the week after we found out her mom was pregnant with Xxx, so there was no way she was changing her middle name either. She didn't say anything more about it.

However, Xxx became more and more confident, started hanging out with other people from school, playing in a new band, and was accepted to ... the University of Edinburgh to study animation. She started going into stores and taking buses to Edinburgh, Glasgow, and lots of other places—either on her own or with her friends. Everything was going great. Happy days! Until...

About a month ago, a letter arrived here for Logan from the Waterside Gender Clinic in Edinburgh; it was addressed to Logan but was actually for Xxx, which is how we found out that Xxx had been seeking gender reassignment. The letter gave Xxx the go-ahead to start taking cross-sex hormones with the intention of undergoing a double mastectomy afterward, followed by the removal of her reproductive organs and whatever other surgical procedures they might have in store for her.

Xxx had gone there without our knowledge. The diagnosis from the clinic barely mentioned her autism; there was a brief mention that her uncles "had a history of DVT" (Deep Vein Thrombosis). That's putting it mildly. Deep Vein Thrombosis is what killed her uncle... at a young age; my other brother nearly died from it last Christmas and is lucky to be alive today; three of my cousins tested positive for it. I didn't, but it's a huge risk factor in our family history, and I feel they downplayed that just as much as they did Xxx's autism—which we believe is the root cause of her gender dysphoria and should have been explored far more thoroughly than the brief time it took for the gender clinic to check off all their boxes.

Xxx spun them a tale about always feeling like a boy—this is very easily debunked, and Xxx knows it. We have plenty of photos and videos of young Xxx happily running around in her ratty, soup-stained Tinkerbell costume, playing with all her girly toys. She told the clinic she played WWE Wrestling with her big brother. He and his friends are all strong allies of the LGBT community; he supports Xxx with her gender issues, but even he admitted the wrestling story wasn't true and acknowledges that Xxx was very much a girly girl. She told the clinic she wore her brother's hand-me-downs. Once she became a teenager, she did start wearing his old checkered shirts, just like pretty much every other teenager does, girls and boys alike. But any hand-me-downs Xxx wore as a child came from her older female cousin, who was also big and tall, or from her mom.

We do not feel the clinic has been thorough in its diagnosis; they have been secretive, making no mention of any of this to our family doctor or the team of NHS health specialists who have been treating Xxx since she was a baby, and certainly no mention of any of this to us.

When she first came out to us recently about wanting to be a boy, she said she only wanted to pass; I told her at the time that that's fine—you already pass. But it won't be enough—you still won't be a boy—so you'll want top surgery; then that won't be enough, so you'll want bottom surgery; then that won't be enough, and you'll realize the road never ends and there's no pot of gold at the end of the rainbow, and you'll have damaged your body. Leave things as they are, and you'll come out the other end in your own good time.

So I was right—passing as a boy wasn't enough for Xxx, and here she is now, about to step onto the treadmill and destroy her body and her life.

Something else we should mention: due to Xxx's difficulties as a child—including Erb's palsy, a speech delay, and developmental issues—she was later diagnosed with autism at age 9. Pretty much from the very beginning, Xxx has been under the care of Community Child Health at NHS Lothian, seeing several doctors and specialists over the years. This included home visits and school visits, as well as regular meetings with us to monitor her development and growth into adulthood. Xxx faced many challenges and overcame numerous obstacles during her childhood, but not once during any of these visits, sessions, or meetings did the topic of gender ever come up. We have kept all the letters and reports we received from the doctors and specialists who cared for Xxx, and it would be easy enough to contact the professionals who treated her to confirm this. It has only been very recently that Xxx has started talking about gender, and we know this is due to social influence, peer groups at school, YouTube, and

TikTok influencers, and I'm guessing any LGBT groups or individuals she has spoken to since starting college.

Gender dysphoria is very common in people with autism, and I would expect any health professional to investigate how Xxx's autism relates to her gender dysphoria before making any irreversible, life-changing recommendations.

As Xxx's parents, we can tell you that Xxx's gender dysphoria developed rapidly, just like it does for most autistic teenage girls who are told they were born in the wrong body. They weren't; they're just teenage girls going through puberty and struggling to cope with it, just as they struggle to cope with everything else in everyday life. Let them work through it, and they'll be fine. It really is that simple.

Anyway, please fill out the Genspect survey and return it to us. Please also keep an eye on your email inbox, as I will send you an electronic copy of this letter and the Genspect survey, which will include all of my answers as well as those from Xxx's mom. It will also include answers from friends and family. I will CC everyone who participated in the survey on the email, and I will also CC Genspect, as they were kind enough to provide us with the survey and are now also concerned about Xxx's well-being.

Thank you; we look forward to hearing from you

--Dad's name-- (Xxx's Dad)
--Mom's name-- (Xxx's Mom)
--address--
--City--
--ZIP Code--
Scotland
email: dadofXxx@hotmail.com