Do No Harm

Testimony of Kurt Miceli, MD

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Chairman Cassidy, Ranking Member Sanders, and members of the Committee on Health, Education, Labor and Pensions, thank you for the invitation and opportunity to present on the dangers of gender transition procedures on minors.

My name is Kurt Miceli. I am a psychiatrist and internist, having worked for hospitals and human-service providers in Southeast Pennsylvania. I am now chief medical officer for Do No Harm, a diverse group of over 50,000 healthcare professionals and concerned citizens committed to ensuring that the practice of medicine is driven by scientific evidence. Our mission is to defend the timeless standards of medical excellence against outside influences that would both erode them and undermine patient trust and public health. We advocate for what should be common sense: children should not be subjected to dangerous, life-altering procedures that lack scientific justification.

At Do No Harm, we have documented the scope of these gender transition procedures on minors. Our Stop the Harm database, launched in the fall of 2024 and based on insurance claims data, shows that nearly 14,000 minors received gender transition treatments between 2019 and 2023. This includes over 5,700 insurance claims for gender transition surgeries throughout the United States.[1]

Comparable to our findings, Landon Hughes et al., in a Research Letter published last year in *JAMA Pediatrics*, estimated that 1.4 out of every 1,000 female adolescents had received a prescription for cross-sex hormones by the time they turned 18.[2] Jason Wright et al., in analyzing the period 2016 – 2020, found that thousands of children had undergone "gender-affirming surgery," with some being as young as 12 years old.[3]

All of this has taken place with little evidence supporting the efficacy or necessity of gender transition procedures for minors — and against the backdrop of research suggesting that most children and adolescents will outgrow their dysphoria if allowed to progress through natural puberty into adulthood.[4] It is also noteworthy that the gender dysphoria diagnosis has been found to lack specificity and, as the Cass Review found, is "not predictive" of

future outcomes.[5]

This weak evidentiary foundation is further underscored by the fact that systematic reviews — the gold standard in evidence-based medicine — consistently rate the quality of research in this area as low or very low.[6] Systematic reviews of evidence assess the entire body of evidence in a manner that is transparent and reproducible. Crucially, systematic reviews do not merely summarize what primary research says but evaluate studies for methodological quality to determine their reliability. Importantly, they consider bias, including publication bias.[7]

These limitations in the evidence base become even more apparent when one examines the very origins of pediatric gender transition, which was launched worldwide on the basis of two Dutch studies. Later systematic reviews that assessed these and subsequent studies, however, found that the research justifying gender transition in minors suffers from serious problems of methodological quality, including selection bias, dubious outcome measures, lack of control groups, and loss to follow-up. For this reason, the quality of evidence for benefit — or certainty about the reported effects of medical interventions — has consistently been rated as low or very low.[8]

Take, for instance, Kellan Baker at al.'s 2021 systematic review, which was conducted to inform the World Professional Association for Transgender Health (WPATH) Standards of Care, eighth edition (SOC-8). Baker et al. noted only three studies focused on adolescents, representing a total sample size of less than 200 individuals. Regarding quality of life (QOL), the systematic review included just one trial of 50 adolescents that showed "no difference in QOL scores after a year of endocrine interventions." And while just three studies on depression showed some improvement, the risk of bias in these studies was determined to be either "moderate" or "serious." Overall, Baker et al.'s systematic review notes a "high risk of bias in study designs, small sample sizes, and confounding with other interventions."[9] The evidence of any benefit from gender transition procedures simply isn't there. Describing these interventions as "medically necessary," as WPATH has done, is irresponsible.[10]

Additionally, Baker et al.'s systematic review offers no evidence that so-called gender-affirming care decreases suicidality. In fact, the review comments on one study, specifically stating, "We cannot draw any conclusions on the basis of this single study about whether hormone therapy affects death by suicide among transgender people."[11] No doubt, the death of any young person by suicide is tragic. It is a loss that reverberates through families, schools, and entire communities, and it deserves compassion rather than politicization.

