

# Pioneers in Child Mutilation: Boston Children's Hospital's Leading Role in Pediatric 'Gender Medicine'

*Documenting chemical castration, irreversible surgeries,  
and the people behind it*

## MassResistance Special Report

By Amy Contrada

April 2023

## **CONTENTS** (Click on heading to go to section.)

[Introduction](#)

[Boston Children's Hospital gender clinic opens in 2007](#)

["Gender-affirming" treatments have no scientific basis](#)

[Social transitioning: BCH guide on names, pronouns; warns against parents; tucking & binding](#)

[Puberty blocking drugs](#)

[Cross-sex hormones](#)

[Eligibility for Surgery at BCH](#)

[Mutilating surgeries performed at BCH](#)

[Mastectomies, aka "Chest reconstruction"](#)

[Male chest surgeries, aka "Breast Augmentation"](#)

[Male bottom surgery – Vaginoplasty \(construction of pseudo-vagina, clitoris & labia\)](#)

[Female bottom surgery - Metoidioplasty \(construction of pseudo mini-penis & testicles\)](#)

[Female bottom surgery - Phalloplasty \(construction of pseudo penis and testicles\)](#)

["Gender-affirming" Hysterectomy & Vaginectomy](#)

[Facial Harmonization](#)

[Transgender Reproductive Health Service](#)

[BCH Center for Gender Surgery's "Research and Innovation"](#)

[Bonus Videos: Drs. Carswell, Spack, and Diamond](#)

[BCH Gender Clinic Staff, Admin, Trustees – Contact info](#)

[WPATH - World Professional Association for Transgender Health](#)

[Reliable sources](#)

## **Introduction**

Have the "gender" doctors at Boston Children's Hospital adopted a new oath, "DO HARM"?

Since opening in 2007, BCH's [Gender Multispecialty Service Clinic \(GeMS\)](#), has engaged in evil experiments on confused young children and teens. No benefit, but only harm, follows their dangerous "gender-affirming" treatments for minors. These include psychological manipulation, puberty blockers, cross-sex hormones, and irreversible surgeries. The clinic staff are denying biological reality and causing permanent harm to their young patients. This must end.

This report details the fraudulent treatments administered by BCH gender clinicians, using their own words and graphic images. It names the perpetrators of what the American College of Pediatricians labels “child abuse.”

This is a call to reinstate the [Hippocratic Oath](#) at Boston Children’s Hospital. The [Trustees](#) of Boston Children’s Hospital should close the gender clinic and surgery center immediately.

## **Boston Children’s Hospital gender clinic opened in 2007 MassResistance was first pro-family group to expose clinic**

[Norman Spack](#), MD opened the pioneering “gender” clinic at [Boston Children’s Hospital \(BCH\)](#) in early 2007. *The clinic would be the model imitated around the country.*

From the hospital’s 2007 announcement:

"It's more important to make the best decision than to make the fast one," says Norman Spack, MD, of the Endocrinology division at Children's, who co-directs the new clinic with David Diamond, MD, of Urology. **"In some cases, it can take weeks to decide what's best for the patient,"** he says. "It's a team decision now, and **no matter what's done**, the parents need support and **the children need to be followed.**" Follow-up research will be conducted to determine the efficacy of the approaches taken and patient satisfaction as they enter adult life. [bold added]

We are still awaiting BCH’s *long-term* follow-up research proving these experiments have been for the good. Ideally, such research should *not* be conducted by [parties interested in promoting gender-affirming care](#).

This author first noted Spack and his clinic on the [MassResistance blog](#) (2005). I quoted the *Boston Globe*:

Dr. Norman Spack, clinical director of the endocrine division at Children's Hospital in Boston, **said gender identity is formed at birth and is not a product of the environment. Much more research still needs to be done around how male and female brains differ and how transgenderism occurs, he said.** Of the more than 100 transgendered people he has treated, many secretly cross-dressed as children and suppressed their gender identity because **their parents were punitive.** “In many cases they went on to live a life that was a sham, getting married and having children,” said Spack, one of the few pediatric endocrinologists in the country who specializes in gender identity and intersex issues. “They go through a difficult time of depression coming to grips with the fact that their body doesn't match their brain.” [bold added]

I later revealed Spack’s connection with degenerate groups, and his plan to use puberty blockers and cross-sex hormones on children. I [posted](#) this in April 2007 about the [“Transcending Boundaries”](#) conference [Spack took part](#) in (October 2006):

Dr. Spack presented a workshop at a radical conference promoting total sexual freedom and dangerous perversions, "Transcending Boundaries", last November [2006] in Worcester. It was organized by transgender radicals and PFLAG and co-sponsored by the New England Leather Alliance (NELA = the BDSM crowd)! How many physicians would be part of a conference where they also held workshops entitled:

- **SM 101** (Not a "How To" but a "What! Huh?"): How to Talk About BDSM/Leather/Fetish – For Allies, Families, and Professionals [i.e., Bondage & Discipline, Sadomasochism, whips, chains, ropes]
- **Polyamory 101** [group sex, multiple partners]
- **Legal Issues and Being Kinky**: Oil and Water! New England Leather Alliance [how to avoid law enforcement & legal problems when engaging in torture, etc.] ...

That post also mentions Spack's talk at the radical U. Mass. Stonewall Center (Feb. 2007):

"Ethical and Treatment Dilemmas in Intersex or Gender-Variant Children and Adolescents" Children and adolescents struggling with gender identity issues present to their families and health care providers **wanting relief from socially imposed or psychological/physical distress**. Medical interventions must take into account the child's physical, emotional and gender identity developmental needs. Families and their providers often struggle to determine the right course of treatment for children exhibiting **gender variance** as well as those who present with intersex conditions (disorders of sex development). Dr. Spack will share his perspective and answer questions on **what it means to initiate medical treatment, such as puberty delaying interventions, for children and adolescents**. [bold added]

A month later in May 2007, MassResistance was (as far as I know) first among conservative media and watchdog groups to file a significant report on the clinic's puberty blocker treatments of confused children. On the MassResistance radio show (WTTT 1150AM Boston), a concerned pharma sales rep and I discussed the horror that was just then beginning at BCH. ([The segment is here](#) at 29:50 minute mark.)

In 2008, the mounting atrocities at BCH had gained enough attention that Brian Camenker (president of MassResistance) was interviewed on Megyn Kelly's national show on Fox News. Despite Kelly's seeming outrage, there was no follow-up in major conservative media then.

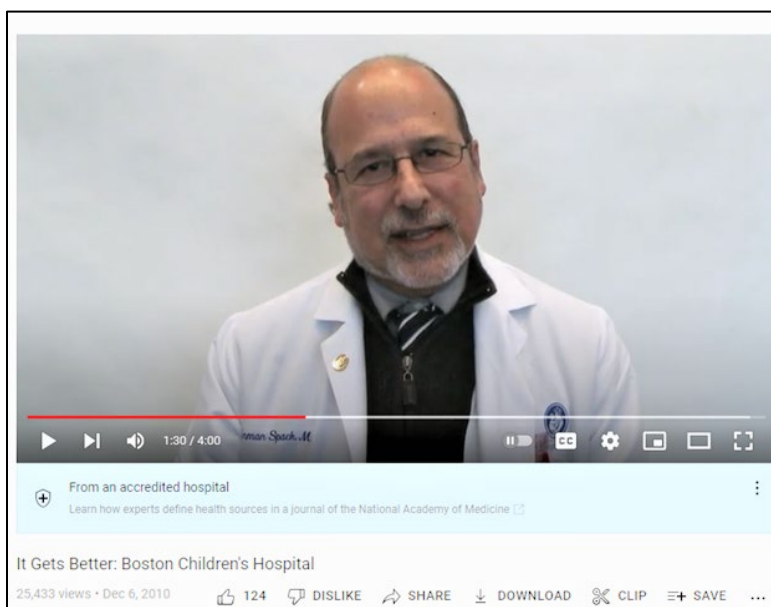


Brian Camenker warned the country on Fox News with Megyn Kelly (May 2008).