At the same time, acknowledging the gravity of suicide does not require us to accept unsupported claims or to overlook the broader clinical realities that shape risk. Yet, in clinics

across the country, parents faced with the decision of consenting to gender transition procedures on their minor child have been asked the rhetorical question, "Would you rather have a dead son or a living daughter?" That question's implicit assertion is simply not supported by the evidence. In comprehensively assessing suicide among adolescents and young adults, Ruuska et al. found that "clinical gender dysphoria does not appear to be predictive of all-cause nor suicide mortality when psychiatric treatment history is accounted for."[12] In other words, once underlying psychiatric conditions are taken into full consideration, there is no convincing evidence that gender-referred youth face statistically higher suicide rates than their peers. Furthermore, claims that suicide rates would surge if puberty blockers or cross-sex hormones were made unavailable are likewise unsupported by the evidence. A 2024 independent review from England and Wales makes this clear.[13]

Furthermore, a recent Finnish nationwide register study looking at over two decades of data assessed the prevalence of severe psychiatric morbidity among adolescents referred for specialized gender services. As the study noted, "[a]mong adolescents who underwent medical gender reassignment, psychiatric morbidity increased markedly during follow-up." Psychiatric needs did not subside after so-called gender-affirming care; instead, they rose, contradicting the proposition that mental health improves following transition-related interventions.[14]

Systematic reviews published by Jo Taylor et al. are also enlightening. One such review focused on puberty blockers in adolescents and included 50 studies, of which only one was determined to be of high quality. Consequently, the review found "insufficient and/or inconsistent evidence about the effects of puberty suppression on gender-related outcomes, mental and psychosocial health, cognitive development, cardiometabolic risk, and fertility." However, there was moderate-quality evidence that "bone density and height may be compromised during treatment."[15] The evidence reveals harms from puberty blockers more than it finds benefit.

Similarly, a systematic review also by Taylor et al. assessing hormonal interventions included 53 studies, of which only one was determined to be of high quality. The result: "a lack of high-quality evidence to support the initiation of hormones for masculinization or feminization in adolescents experiencing gender dysphoria/incongruence."[16]

These reviews by Taylor et al., along with four more, were a key part of the academic research commissioned by the Cass Review. Released in April 2024, the Cass Review confirmed the weakness of evidence in pediatric medical transition and specifically stated that "we have no good evidence on the long-term outcomes of interventions to manage gender-related distress."[17] Indeed, studies related to pediatric medical transition in minors — outside of systematic reviews, which provide the most reliable evidence — are often of low quality given small sample sizes, significant attrition of enrollees, and relatively short follow-up periods. Selection bias, uncontrolled confounding, and the lack of a comparison group also weigh heavily on many of these studies. All this leads to low-quality evidence, which

simply should not be used to make clinical decisions — especially those that are life-altering, as is the case with these procedures.

Additional systematic reviews have found the same. Thompson and colleagues, in their research article "A PRISMA systematic review of adolescent gender dysphoria literature: 3) treatment," found that "[t]he evidence base for the outcomes of gender dysphoria treatment in adolescents is lacking." Further, "[i]t is impossible from the included data to draw definitive conclusions regarding the safety of treatment."[18]

The pattern is clear: the evidence supporting gender transition procedures in minors is at best of very low quality and at worst nonexistent. However, the harms caused by these interventions cannot be ignored. Take cross-sex hormones, for instance. Outside of the cardiovascular risks and various cancer risks associated with taking exogenous hormones, the risk of infertility is real.[19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30] It is for this reason that even the Endocrine Society's guidelines recommend that "clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults."[31]

Likewise, the American Academy of Pediatrics' Policy Statement — in a footnote — acknowledges that "the effect of sustained puberty suppression on fertility is unknown." It further states that "when cross-sex hormones are initiated without endogenous hormones, then fertility may be decreased."[32] Never mind the additional surgical complications that may arise from these interventions, which, in the case of genital surgeries, range from wound-related to urological, including, but not limited to, infection, "wound dehiscence," "trauma from intercourse/dilation," "change in voiding function," and "urethral stenosis."[33]

Do No Harm's 2025 report "Hormonal Interventions for Minors with Gender Dysphoria Cause Significant Harm" further addresses the risks associated with cross-sex hormones. As the report makes clear, risks to patients' sexual and reproductive systems include not only infertility but pelvic pain and discomfort during sexual activity.[34] Cardiovascular risks include an increased incidence of heart attacks among women who receive hormonal interventions,[35] as well as a seven-fold higher rate of erythrocytosis (increase in red blood cell concentration, which may increase risk of blood clots, leading to heart attack and stroke) compared to men not taking testosterone.[36]

Women taking testosterone may experience changes that lead to unsatisfactory or harder-to-interpret Pap smear tests, which can make cervical cancer screening far more challenging.[37] In cases of severe obesity, endometrial cancer (cancer of the uterine lining) appears to increase with the duration of testosterone use.[38]