At the time, we hoped that the public would be appropriately shocked and demand the BCH gender clinic be shut down. But apparently, the larger public was not able to deal with this ugly topic, or possibly hoped it would go no further than Boston. But the major medical and mental health professional associations were already committed to the transgender ideology, so it was wishful thinking to expect this cancer would not spread beyond Boston.

And now, the abuse of children in the name of “gender” ideology has ballooned seemingly out of control as the [medical professional associations](#), [CDC](#), and [children’s hospitals](#) nationwide have capitulated to Big LGBTQ+ and [Big Pharma](#). A recent estimate (2022) is that “[at least 13 U.S. hospitals](#) perform gender surgeries on minors.” Even ten years ago, there were [about 50 clinics](#) treating “transgender and gender-expansive youth,” which would include puberty blockers and cross-sex hormones, though most were not then offering surgeries. Independent providers and Planned Parenthood clinics have since joined the major hospitals and now offer puberty blockers and cross-sex hormones to minors. There are now [over 300 such clinics in the U.S.](#)

It is not just about money to be made; pure evil is at work as well. Those participating in this evil must be exposed by name. But Boston Children’s Hospital is now providing cover for their staff. BCH has removed web pages and videos. So, this report has published pages from the Internet Archive as well as current postings to document the violations of the Hippocratic Oath now taking place at BCH.



Boston Children’s Hospital GeMS Clinic founder, [Dr. Norman Spack](#), appeared in the 2010 LGBT promotional [video](#), “[It Gets Better](#),” with other BCH staffers.

## **“Gender-affirming” treatments have no scientific basis Based on undefined anti-scientific concepts and myth of suicide risk**

The [GeMS clinicians at Boston Children’s Hospital](#) dismiss the reality of children’s biological sex, and instead support fantasies of “gender identity.” This irrational approach will inflict serious long-term health problems on these children who often will become “patients for life.”

The BCH GeMS clinic’s existence is based on concern for a newly discovered condition, “gender dysphoria.” BCH attempted to [define gender dysphoria](#) in this *archived* page.

**What is gender dysphoria?** Gender dysphoria occurs when there is a conflict between the sex you were assigned at birth and the gender with which you identify. This can create significant distress and can make you feel uncomfortable in your body. People with gender dysphoria may want to change the way that they express their gender. This may mean changing the way they dress, transitioning socially (using the pronouns and public bathroom associated with their affirmed gender), transitioning medically or surgically, or some combination of these.

Note the *failure to clearly define the underlying concept of “gender.”* And the anti-science phrase, “sex assigned at birth,” is simply a denial of biological reality. The “distress” children experience over their mental fantasies (“gender identity”) becomes the basis for serious medical interventions, subjecting their healthy bodies to unnatural hormones and mutilating surgeries. So the underlying concept is crucial.

An [archived BCH video](#) tried to define “gender identity” (in order to distinguish it from “sexual orientation”). The psychologist explains that “*gender identity is someone’s internal sense of self; who they are; the gender that they feel is authentic to them.... Your gender identity is how you feel in your heart and in your mind.*” It’s still not clear what “gender” (or even “self”) is. It’s all totally subjective, all about feelings.

From the *current* [BCH website](#):

### **Gender dysphoria symptoms**

People with gender dysphoria feel that **the sex they were assigned at birth does not match the gender with which they identify.** For example, someone who was born with the reproductive organs and other physical traits of a male may identify as female. The word “dysphoria” means significant uneasiness and dissatisfaction, and gender dysphoria can start to present as early as childhood in some people. **Other symptoms** associated with gender dysphoria include:

- distress
- anxiety
- depression
- negative self-image
- strong dislike of your sexual anatomy
- strong preference for the toys and activities associated with the other gender (in children).

The distress related to gender dysphoria has been associated with an increased risk of substance abuse, self-harming behaviors, and suicide attempts. This is mostly because of the increased risk of discrimination for individuals who are transgender or gender non-conforming.

... **We still don't know exactly what causes gender dysphoria**, although some experts believe that hormonal influences in the womb may be involved.

Gender dysphoria was sometimes previously called "gender identity disorder" and "transsexualism," but these terms are outdated and may be considered offensive. Gender dysphoria is not the same as homosexuality, which refers to sexual orientation rather than gender identification. It is also different from gender non-conformity, which refers to engaging in behaviors that don't conform to gender norms or stereotypes, such as cross-dressing. [bold added]

Couldn't the cited symptoms occur in people who *do not* identify as "transgender" or "gender diverse"? It is stated as fact (without evidence) that *discrimination* leads to the "distress" the child is feeling. The clinic admits they have no idea what *causes* this phantom condition, yet will proceed to treat shoddily "diagnosed" children with powerful drugs, hormones of the opposite sex, and surgeries that are experimental, gruesome, sterilizing, and often debilitating.

BCH recently removed videos featuring explanations of "gender" treatments and advice offered by the clinic. In the [archived video](#) below, psychologist Kerry McGregor describes the patients she sees, *some as young as two years old*. Parents are instructed to support *without question* whatever their child says about "their gender" (after the child has been tutored in the terminology by the gender clinicians):



BCH psychologist Kerry McGregor in [archived video](#). More on McGregor [here](#).

So most of the patients we have in the GeMS clinic actually know their gender, usually around the age of puberty. But **a good portion of children do know as early as seemingly from the womb, and they will usually express their gender identity as very young children, some as soon as they can talk. They might say phrases such as, "I'm a girl!" or "I'm a boy" or "I'm going to be a woman" or "I'm going to be a mom."** Kids know very, very early. So in the GeMS clinic we see a variety of young children, all the way down to ages two and three, and



usually up to the ages of nine. When they come into the clinic, they'll see one of our psychologists, and **we'll be talking to them about their gender**, we'll be talking to their family about how to best support that child, and how to **make sure that child has the space and support to explore their gender**, and do well throughout their development, and we'll be answering any parent questions. A lot of parents do have questions, so we answer those questions. **The biggest piece of advice I give parents** who are coming through the gender clinic at Boston Children's Hospital is to **just be supportive. Um, sometimes you might not understand, and sometimes you feel like you don't know the terms, or you don't get exactly what the child means when they say that they might be this gender.** But the biggest thing you can do is just love your child and support them and just allow them to express themselves. That's the biggest protector as well against negative mental health effects such as depression, suicidality, anxiety that we worry about for **our** gender-diverse kids and young adults. So that support from a parent is one of the best protective factors, and one of the best things they can do. [bold added; transcript by author]

The former director of the GeMS clinic, Jeremi Carswell, MD, stated (in an [archived video](#)) that very young children may already know their true "gender":

**A child will often know that they are transgender from the moment that they have any ability to express themselves**, and parents will often tell us this. We have parents who tell us that their kids – **they knew from the minute they were born, practically, in actions like refusing to get a haircut, or standing to urinate, trying to stand to urinate, refusing to stand to urinate, trying on siblings' clothing, playing with the "opposite gender" toys, things like that.** There is, more and more, a group of **adolescents** that we are seeing that really are coming to the realization that they may be trans or gender-diverse a little bit later on in their life. So what we're seeing from them is that **they always sort of knew that something was maybe off and didn't have the understanding to know that they might be trans or have a different gender identity [sic] than the one they had been assigned.** So that is a growing population that we are seeing and is being recognized as indeed trans and able to be treated. [bold added; transcript by author]



Jeremi Carswell, MD, former director of GeMS, in archived BCH [video](#). More on Carswell [here](#).