Nor do males who take estrogen avoid their own health risks. In addition to fertility consequences, such men face an increased risk of venous thromboembolisms (clots in veins that can pass to the lung and cause death),[39] retinal vein occlusions (blockages in blood flow from the eye),[40, 41] strokes,[42] and invasive breast cancer. The latter is 46 times

more likely to occur in men who take estrogen than in men who don't.[43] Worse, these individuals face a markedly elevated mortality.[44]

Similarly harrowing on this topic of harms is the U.S. Department of Health and Human Services' 2025 report "Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices." According to that document, endocrine and surgical interventions on minors carry the risk of "infertility/sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive impacts, cardiovascular disease and metabolic disorders, psychiatric disorders, surgical complications, and regret." Moreover, "there has been inadequate research into the frequency and severity of these harms," leaving a gap that raises significant safety concerns.[45] Regarding cognitive impacts, it should be noted that there is evidence from both animal and human research that puberty blockers may arrest brain development.[46]

Despite these documented concerns, organized medicine in the United States has, for the better part of the last decade, largely endorsed and promoted so-called gender-affirming care — including social transition, puberty blockers, cross-sex hormones, and surgeries — for minors experiencing gender dysphoria. Major professional organizations such as the American Academy of Pediatrics (AAP),[47] the Endocrine Society,[48] and the American Medical Association (AMA)[49] have followed WPATH[50] in issuing guidelines or policy statements framing these interventions as medically necessary and evidence-based standards of care. This institutional consensus has helped to shape clinical practice, insurance coverage, medical education, and public messaging, often portraying dissent or calls for caution as ideologically driven rather than grounded in emerging evidence.

In 2018, for example, the AAP released a policy statement entitled "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents."[51] This document framed skepticism towards pediatric medical transition as pathologizing, urging an affirmation-only approach. It presented affirmation as settled science while downplaying evidence gaps.

But the AAP did not act alone, as *The New York Times* and other publications have reported.[52] In fact, on the issue of pediatric gender transition, the AAP and other major U.S. medical organizations have largely followed the lead of WPATH, which has positioned itself as the leading authority in transgender healthcare, noting that its standards of care are the "foremost evidence-based guidelines for the provision of [transgender and gender diverse] healthcare."[53] Its guidelines and its members have held themselves out as the global experts, exerting outsized influence over clinical practice, policy, and litigation across the United States and internationally. In short, pediatric gender medicine is WPATH, and WPATH is pediatric gender medicine.

Accordingly, WPATH's credibility and authority has been invoked by almost two dozen major medical groups, including the AMA, in legal briefs.[54, 55] And, most significantly, its recommendations have received the imprimatur of the AAP and the Endocrine Society,

whose own guidelines on youth gender transition were either written by WPATH members or heavily influenced by the WPATH approach.

Furthermore, to understand WPATH's broad influence, consider that the Standards of Care eighth edition (SOC-8) are referenced in many insurance policies for gender transition procedures on minors.[56, 57, 58] In some states, such as New York, "health maintenance organizations and health insurers must apply utilization review criteria consistent with version 8 of the World Professional Association for Transgender Health (WPATH) Standards of Care when conducting utilization review of treatment for Gender Dysphoria."[59] Similarly, some children's hospitals list WPATH guidelines as educational resources.[60, 61]

The organization's influence has been profound in the realm of pediatric medical transition, as the medical community within the United States, and even worldwide, has historically yielded deference to WPATH as the preeminent authority in this field. Through this widespread adoption — by public and private insurers, healthcare providers, professional societies, and regulatory bodies — WPATH's standards became the de facto framework guiding care for gender-dysphoric youth across the United States, propping up the guidelines and statements from the Endocrine Society,[62] AAP,[63] American Psychiatric Association,[64] and American Psychological Association.[65] WPATH's continuing medical education courses, offered through its Global Education Institute (GEI) Certified Training Courses, have been widely used and have shaped the medical education of countless doctors across the country and planet in the area of youth gender medicine.[66] All of this even as questions mounted about the strength of the underlying evidence.

Indeed, the foundation upholding WPATH's recommendations has effectively collapsed. In 2016, WPATH issued a position statement adjudging as "medically necessary" transgender "treatment, sex reassignment, and insurance coverage in the U.S.A."[67] This language appears repeatedly in SOC-8, where "medically necessary gender-affirming medical treatment" is detailed for adolescents, as are "aspects of medical[ly] necessary care intended to promote the well-being and gender-related needs of children."[68] Yet, as reported in *The New York Times*, one SOC-8 author noted how casting gender transition procedures as medically necessary could advantageously be "a tool for our attorneys to use in defending access to care."[69] In reality there was no true medical necessity; the phrase was a strategic declaration designed to strengthen legal and insurance defenses rather than a conclusion grounded in robust, high-quality clinical evidence, particularly when it came to the care of minors.

By 2024, internal WPATH communications obtained by the state of Alabama through subpoena further underscored this pattern, revealing evidence of serious misconduct in the development of the SOC-8 guidelines.[70, 71, 72, 73, 74] In a particularly revealing episode, WPATH commissioned The Johns Hopkins University Evidence-Based Practice Center to conduct multiple systematic reviews to inform SOC-8. Systematic reviews are considered the gold standard in evidence-based medicine because they evaluate the totality of evidence and, crucially, examine the underlying methodological quality of the research, allowing for determinations about the quality of evidence.[75]

However, as reported in *The Economist*, "documents show that [WPATH's] leaders interfered with the production of [these] systematic reviews." The report continued, "From early on in the contract negotiations, WPATH expressed a desire to control the results of the Hopkins team's work."[76] This is not how independent scientific research is conducted. As a result, even the Evidence-Based Practice Center's ostensibly impartial analyses were ultimately constrained by WPATH's requirement that nothing be used without its sign-off. Further, WPATH adopted a policy giving it the authority to "nip papers in the bud on the basis of their conclusions." The result: only one paper from the Hopkins team was published after this policy took hold, despite the group "having provided WPATH with the material for six systematic reviews," according to *The Economist*.[77]

Indeed, as revealed by *BMJ Investigation*, some WPATH SOC-8 authors worried that "independent appraisals of the evidence would undermine legal efforts to protect affirming interventions from legislative restriction in minors." *BMJ* continued, "a chapter author wrote, 'Our concerns, echoed by the social justice lawyers we spoke with, is that evidence based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits.'"[78]

By August 2020, the Hopkins team reported to the Agency for Healthcare Research and Quality at the U.S. Department of Health and Human Services (HHS) that they found "little to no evidence about children and adolescents" and that WPATH was "trying to restrict our ability to publish."[79] WPATH leadership effectively suppressed manuscripts whose conclusions did not align with the organization's preferred positions, successfully pressuring the researchers not to publish their findings. SOC-8 nevertheless proceeded to advance claims of medical necessity, falsely asserting that a systematic review of adolescent outcomes was "not possible."[80] Such actions represent a serious breach of scientific integrity and ethical standards in guideline development.

News of WPATH's misconduct later appeared in the mainstream press, including liberal media. "Research into trans medicine has been manipulated," read a headline in *The Economist*.[81] "The World Professional Association for Transgender Health interfered with systematic reviews it commissioned from a research team at Johns Hopkins University," wrote the editorial board of *The Washington Post*.[82] "This is not how evidence-based medicine is supposed to work," reported *The Atlantic*.[83]

WPATH's misgivings did not end there. As reported in *The New York Times*, President Biden's Assistant Secretary for Health, Admiral Rachel Levine, "had been instrumental in WPATH's mysterious last-minute deletion of the age minimums in SOC-8."[84] Released in late 2021, WPATH's draft guidelines proposed specific lower age thresholds than had been in previous versions of its Standards of Care: "14 for hormonal treatments, 15 for mastectomies, 16 for breast augmentation or facial surgeries, and 17 for genital surgeries or hysterectomies."[85] However, within hours of publishing the final standards of care in September 2022, WPATH deleted from the document age minimums for all hormonal interventions and most surgeries, issuing a "correction," according to *The Economist*. The news magazine continued, noting that "the head of the drafting committee, Eli Coleman,

said the publisher went ahead 'without approval' before final changes were made."[86] Thus, the age thresholds that appeared in the draft — and initially in the published version — were swiftly excised from the final document.

As emails revealed, this decision followed sustained pressure from Levine, whose political support WPATH needed, and from the AAP. Specifically, Levine's staff urged WPATH to remove these explicit age limits over concerns that they could fuel political opposition and restrict access to care for transgender youth.[87] Ultimately, the corrected SOC-8 omitted nearly all age minimums, stating "no recommendations on specific ages," with one exception: phalloplasty, which "WPATH stressed should not be performed under the age of 18 years owing to its complexity."[88] These decisions weren't driven by science but, rather, political pressure.