(Note that even she can't keep the trans terminology straight: It should be "sex" – not "gender identity" – that the children "had been assigned.")

The [American College of Pediatricians](#) presents the dissenting view:

**Sex is a Biological Trait of Medical Significance** (Abstract)

In the midst of society's questioning of the gender binary, the American College of Pediatricians (ACPed) is concerned that the field of medicine risks denying the reality of biological sex. Sex is a dimorphic, innate trait defined in relation to an organism's biological role in reproduction. In humans, primary sex determination occurs at fertilization and is directed by a complement of sex determining genes on the X and Y chromosomes. This genetic signature is present in every nucleated somatic cell and is not altered by drugs or surgical interventions. Sex differences arise from at least four different genetic mechanisms, in addition to the actions of sex hormones and environmental influences. Consideration of these innate differences is critical to the practice of good medicine and to the development of sound public policy for children and adults alike.

Further, ACPeds explains that there is no scientific evidence that puberty-blocking drugs, cross-sex hormone regimens, and chest or bottom surgeries are either safe or effective in reducing a transgender-identifying person's psychological distress:

Gender has been defined as "an internal sexed identity" and it is now claimed that just as every person has a sex, every person also has "an internal sexed identity" [gender]. **There is not a single medical test to diagnose a person's "internal sexed identity" [gender or gender identity] because these exist in the mind not in the body. No child is born "trans". But experts claim medical intervention is life saving; this is a lie. There is not a single long term study to demonstrate the safety or efficacy of puberty blockers, cross-sex hormones and surgeries for transgender-believing youth. This means that youth transition is experimental, and therefore, parents cannot provide informed consent, nor can minors assent to these interventions. Moreover, the best long-term evidence we have among adults shows that medical intervention fails to reduce suicide.** [bold added]

ACPed forthrightly states that "gender" treatments for children amount to *child abuse*:

**Conditioning children into believing a lifetime of chemical and surgical impersonation of the opposite sex is normal and healthful is child abuse.**

Endorsing gender discordance as normal via public education and legal policies will confuse children and parents, leading more children to present to "gender clinics" where they will be given puberty-blocking drugs. This, in turn, virtually ensures they will "choose" a lifetime of carcinogenic and otherwise toxic cross-sex hormones, and likely consider unnecessary surgical mutilation of their healthy body parts as young adults [*or even earlier*, as noted below].

These interventions are based on sloppy research. Many serious adverse physical and psychological effects are now documented to be associated with treatments the BCH clinic purveys. "The most reliable research shows that in the long run, medical transition does not reduce and may even exacerbate the psychological distress that could lead to suicide." The Internet and social media are replete with personal testimonies of regret and suffering from people who submitted to "gender-affirming" treatments, whose psyches and bodies are wounded for life.

Since mood disorders often persist with gender treatments, it's not surprising that a much-cited long-term follow-up study in Sweden showed that rates of suicide are



[substantially higher](#) among adults who had completed their “transition.” But the [myth](#) has been spread that “transgender” children will be suicidal if not supported in their new identity. This amounts to “emotional blackmail” of parents, [pushing them](#) to turn their children over to the gender clinics.

**The BCH GeMS clinic was founded on the back of that suicide myth.** (This is also true of the [LGBT programs in the schools](#) that are contributing to the explosion in numbers of children identifying as trans.)

Returning to the [hospital’s announcement](#) on the gender clinic’s opening in 2007, it was admitted that the children they would treat had **“no known anatomic or biochemical disorder, yet feel like a member of the opposite sex.”** So the *raison d’etre* for the clinic would hang on the need to alleviate their “psychological distress”:

Unique in the Western hemisphere, the [GeMS] clinic will also care for children and young adults who **present as transgendered — those who have no known anatomic or biochemical disorder, yet feel like a member of the opposite sex.** Such feelings can emerge early, even in the preschool years, and can cause considerable psychological distress. For that reason, transgendered young people are often assumed to have a psychiatric disorder and are placed on psychotropic medications. By late adolescence, a high percentage have attempted suicide.

"This will be the first major program in the country that is not only treating DSDs [disorders of sexual differentiation, a true biological condition], but also welcoming young people who **appear** to be transgendered and are considering medical protocols that **might** help them," says Dr. Spack. [bold added]

How could a child know how it “feels” to be the opposite sex? It’s not even clear to the doctors that the children are *really* transgender (however that was defined then); some just “appear” to be. But the clinic will treat them anyhow, with protocols that “might” help them. It’s all a crazy experiment.

The announcement further stated, “transgendered young people are often assumed to have a psychiatric disorder” (beyond gender confusion). But it is likely these children *do* in fact have underlying psychiatric disorders or they wouldn’t be enticed by this anti-reality cult. And new research is revealing that many are on the [autism spectrum](#). How to address these issues is the question. Why are “gender-affirming” treatments the only recourse?

The national medical establishment has [bought into](#) the irrational and unscientific transgender ideology. On October 3, 2022, the American Medical Association, the American Academy of Pediatrics, and the Children’s Hospital Association jointly [called for action by the federal Department of Justice](#) and technology companies to squelch any factual, critical reporting on transgender “health” programs at children’s hospitals. These medical associations call “gender-affirming” treatments “evidence-based health care” while labeling any criticism “disinformation.”



Boston Children's Hospital staff marching in the Boston Gay Pride parade. (MassResistance photo)

Any BCH clinician or staffer who would voice disagreement with LGBT ideology and the “gender” treatments would no doubt be considered guilty of unlawful discrimination and lose his job or hospital privileges. *No dissent* allowed. Under current Massachusetts law, a hospital is a public accommodation so cannot allow anything that could be perceived as “anti-transgender” discrimination. (But who gets to determine “discrimination”? How is it discriminatory to protect children from experimental treatments now known to create lasting, often irreversible, damage to their health?)

**Overview**

Meet Our Team

Conditions & Treatments

Your Visit

Patient Resources

Contact Us

### External resources

Please note that neither Boston Children's Hospital nor the Gender Multispecialty Service unreservedly endorse all of the information found at the external websites listed below. These links are provided as a resource.

**Cambridge Institute** Summer camp for gender non-conforming youth ages 7 to 18

**Campus Pride** Extensive information about LGBTQ+ resources in colleges and universities throughout U.S.

**The Family Acceptance Project** Research, intervention, education and policy initiative that works to prevent health and mental health risks for LGBTQ+ youth

**Gay and Lesbian National Hotline** Anonymous peer counseling, information, and referrals with a huge database (888.774.6464)

**Gay and Lesbian Advocate and Defenders (GLAD)** Legal rights advocacy

**Gay, Lesbian and Straight Education Network (GLSEN)** Provides educators and families support, training, advocacy tools, and research to create safe and affirming schools for all

**Gender Spectrum** An organization that helps families, organizations, and institutions increase the understanding of gender

**Gender Embodiment Society** Offers a variety of educational materials for gender-diverse patients and their families

**Parents, Families, and Friends of Lesbians and Gays (PFLAG)** National and local listings available for family LGBTQ+ support

**Safe Schools Program for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Students** In joint initiative of the US Department of Elementary and Secondary Education and the Massachusetts Commission on LGBTQ+ Youth


**Trans Youth Family Allies (TYFA)** Collaborates with service providers, educators and communities

**Trans Youth Equality Foundation (TYEF)** Support, resources and networking services, based in Portland, ME

**The Trevor Project** The leading national organization providing crisis intervention and suicide prevention services to LGBTQ+ people under 25

**Trans Students Educational Resources** Includes the “Gender Unicorn” infographic, which helps explain gender in an easy-to-understand image

**Welcoming Schools** A project of the Human Rights Campaign Foundation provides educators with a comprehensive approach to improve elementary school climates, to embrace diversity, avoid gender stereotyping and anti-bullying



**Contact Us**

CONTACT US  
617.355.4967

Radical LGBTQ groups on BCH online [resource list](#) in 2023.