Even some WPATH leaders were upset by this outside meddling. "I don't know how I feel about allowing U.S. politics to dictate international professional clinical guidelines that went through Delphi," wrote one.[89] Delphi refers to the Delphi method, a structured, iterative consensus-building process commonly used in healthcare guideline development when high-quality evidence is limited or mixed.[90] SOC-8 specifically notes that "[c]onsensus on the final recommendations was attained using the Delphi process that included all members of the guidelines committee and required that recommendation statements were approved by at least 75% of members."[91] Clearly, this episode underscores a deeper tension in the development of SOC-8: the gap between the formal consensus process and the final guidelines that emerged after external intervention. Removing age minimums — after they had already achieved Delphi consensus — prioritized political considerations over caution in an area where systematic reviews were finding the evidence base to be weak.

Nevertheless, when the AAP threatened to publicly oppose WPATH's guideline unless they got rid of the age minimums, WPATH relented.[92] WPATH's president wrote in an email that it was "disappointing that politics always trumps common sense and what is best for patients."[93] A former WPATH president involved in the guideline process wrote that the deletion of age minimums "is a balancing act between what I feel to be true and what we need to say."[94]

Additionally, in WPATH's development of its guidelines, "opaque conflict of interest management" was also evident,[95] with significant deviation from standard practice. Subpoenaed emails and later depositions revealed how WPATH leaders failed to manage conflicts of interest among guideline authors.[96, 97,98] Nevertheless, the published version of SOC-8 states that "[n]o conflicts of interest were deemed significant or consequential."[99]

This lax approach manifested in fundamental procedural failures. For one, conflict-of-interest disclosure forms were not due until after SOC-8 committee members were selected. This information was not part of the selection process. As Leor Sapir noted in his article "The Deposition of Eli Coleman," Coleman, the lead author and chair of SOC-8, "testified that he knew 'most' members of SOC-8 had conflicts." [100]

Take, for example, one of SOC-8's authors, a plastic surgeon who has performed multiple "gender-affirming surger[ies]" on pediatric patients.[101] That surgeon is now the incoming president of WPATH.[102] He declared no conflict of interest in SOC-8. Similarly, in a legal deposition, Marci Bowers, a gender surgeon and former president of WPATH who also authored its guideline, admitted to making over one million dollars from performing gender surgeries in 2023 alone.[103, 104] No conflict of interest was declared in SOC-8.

Nevertheless, Coleman and his SOC-8 co-chairs determined that all of these conflicts were "neither 'significant' nor 'consequential.'" As a result, "they thought, WPATH did not need to specify how, if at all, they were managed, and did not need to disclose them in the relevant section of the published guideline."[105]

Taken together, these revelations illustrate a broader, deeply concerning pattern: WPATH's SOC-8 was driven by ideological advocacy, legal strategy, and political pressure rather than by transparent, rigorous, and independent science — undermining the very foundation of evidence-based medicine. This seeming malfeasance is further discussed in a *United States v. Skrmetti* amicus brief that reads as a startling narrative of message-shaping on the part of WPATH rather than scientific prowess.[106]

Yet, WPATH's influence throughout the halls of pediatric gender medicine reigned supreme. In its September 13, 2017, press release, the Endocrine Society issued its guidelines for "gender-affirmation treatment," officially listing WPATH as a co-sponsor.[107] In fact, many of the Endocrine Society guideline authors on the same topic were either WPATH members or had other close ties to the organization.[108]

This interconnected web of guidelines promoting gender transition procedures for minors extended even further. Jo Taylor and colleagues have shown that gender medicine guidelines repeatedly drew upon one another, with many "cit[ing] and draw[ing] on the World Professional Association for Transgender Health (WPATH) guidelines."[109] The result was a self-reinforcing cycle in which position statements and guidelines repeatedly referenced one another, creating the appearance of a robust evidentiary foundation in pediatric gender medicine — one that, through repetition across the medical literature and within organized medicine, came to seem unquestionable.

Under these conditions, the U.S. health system effectively institutionalized gender transition procedures for minors as standard care. Major medical organizations, hospitals, and insurers treated WPATH's SOC-8 and the closely aligned Endocrine Society guidelines as authoritative, leading to widespread adoption of puberty blockers, cross-sex hormones, and surgeries — often with minimal gatekeeping. This occurred even as rigorous, gold-standard evidence reviews — including the Cass Review in the UK and multiple European systematic reviews — concluded that the benefits of these interventions were of very low certainty, while the risks were substantial.