BCH has been totally captured by the radical LGBT movement for some time. A powerful [LGBTQ Ally group](#) seems to be setting the tone for the hospital. The clinic's [External Resources](#) web page and ["Gender Resources" list](#) are a catalogue of the most radical advocacy and youth "support" groups, including: [GLSEN](#), the [Trevor Project](#), Human Rights Campaign's [Welcoming Schools](#), [Gender Spectrum](#), [BAGLY](#), [PFLAG](#), [Campus Pride](#), [Trans Student Educational Resources](#) ("Gender Unicorn" creator), [Trans Youth Family Allies](#), [GLBTQ Advocates and Defenders \(GLAD\)](#), Massachusetts' [Safe Schools Program for LGBTQ Students](#), etc.

The Human Rights Campaign named BCH a "[LGBT Healthcare Equality Leader](#)" in 2017. HRC has a campaign underway now to [intimidate other children's hospitals](#) to follow BCH's model for "gender-affirming" treatments. The numbers of LGBTQ youth are, after all, increasing, so there is a need to be met. And there are numerous LGBTQ-identified hospital workers eager to help. According to [HRC](#):

LGBTQ youth present for care at children's hospitals across the country, seeking either routine health care or care related to their sexual orientation or gender identity. **An estimated 10.4% of youth in high schools across the United States identify as lesbian, gay, or bisexual (LGB), 2% identify as transgender, and 4.2% are unsure of their sexual identity, according to the Centers for Disease Control. ... LGBTQ people make up 9% of workers in hospitals, compared to just 5% of all workers nationwide. [bold added]**

The former CEO of BCH, Sandra Fenwick, joined forces with the HRC and [bragged](#) about BCH's gender clinic being on the forefront of pediatric LGBTQ+ care. From 2020:

**I am so proud of Boston Children's role as a HEI [Healthcare Equality Index] LGBTQ Healthcare Equality Leader, and even more proud of the extraordinary work that all of us are doing to deepen our understanding of what our LGBTQ+ patients, families and employees need, and bridging the gaps in their support and care. The more we understand, the better equipped we are to evolve with those needs, and eventually get ahead of them instead of striving to catch up. Whether we're working to enhance the health of LGBTQ+ patients and families, engaged in the groundbreaking research that will play so crucial a role in defining the future of LGBTQ+ healthcare, or providing education around the inherent respect of honoring a person's gender identity, the work we are all doing in this area is essential and so meaningful. [bold added]**

While BCH has never really defined "gender" or "transgender," note that its former CEO added the undefined Q and + ("plus") to the acronym: "**LGBTQ+ patients.**" So minor children can now be labelled "queer" or "plus" by BCH medical professionals. (What exactly might the "plus" include? "pan" – "poly" – "neutrois" – "agender" – "pedo"– etc.? One activist group says, "The 'plus' is used to signify all of the gender identities and sexual orientations that letters and words cannot yet fully describe.")

BCH gender surgery clinic co-director Dr. Oren Ganor is [recommending](#) children's gender clinics nationally ramp up their capacity to make up for new restrictions on "gender-affirming" care for children in a growing number of states.

People across the country are finally comprehending the damage these clinics are doing. And the gender clinicians sensed opposition was growing. In 2019, BCH staff attempted to tackle the ethical issues of operating a gender clinic in a paper in the journal [Pediatrics](#): “Ethical Issues Considered When Establishing a Pediatrics Gender Surgery Center.” Notably, “gender” itself is once again never defined, while the condition the clinic purports to treat, “gender dysphoria,” is based on that undefined concept. One question addressed in the paper: “Is there a sound medical rationale for the treatment or surgery to be provided through the center?” Here is the prevaricating answer (in part):

The [BCH] center planned to offer gender affirmation chest reconstruction, phalloplasty, and metoidioplasty for transmasculine individuals (those assigned female at birth with a more male gender identity) and breast augmentation and vaginoplasty for transfeminine individuals (those assigned male at birth with a more female gender identity). **Although the quality of the evidence base is low and relies mostly on short-term follow-up, the limited existing reports suggest** that these treatments can be an effective way to improve gender congruence and body satisfaction for transgender individuals who are interested in such surgeries, and they have also been shown to improve depression, anxiety, and overall quality of life.... On the basis of research in the field, the **clinicians were able to present solid evidence that the treatments to be provided at the center were medically sound and necessary** to improve the health and well-being of the patients to whom they would be provided, including reduction or alleviation of symptoms of gender dysphoria. [bold added]

The BCH Center for Gender Surgery includes [this notice](#) on its home page, confirming that they make medical policy in part based on *political and social considerations*. Note the phrase “gender diverse youth” (another undefined term) is now added alongside “transgender”:

The proposed bans on medical care, sports participation and other legislation aiming to restrict the rights of transgender and gender diverse youth are in direct opposition to our commitment to equity, diversity and inclusivity, as well as the standard of care that we live by. Here in Massachusetts, we have been fortunate—there has not yet been movement on any of these initiatives. You may recall that in 2016, Massachusetts voters upheld legislation designed to protect the rights of transgender residents in public accommodations. Boston Children’s was proud to be part of the coalition that worked in support of that ballot question.

I [author unidentified] also want to let you know that Boston Children’s has signed on as an endorsing organization of the Equality Act, which is federal legislation that would provide affirmative, legal nondiscrimination protections for LGBTQ Americans both in the workplace and the community by adding sexual orientation and gender identity to the list of protected characteristics in federal civil rights laws.

We are here to affirm, uplift, and advocate for transgender and gender diverse youth, and we remain committed to doing all we can to support their care and well-being.





Staff member at BCH in [LGBT promotional video](#) from 2010 (promising children "[It Gets Better](#)"), proudly showing a drawing by a "cross-gender" child.

Not all dissenting doctors are afraid to speak against these powerful groups. [Fox News](#) [pointed to serious challengers](#):

[Assistant Secretary for Health at HHS] Rachel Levine's claim [that] all agree on "gender-affirming care" is slammed by doctors [who are] "in hiding." Several medical professionals tell Fox News their colleagues are afraid to "challenge this narrative" on gender.

Dr. William Malone, an Idaho-based assistant clinical professor of endocrinology, is a member of the Society for Evidence-Based Gender Medicine (SEGM), which is an international group of more than 100 clinicians and researchers concerned about what they call the "lack of quality evidence for the use of hormonal and surgical interventions as first-line treatment for young people with gender dysphoria."

On April 7, SEGM released an **extensive rebuttal of the March guidance from the HHS**, alleging that the department failed to adequately review available literature and also rendered biased recommendations without taking into account the low quality of evidence, diversity of clinician viewpoints or possible alternative treatments.

A board-certified endocrinologist, Malone has waded into the international debate on such issues by raising concern about the potential long-term physical effects of treating gender-dysphoric youth with puberty blockers, cross-sex hormones and surgery, as endorsed by the Endocrine Society (ES).

In March 2021, he and several colleagues penned a **[letter to the editor of \*The Journal of Clinical Endocrinology & Metabolism\*](#)**, pointing out that the "standards of care" laid out by WPATH and the ES are technically only practice guidelines that are potentially subject to the bias of their sponsor. [bold added]

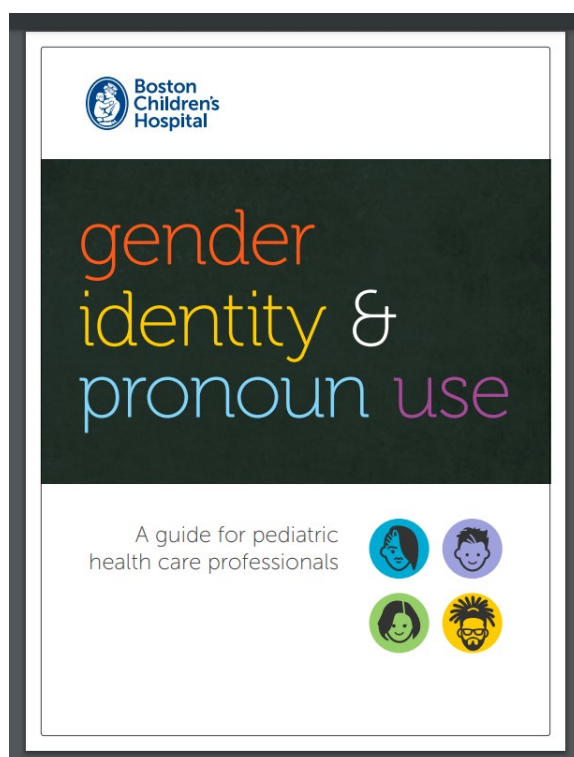
Meanwhile, [European nations](#) (UK, Sweden, Finland, France) are [backing away from transitioning children](#).

## Social transitioning: BCH guide on names, pronouns, clothing, records; warns against parents; tucking and binding

The process of confirming a child's new identity begins with "social transitioning." This includes using [new names](#) and [pronouns](#), a new biological sex designation on school and medical records, changes in clothing and hairstyle, etc. It is the trans "coming out" process encouraged and guided by therapists, social workers, and school counselors.

The BCH GeMS clinic psychologists and social workers support social transitioning. The BCH booklet, "[Gender Identity & Pronoun Use](#)" (2017), is intended for physicians, therapists, social workers, schools, and parents.

The booklet's authors: [Sabra L. Katz-Wise](#), PhD, is an Associate Professor at BCH and Harvard Medical School. Her areas of expertise are "sexual orientation and gender identity development, sexual fluidity, health inequities related to sexual orientation and gender identity in adolescents and young adults, and psychosocial functioning in families with transgender youth." She is a member of the Queer Leadership Council for the BCH Rainbow Alliance and the BCH Equity, Diversity, and Inclusion Council. [Katharine Thomson, PhD](#), is a clinical psychologist at BCH "involved in LGBTQ+ (lesbian, gay, bisexual, trans, queer/questioning and others) education and advocacy." She is co-chair of the BCH Rainbow Consortium on Sexual and Gender Diversity, and lead facilitator of BCH Safe Zone.



The booklet begins:



Everyone has a gender identity. Some people identify as cisgender — a gender that corresponds with the sex they were assigned at birth. Others identify with a gender that is different from what they were assigned at birth. Regardless of a person’s sex assigned at birth, a person may identify as a woman, a man, both or neither, or they may switch between genders (gender fluid). In a health care setting, respecting a patient’s gender identity and asking about the name and pronouns they use is a crucial element of good clinical care....

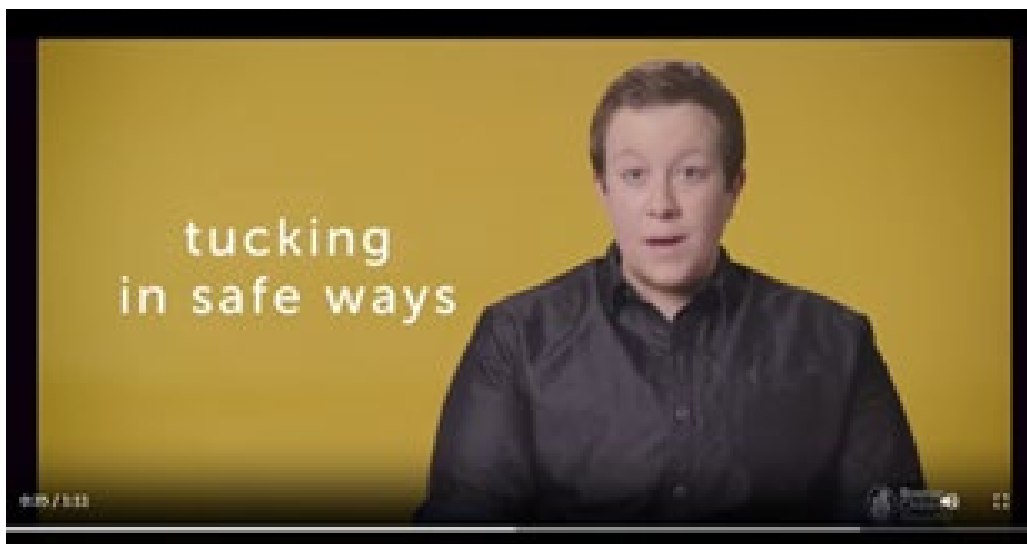
The publication warns that parents might be “unsafe” for their “transgender” child:

Ideally, providers are able to ask a youth about their pronouns in a location that is private and separate from their guardians.... **For safety reasons, providers may be asked to switch between pronouns for the patient, depending on which guardian is in the room.** This is very important to respect; **using the affirmed pronouns when the guardians have not been previously informed can put the youth at risk for negative reactions or even rejection from their guardians.** [bold added]

This message – that parents can be a danger to their own child – underscores how the radical transgender movement has divided families, harming both child and parents. And the BCH GeMS clinic is out front with this vile message.

Archived videos from BCH makes it clear that the gender clinic offers their socially transitioning adolescent patients lessons on genital tucking and breast binding. Once the teens experience the discomfort they cause, they may want to seriously consider surgery.

BCH psychologist Col Williams, advises how a boy can “safely tuck” his genitals:

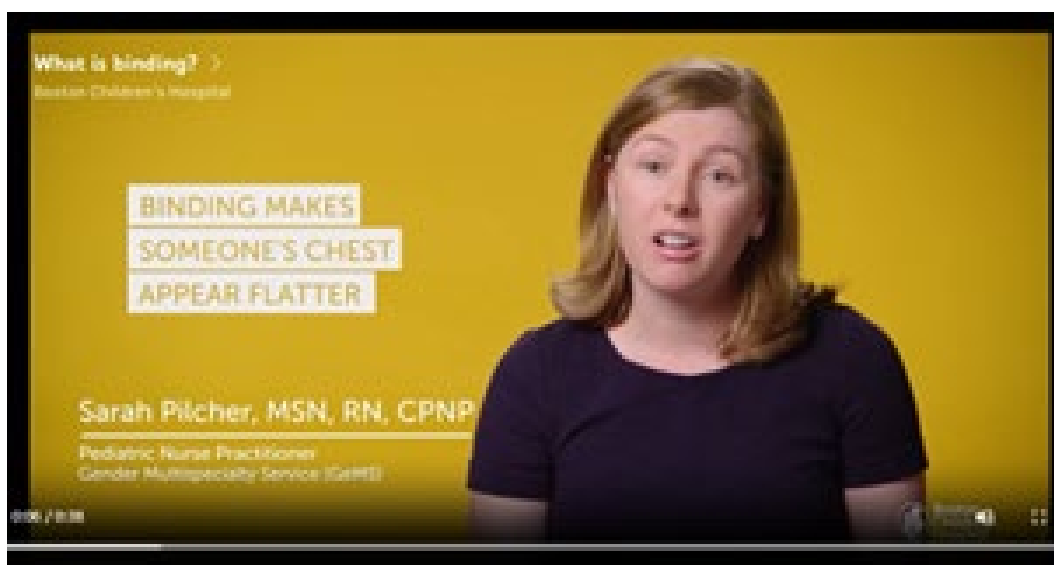


BCH archived video says tucking male genitals can be done safely.