Yet the past makes clear that medicine is not immune to profound error — and, at times, to grave wrongs. History offers sobering reminders: physician-endorsed smoking,[110] the

brutality of lobotomies,[111] the use of diethylstilbestrol (DES) in pregnancy,[112] the Tuskegee Syphilis Experiment,[113] and, most recently, opioid overprescribing and the resulting crisis[114] — to name just a few examples. The record of modern medicine is marked by episodes of misjudgment and sometimes serious scandal. Entire books and scholarly analyses have been devoted to understanding how harmful practices are introduced, or why ineffective and unsafe treatments persist long after evidence has shown they should be abandoned. As physicians, we hold the capacity to do immense good — but also, if we are not vigilant, immense harm.

Our profession is far from infallible. Yet it is not the absence of error that earns the public's trust in medicine. Rather, it is our willingness, as physicians, to confront mistakes honestly, to reassess our assumptions, and to correct course when the evidence demands it.

For this reason, open inquiry, rigorous debate, peer review, critical appraisal of evidence, and independent evaluation are indispensable. These commitments gave rise to evidence-based medicine — a systematic approach to clinical decision-making grounded in the best available scientific data.

Yet today, in the case of pediatric medical transition, empirical evidence has been systematically sidelined in favor of ideology. Such widespread politicization has prevented these self-corrective processes from operating as intended. Self-appointed experts have broken the chain of trust, and the medical community has been misled by ostensible authorities who have minimized or, in some cases, veiled altogether the gaps in their knowledge.

Gradually, however, the tide has begun to turn. Given the weak quality of evidence and the obvious harms of gender transition procedures on minors, countries throughout the world, as well as 27 states here at home, have taken a stance to protect children by stopping many of these interventions from occurring. In May 2024, England, for example, banned the clinical use of puberty blockers in those under 18 years of age.[115] This followed publication of the Cass Review, whose methodology was recently found to be "robust" by the British Medical Association's board of science.[116] That ban on puberty blockers had the support of Conservative and Labour governments alike.[117] And just a few months ago, *BMJ* reported that "NHS England has 'paused' the prescribing of gender affirming hormones to treat gender incongruence or dysphoria for young people under 18."[118]

Likewise, in recent years Sweden and Finland — among the world's most socially progressive nations — have imposed limits on gender transition procedures for minors, all of them initiated under left-leaning governments.[119] Their actions were driven by evidence — or, more precisely, by the lack of evidence supporting so-called gender-affirming care. Systematic reviews prompted these course corrections. In Sweden's review, for example, the evidence for hormone treatment in minors was deemed "insufficient," and the long-term psychosocial effects of hormone therapy were described as "unknown." The authors further classified puberty blockers as an "experimental treatment."[120] Today, nearly two dozen systematic reviews have all consistently demonstrated the absence of a credible evidence

base.[121]

An increasing number of medical professionals are also coming to recognize that pediatric gender transition is the medical scandal of our generation. In my role at Do No Harm, I hear this regularly. Over the past year alone, our organization has grown substantially as more and more clinicians have become aware of the risks associated with youth gender transition. We routinely receive messages from physicians who know this to be a scandal, but who feel unable to voice their concerns within their professional circles for fear of personal or professional reprisal. This climate of silence creates the misleading impression that most physicians support these interventions. They do not. In a survey of Florida physicians, for example, we found that 66 percent supported the state's prohibition on gender transition procedures for minors.[122]

In fact, in February of this year, the American Society of Plastic Surgeons (ASPS), representing over 11,000 surgeons,[123] became the first major U.S. medical society to recognize the grave concerns associated with gender transition procedures on minors. ASPS's position statement openly acknowledged the lack of supportive evidence for these procedures, explicitly calling out "gender-related endocrine and surgical interventions." It therefore recommended against gender-related surgeries in anyone under 19.[124]

Additionally, ASPS emphasized an often-ignored truth: "the natural course of pediatric gender dysphoria remains poorly understood."[125] For one, clinicians cannot reliably predict which children will persist in their distress and which will desist. This uncertainty is not a minor footnote. The 2025 guidelines from Germany recognize this fact, providing no criteria to differentiate between those children with "temporary 'gender non-contentedness'" and "stable/persistent cases."[126] ASPS was thereby right to recognize that, when a condition's trajectory is uncertain and the interventions irreversible, medical ethics requires caution, not acceleration. This applies to both surgeries and medications, including puberty blockers and cross-sex hormones, whose long-term physiological effects and side effects cannot be fully undone.

Moreover, ASPS's position statement sharpened the proper role of autonomy in clinical ethics. Patient autonomy does not obligate physicians to provide interventions when the risk–benefit profile is uncertain or unfavorable — particularly for minors whose decision-making capacity is still maturing. Medicine must move away from the "have it your way" model of care that has failed children with gender dysphoria, fast-tracking them to hormones and surgeries despite systematic reviews showing very low evidence of benefit and significant risk of harm.

This is especially true given the ethical concerns raised by the impossibility of informed consent (or even informed *assent*) on the part of adolescents whose brains have not yet fully developed. As ASPS's position statement points out, "gender-related surgery procedures intervene directly in the processes of identity formation and psychosexual development. These are areas of ongoing maturation during adolescence that warrant particular ethical caution as surgeons assess adolescent medical decision-making capacity."[127] The same can

be said for puberty blockers and cross-sex hormones, which similarly disrupt critical windows of brain and bodily development during a period when true informed decision-making capacity remains fundamentally limited.

All of this comes on the heels of the comprehensive umbrella review conducted by the U.S. Department of Health and Human Services, which itself has undergone peer review and provides a methodologically sound and transparent assessment of the evidence.

The HHS Review makes it clear: the quality of evidence regarding key domains such as psychological outcomes and quality of life, as well as long-term health, is very low. The benefits simply aren't there. Yet, the evidence for harms clearly exists and can be drawn from "established knowledge about human physiology and the effects and mechanisms of the pharmacological agents used."[128] These effects are real and can't be ignored.

In coming to these conclusions, the HHS Review performed a substantial evidence review. Following the recommendations for overviews of systematic reviews as per the *Cochrane Handbook for Systematic Reviews of Interventions*, thousands of studies were screened, with ultimately 17 systematic reviews included. As noted in the HHS Review, "two reviewers independently screened titles and abstracts, and then full texts, to determine study eligibility." The Risk of Bias Assessment Tool for Systematic Reviews (ROBIS) was used to assess the included systematic reviews. Evidence synthesis was performed and organized by outcomes. The effect estimates and quality of evidence followed the GRADE methodology.[129]

The HHS Review, however, didn't stop there. It included evidence from basic science and physiology to help best understand the harms of puberty blockers and cross-sex hormones. It reviewed international clinical-practice guidelines, utilizing key systematic reviews. It also added a critically important chapter on ethical considerations as well as psychotherapy as a means of caring for children suffering from gender dysphoria.

Having released an early version of their Review in May of last year, the HHS Review team invited skeptical physicians and medical associations to scrutinize their conclusions. It invited critics to offer a peer review, specifically reaching out to groups such as the AAP, the Endocrine Society, and the American Psychiatric Association (APA). Regrettably, all three organizations have strongly supported gender transition procedures on minors, and they vehemently opposed HHS's initial review in May 2025, with the AAP condemning the Review within hours of its May 1 release.[130]

Yet, despite HHS's attempt to engage them, the AAP and the Endocrine Society declined to provide a peer review. That choice speaks for itself: when invited to present evidence supporting medical interventions for minors, they opted not to participate. If they had strong, well-supported arguments, they would have taken the opportunity to lay them out and challenge the findings in the HHS Review. They didn't.

Only the APA, to its credit, submitted a peer review. Still, the review offered very little

meaningful critique. The APA even appeared to overlook key sections of the Review, asserting that HHS had failed to outline its methodology when the Review clearly did so. In the end, the APA identified no substantive flaws in the HHS findings and raised no objections to the Review's treatment of psychotherapy as an alternative to hormonal interventions. At the end of the day, none of the critical reviewers disproved the central conclusions of the HHS Review. Please read those critiques for yourself, and you'll see that the HHS Review withstood peer-review scrutiny, earning its place as a robust umbrella review.