**Tucking** is definitely a topic that comes up for transgender and gender-diverse folks, particularly people who have a feminine or female gender identity and were perhaps **assigned male sex at birth.** **The purpose of tucking is that it helps them feel better, feel more congruent and aligned with the body that they do have. That can help reduce gender dysphoria.** And gender dysphoria is that negative, or that uncomfortable, distressed feeling

that possibly comes with having a gender identity that's different than your sex assigned at birth. So when I think about tucking, I want to be sure that people are **tucking in safe ways**. Um, and I think that one of the best things that folks can do, and families can do who are helping children or teenagers navigate this topic, is talk to a gender-affirming medical provider that's involved in their child's care, or that's involved in your care. I would really **recommend that people take breaks from tucking**. Often people can tuck for a long period of time. And we want to make sure that you're listening to your body, that you're not in any pain. **The pain might feel like an uncomfortable sensation, or a tingly sensation**. And that's definitely something you want to take a break from and I'd talk with your medical provider about it. [bold added; transcript by author]

BCH Nurse Practitioner Sara Pilcher (MSN, RN, CPNP) instructs girls on how to measure and wear breast binders "safely" in this [archived video](#). Note that she studiously avoids using the word "breasts." Binders uncomfortably and unsafely constrict a girl's breasts and ribcage.



BCH [archived video](#) on breast binding

Binding is essentially when someone who is assigned female wears something on their chest to make it appear flatter. And a lot of my patients who identify as transgender male, or non-binary, or male leaning like to do that. That top three tips I have for safe binding are to: First, make sure you're measuring correctly. And sometimes it might take the assistance of like a parent or trusted friend to do it right. Second, making sure that you're buying the correct size not only for your chest measurement but for your shoulder measurements too, because a lot of people make mistakes there. And the third tip is: definitely not wearing it for more than ten hours a day. [transcript by author]

Furthermore, the BCH booklet names the [National LGBTQIA+ Health Education Center](#) (at the Fenway Institute, Boston) as a resource. In that organization's "[Gender-Affirming Pediatric Care Toolkit](#)" is a section on "Social Gender Affirmation" which gives advice on "[safer tucking](#)" (of the genitals) for boys and "[breast binding](#)" for girls. (The "Safer Tucking" pamphlet is produced by HOTT, [Health Outreach to Teens](#).)



“SAFE ZONES” might *not* include a child’s home, warns Boston Children’s Hospital. But a child is “safe” at the gender clinic.  
(Image: U. Mass. Stonewall Center)

The numbers of children taking at least this first step, social transitioning (claiming a “trans” identity), is growing fast. The societal forces pushing children’s identification as transgender have had a huge impact.

The CDC’s analysis of the [2017 Youth Risk Behavior Survey](#) of high school students showed that 1.8% responded, “I am transgender”; 1.6% responded, “I am not sure if I am trans-gender.” By 2021, that [CDC survey](#) showed that 75.5% of students identified as heterosexual, while “3.2% [identified] as gay or lesbian, 12.1% as bisexual, 5.2% as questioning, and 3.9% as other.” In 2022, the LGBT-affirming [Williams Institute](#) at UCLA [reported](#): “Among youth ages 13 to 17 in the U.S., 1.4% (about 300,000 youth) identify as transgender.” A [Pew Research Center poll](#) from 2022 found: “Adults under 30 are more likely than older adults to be trans or nonbinary. Some 5.1% of adults younger than 30 are trans or nonbinary, including 2.0% who are a trans man or trans woman and 3.0% who are nonbinary.” A [Gallup poll](#) in early 2022 found, “Roughly 21% of Generation Z Americans [born 1997-2003] who have reached adulthood identify as LGBT.”

## Puberty blocking drugs

The BCH GeMS clinic has no information on its website about its puberty blocking protocol for younger children. So we must turn to other sources for information on what the hospital’s standards for this treatment *may* be.

[BCH endocrinology doctors](#) supervise treatment with puberty blockers or cross-sex hormones. The current hospital website does not identify which of these doctors are now with the GeMS clinic. But the [2019 list \(below\)](#) named seven GeMS endocrinologists.

The [American College of Pediatricians](#) (which opposes these treatments) states:

**Puberty is not a disease and puberty-blocking hormones can be dangerous. Reversible or not, puberty-blocking hormones induce a state of disease – the absence of puberty – and inhibit growth and fertility in a previously biologically healthy child.**

According to the DSM-5 [American Psychiatric Association’s diagnostic manual], **as many as 98% of gender confused boys and 88% of gender confused girls eventually accept their biological sex after naturally passing through puberty.**

Pre-pubertal children diagnosed with gender dysphoria may be given **puberty blockers as young as eleven ...** [or younger in 2023; bold added]

At what age do BCH doctors administer puberty blockers to young children? In 2008, clinic founder Dr. Norman Spack told the *Boston Globe*:

*At what age do you give kids drugs to delay puberty?*

The puberty-blocking drugs work best at the beginning of the pubertal process, typically age 10 to 12 for a girl and 12 to 14 for a boy. **Stopping puberty is, in itself, a diagnostic test. If a girl starts to experience breast budding and feels like cutting herself, then she's probably transgendered. If she feels immediate relief on the [puberty-blocking] drugs, that confirms the diagnosis.**

*So the aim of your treatment is to protect children from harming themselves?*

**Transgendered kids have a high level of suicide attempts.** Of the patients who have fled England to see me, three out of the four have made very serious suicide attempts. And I've never seen any patient make [an attempt] after they've started hormonal treatment. [bold added]

Note Dr. Spack’s absurd statement that if a girl starts cutting herself as she enters puberty, “she’s probably transgendered”! And he trots out the suicide myth, which continues to be held over parents to convince them to enroll their children in these treatments.

With the age at onset of puberty falling, the starting age for puberty blockers has been lowered since that statement from 2008. The Cleveland Clinic reports **the drugs are now given as young as age 8 for a girl, and 9 for a boy.**

WPATH, the World Professional Association for Transgender Health (comprised of *activists* from inside and outside the medical community) – which BCH cites as an authoritative resource – recommends in its latest Standards of Treatment (Version 8, Sept. 2022) that puberty blocking drugs begin at Tanner Stage 2, the normal onset of puberty. (See information on Tanner stages, see here and here.) **For boys in the U.S., that would fall between ages 9 and 14; for girls, between ages 8 and 13.**

**Recommendations** [WPATH, v.8]

12.1- We recommend health care professionals begin pubertal hormone suppression in **eligible\*** transgender and gender diverse adolescents after they first exhibit physical changes of puberty (Tanner stage 2).