Put simply, the latest HHS Review is the most comprehensive and evidence-based review of gender transition procedures on minors. It lends support to the many states across our country that have taken a stance to keep kids safe from these interventions, for which the evidence of benefit is lacking and the harm is unfortunately lasting and significant.[131]

Such laws echo common sense and public sentiment. In a *New York Times*/Ipsos survey from last year, 71 percent of respondents agreed that "no one under age 18 should have access [to puberty-blocking drugs or hormone therapy]" when used for transgender care. Among Democrats, only 19 percent felt minors as young as 10 should be allowed access to puberty blockers for these purposes, while 54 percent said no one under 18 should have access.[132]

It is also important to recognize that many children later come to regret their transition and themselves detransition years later. By one study's account, at least 30 percent of youth discontinue medical transition within just a few years, but many of the effects of hormones and surgeries are irreversible.[133] While low regret from pediatric medical transition is frequently cited in the popular press, this conclusion is based on flawed studies with narrow windows of time for follow-up, high rates of attrition (i.e., individuals "lost to follow-up" who simply stopped coming to their appointments), and biased samples or those that cannot be generalized.[134] In reality, the true rate of regret is not known.[135]

It is in part for this reason that Do No Harm recently urged the Centers for Disease Control and Prevention to create new medical diagnosis codes (known as ICD-10 codes) for desistance and detransition.[136] Currently, the lack of a specific code for detransition makes those who have detransitioned effectively invisible to the healthcare system, obscuring their medical needs and limiting the real-world research, follow-up care, and outcome monitoring that responsible practice requires.

Moreover, many within the current cohort of gender-dysphoric youth differ markedly from earlier ones. In recent years there has been a dramatic surge in adolescents — predominantly female adolescents — with "rapid-onset gender dysphoria," as described by Lisa Littman in 2018. These youth, often influenced by peer groups and social media,

frequently suffer from significant psychiatric or neurodevelopmental comorbidities in addition to their gender confusion.[137, 138] It is these co-morbid mental health conditions that should be the focus of treatment.

Instead, the rush has been to treat gender dysphoria with an affirming model inclusive of medications and surgeries. In many cases, supply has unfortunately created its own demand: simply being seen by a gender specialist is itself a strong predictor that a child will proceed with social and medical transition.[139]

By contrast, a major follow-up study of boys diagnosed with gender identity disorder found that more than 87 percent desisted by early adulthood — that is, they no longer experienced gender dysphoria.[140] Many of these boys later identified as homosexual. Consistent with this, the *DSM-5-TR*, last published in March 2022, notes that the rate of persistence for childhood gender dysphoria into adolescence or adulthood ranges from only 2.2 percent to 50 percent, meaning the clear majority of cases resolve on their own or desist.[141]

Desistance is real, and psychotherapy can be genuinely beneficial to youth struggling with gender confusion, particularly when depression, suicidal thoughts, and self-harm coexist. These children need high-quality behavioral healthcare, not gender transition procedures. Finland, for example, has recognized this explicitly, recommending that "first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders."[142]

For the sake of our children, it is time to bring an end to gender transition procedures for minors. The evidence base is weak, with systematic reviews finding no reliable data supporting these interventions. It is time for pediatric gender medicine to move beyond WPATH's SOC-8, a document shaped by opaque processes, marked by conflicts of interest, and influenced by ideological advocacy that has sacrificed science for activism, resulting in the reckless promotion of low-evidence, high-risk medical interventions on minors. Instead, we must acknowledge the certainty of harms done by pediatric medical transition alongside the uncertainty of any benefit. No responsible field of medicine would continue to promote interventions where the harms are well-established and the benefits remain unproven.

If one wishes to look beyond the evidence, then please listen to those who have detransitioned; their stories are powerful reminders of the compassion we must have in caring for youth with gender dysphoria, as well as the resolve we need to first and foremost end these experimental gender transition procedures on minors.

To my fellow physicians: Many of us have relied on colleagues regarded as experts in gender medicine. That is common in a field as complex as the medical profession — no one can master every specialty. But our responsibility is not solely to trust, or defer, but also to verify. Given the documented harms and the vulnerability of the children involved, unquestioning trust is no longer acceptable. I urge my peers to look beyond partisan narratives and examine the evidence directly. If we hope to restore the public's confidence in

our profession, we must begin by acknowledging that we have made mistakes — grave ones -- and that the time to correct them is now.

It is time for the medical profession to return to the evidence. It is time for us to stand with the nation in protecting vulnerable children and ending procedures that carry irreversible harm. It is time to enshrine in law a clear commitment to safeguarding children who are struggling with gender dysphoria and related mental-health challenges. They deserve quality therapy and robust psychosocial support — not irreversible, life-altering medical interventions. Above all, we must remember our duty: First, do no harm.

Thank you for your time and for reading my testimony. I look forward to further discussing this important matter with the Committee.

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Do No Harm

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