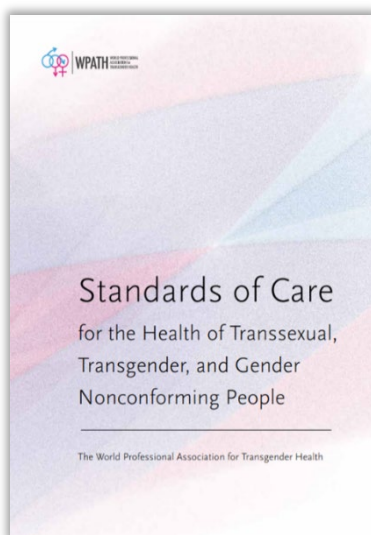
12.2- We recommend health care professionals use gonadotropin releasing hormone (GnRH) agonists to suppress endogenous sex hormones in **eligible\*** transgender and gender diverse people for whom puberty blocking is indicated.

12.3- We suggest health care professionals prescribe progestins (oral or injectable depot) for pubertal suspension in **eligible\*** transgender and gender diverse youth when GnRH agonists are either not available or are cost prohibitive.

12.4- We suggest health care professionals prescribe GnRH agonists for suppression of sex steroids without concomitant sex steroid hormone replacement [cross-sex hormones] in **eligible\*** transgender and gender diverse adolescents seeking such intervention and who are well into or have completed pubertal development (past Tanner stage 3) but are either unsure about or do not want to begin sex steroid hormone therapy.... [p. S111]

The asterisks above (appearing in the original) define a child's eligibility for treatment to include that he *"demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment."* [p. S256] How is that remotely possible for a child between the ages of 8 and 14? After all, children's brains are still developing and they are not capable of mature decision-making until in their early-to-mid 20s.

Even for a parents, "informed consent" for experimentation on their child is impossible (unless it means simply they accept that the result is unpredictable, thus negating the idea of truly "informed consent").



WPATH "Standards of Care" V.7

Note its title language is now considered outdated. The terms "transsexual" and "gender nonconforming" are no longer in favor. Version 8 employs "transgender and gender diverse people." The terminology cannot keep pace with their ever evolving concepts.

WPATH's earlier guidelines, Version 7, included this:

**Neither puberty suppression nor allowing puberty to occur is a neutral act.** On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, **there are concerns about negative physical side effects of GnRH analog use [as puberty blocker] (e.g., on bone development and height).** **Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising, ... the long-term effects can only be determined when the earliest treated patients reach the appropriate age.** [pp. 18-20; bold added]

In other words, the long-term effects are still not known. For BCH to cite WPATH or the Endocrine Society as indisputable authorities behind their puberty blocking protocols is deceptive. [Dissident MDs](#) note that WPATH's and the Endocrine Society's endorsement of puberty blockers is highly questionable:

The World Professional Organization for Transgender Health (WPATH) also acknowledges that despite the misleading name, WPATH Standards of Care 7 are also **practice guidelines, not standards of care**. Unlike standards of care, which should be authoritative, unbiased consensus positions designed to produce optimal outcomes, practice guidelines are suggestions or recommendations to improve care that, depending on their sponsor, may be biased. In addition, the ES [Endocrine Society] claim of effectiveness of these interventions is at odds with **several systematic reviews, including a recent Cochrane review of evidence, and a now corrected population-based study that found no evidence that hormones or surgery improve long-term psychological well-being**. Lastly, the claim of relative safety of these interventions ignores the **growing body of evidence of adverse effects on bone growth, cardiovascular health, and fertility, as well as transition regret**. [bold added]

While WPATH calls puberty blockers “fully reversible” (e.g., p. S43 in [V. 8](#)), that is not accurate according to the [American College of Pediatricians](#) who explain:

**Puberty blockers may actually cause depression and other emotional disturbances related to suicide.... Temporary use of Lupron has also been associated with and may be the cause of many serious permanent side effects including osteoporosis, mood disorders, seizures, cognitive impairment and, when combined with cross-sex hormones, sterility....**

GeMS clinic director, Dr. Jeremi Carswell, admits some of the unknown lasting effects of puberty blockers in [two short clips](#):

“If you are giving something that shuts down your estrogen or shuts down testosterone entirely, you’re going to stop ... producing sperm or eggs,” Carswell says before going on to say, “If you never started, you’re not going to ... advance the gonads to be able to do that.” Despite being the director of the clinic, Carswell was unable to answer an audience member when she was asked whether or not the administration of puberty-blocking drugs could result in an inability to orgasm.

A 2017 report at *STAT News* linked GnRH analogues (Lupron and others) to [degenerative \(brittle\) bones, joint problems, mental health issues, and even deadly seizures](#). More recently, the [FDA issued a new warning](#) about a possible side effect (brain swelling) when the drug is used to block puberty. Furthermore, [sexual functioning](#) (capability for orgasm and sensual pleasure) may be destroyed by the blockers (and later surgeries).

Mayo Clinic [acknowledges](#) some of these possible side effects of puberty blockers (while also suggesting their use with “transgender and gender-diverse children”):

**Possible side effects of GnRH analogue [puberty blocker] treatment include: Injection site swelling – Weight gain – Hot flashes – Headaches**  
**Use of GnRH analogues might also have long-term effects on: Growth spurts – Bone growth and density – Future fertility** (depending on when pubertal blockers are started)



Children may have their height checked every three months. Bone density is also checked periodically. If bone growth or density is a concern, your child's health care provider might prescribe a different medication, stop treatment with GnRH analogues or recommend the best time to start cross-hormone therapy.

**If children with male genitalia begin using GnRH analogues early in puberty, they might not develop enough penile and scrotal skin for certain gender affirming genital surgical procedures, such as penile inversion vaginoplasty.** Alternative techniques, however, are available. [This is [what happened to the unfortunate boy "Jazz" Jennings.](#)]

**In addition, delaying puberty beyond one's peers can be stressful. Your child might experience lower self-esteem.** [bold added]

Frequent clinic appointments are required with puberty blocking treatments. Mayo Clinic explains:

While most children take the medication for a few years, every child is different. After suppressing puberty for a few years, **your child might decide** to stop puberty blocking therapy or pursue other hormone treatments.

... GnRH analogue treatments for children are prescribed, administered and monitored by a pediatric endocrinologist. The medication is typically given as injections, either monthly or every three months, or through an implant placed under the skin of the upper arm. The implant typically needs to be replaced every 12 months.

While taking pubertal blockers, your child will have **regular blood tests to monitor the medication's effectiveness.** Your child will also be **monitored for any side effects.** [bold added]

Commonly prescribed drugs (used off-label) are (according to the [Cleveland Clinic](#)): [Goserelin injection](#) (Zoladex®), [Histrelin implant](#) (Supprelin®LA), [Leuprolide injection](#) (Lupron Depo – Ped®), and [Triptorelin injection](#) (Trelstar®). (See links for possible side effects.) The cost of the drug (without insurance) in 2015 ran [between \\$4,000 and 25,000/year](#).

BCH links to a resource by the National LGBTQIA+ Health Education Center (at the Fenway Institute, Boston): "[Gender-Affirming Pediatric Care Toolkit](#)." It includes a webinar (2020) on "Puberty Blockers and Hormone Therapy for Gender Diverse Youth and Adolescents" by Dr. Carswell of BCH.



[LGBTQIA+ Health Education Center](#) trans health icon

## Cross-sex hormones

“Cross-sex hormones” refers to testosterone given to females, and estrogen given to males to “affirm” their “gender identities.” This means children and adults who want to impersonate the opposite sex are given hormones of the opposite sex. The activist doctors call this “gender-affirming hormone treatment” (GAHT).

The [BCH endocrinology doctors](#) supervise these hormone treatments. The hospital website does not currently identify which of these doctors are with the GeMS clinic. (See the clinic’s [2019 staff list below](#), which named seven endocrinologists.)

The American College of Pediatricians [summarizes](#) problems with gender clinics’ interference in normal hormonal functioning:

Pre-pubertal children diagnosed with gender dysphoria may be given puberty blockers as young as eleven [now possibly at 8 or 9], and will require cross-sex hormones in later adolescence to continue impersonating the opposite sex. **These children will never be able to conceive any genetically related children even via artificial reproductive technology.** In addition, cross-sex hormones (testosterone and estrogen) are associated with **dangerous health risks including but not limited to cardiac disease, high blood pressure, blood clots, stroke, diabetes, and cancer.** [bold added]

That [organization notes](#) that these children will become lifelong patients, unless they go through a difficult desistance process:

... cross-sex hormones put youth at an increased risk of heart attacks, stroke, diabetes, blood clots and cancers *across their lifespan*.

[Research](#) suggests that cross-sex hormones may disrupt mental health as well.

The GeMS clinic has no information on its website about their protocols for cross-sex hormone treatments for teens (and *possibly* younger children). So we must look at other sources for information on what the hospital’s standards may be.

At what age does Boston Children’s Hospital recommend initiating cross-sex hormones? What is the earliest age they have done so, and for what reasons? Does BCH fully disclose the negative long-term effects to their patients?

In 2008, GeMS clinic founder Dr. Normal Spack [told](#) the *Boston Globe*:

*At what age should children be allowed to take hormones, like estrogen and testosterone, that will forever change the way their bodies develop?*

**Well, the Dutch would say 16. But I think more flexible guidelines will be coming out. For some kids, 16 might be appropriate. For others you lose opportunities if you wait.** [One of my patients, a] transgendered girl from the UK, was destined to be a 6-foot-4 male. With treatment, she's going to end up 5-foot-10.

What are the most difficult ethical issues you face?

**The biggest challenge is the issue of fertility.** When young people halt their puberty before their bodies have developed, and then take cross-hormones for a few years, **they'll probably be infertile.** You have to explain to the patients that if they go ahead, they may not be able to have children. **When you're talking to a 12-year-old, that's a heavy-duty conversation. Does a kid that age really think about fertility? But if you don't start treatment, they will always have trouble fitting in.** And my patients always remind me that what's most important to them is their identity. [bold added]



This *Boston Globe* report from 2011 featured one of [Dr. Spack's](#) patients. The boys are identical twins, and the **boy on the left was "transitioned" by Dr. Spack.** The headline – "**Led by the Child Who Simply Knew**" – underscores that confused children are [to some extent] leading the adults. Or at least that's the excuse to treat them. Clearly, unethical adults are leading these children and their parents into this treatment nightmare. ([MassResistance photo](#))

[WPATH \(V.8\)](#), the World Professional Association for Transgender Health (comprised of activists from inside and outside the medical community) – which BCH cites as an authoritative resource – makes it clear that puberty suppression will *usually* be followed by cross-sex hormones:

Depending on the developmental stage of the youth, this hormone therapy generally comprises two phases, namely pubertal suppression followed by the addition of GAHT [gender-affirming hormone treatment, i.e. cross-sex hormones]. During the first phase, **pubertal development is halted to allow the youth to explore their gender identity and embodiment goals to prepare for the next phase, which may include GAHT.** [bold added]

WPATH's "Standards of Care" ([Version 7](#)) classifies cross-sex hormone therapy as "partially reversible," but *names only breast augmentation on boys as reversible.* But since transgender activist professionals declare hormone therapy to be "medically necessary," therefore it is. So they proceed with these irreversible interventions.

[p. 18] **Partially reversible interventions.** These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia [enlarged breasts in males] caused by estrogens), while other changes are not reversible (e.g., deepening of the voice [in females] caused by testosterone).

[pp. 33-47] **Feminizing/masculinizing hormone therapy** – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – **is a medically necessary intervention** for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria ...

**The criteria for hormone therapy are as follows:**

1. Persistent, well-documented gender dysphoria;
2. **Capacity to make a fully informed decision and to consent for treatment;**
3. Age of majority in a given country (if younger, follow the Standards of Care outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled....

**Informed Consent.** Feminizing/masculinizing hormone therapy may lead to **irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court**

The Standards of Care  
7TH VERSION

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease <sup>A</sup> Gallstones Elevated liver enzymes Weight gain <b>Hypertriglyceridemia</b>	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors <sup>B</sup>	Cardiovascular disease	
Possible increased risk	<b>Hypertension</b> Hyperprolactinemia or prolactinoma <sup>A</sup>	Elevated liver enzymes <b>Hyperlipidemia</b>
Possible increased risk with presence of additional risk factors <sup>A</sup>	<b>Type 2 diabetes<sup>A</sup></b>	Destabilization of certain psychiatric disorders <sup>C</sup> Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	<b>Breast cancer</b>	Loss of bone density <b>Breast cancer</b> Cervical cancer Ovarian cancer Uterine cancer

<sup>A</sup> Risk is greater with oral estrogen administration than with transdermal estrogen administration.  
<sup>B</sup> Additional risk factors include age.  
<sup>C</sup> Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

40 World Professional Association for Transgender Health

“Risks associated with hormone therapy” from [WPATH \(V. 7\)](#), Table 2, p. 40

**to be emancipated minors ...** Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity....

**The SOC [WPATH Standards of Care] are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols** to the approach and setting in which these services are provided....

**The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2.** [p. 40] ...

**To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature.** [bold added]

WPATH's latest edition of its "Standards of Care" ([Version 8, Sept. 2022](#)) includes vague guidelines on when to begin cross-sex hormone treatments for adolescents. (Note their evolving standards from 1998 on.) [Why the vagueness?](#) It [empowers and protects local clinics](#) to *experiment* with their own ideas. (BCH clearly states that they are conducting "research," which means experimentation. See the [section below](#), "Center for Gender Surgery's [Research and Innovation](#).")

[WPATH V. 8] A specific World Professional Association for Transgender Health's (WPATH) *Standards of Care* section dedicated to the needs of children and adolescents was first included in the 1998 WPATH *Standards of Care*, 5th version (Levine et al., 1998). Youth aged 16 or older were deemed potentially eligible for gender-affirming medical care, but only in select cases. The subsequent 6th (Meyer et al., 2005) and 7th (Coleman et al., 2012) versions divided medical-affirming treatment for adolescents into three categories and presented eligibility criteria regarding age/puberty stage—namely fully reversible puberty delaying blockers as soon as puberty had started; partially reversible hormone therapy (testosterone, estrogen) for adolescents at the age of majority, which was age 16 in certain European countries; and irreversible surgeries at age 18 or older, except for chest "masculinizing" mastectomy, which had an age minimum of 16 years. Additional eligibility criteria for gender-related medical care included a persistent, long (childhood) history of gender "non-conformity"/dysphoria, emerging or intensifying at the onset of puberty; absence or management of psychological, medical, or social problems that interfere with treatment; provision of support for commencing the intervention by the parents [or] caregivers; and provision of informed consent. [p. S43]

WPATH ([Version 8](#)) admits that long-term effects of cross-sex hormones are not positive, and patients will need *lifelong monitoring* for related problems. There are so many unknowns, yet providers are forging ahead.

In most cases, GAHT [gender affirming hormone therapy] is maintained throughout life. It is not known if doses of GAHT should be reduced in older TGD [transgender & gender diverse] people. Discontinuation of hormone therapy may result in bone loss in TGD individuals and will definitely do so in individuals whose gonads have been removed....

Epidemiology studies have reported an increased incidence of cardiovascular disease and venous thromboembolism (VTE) in TGD people receiving estrogen, most notably in older people and with different preparations of GAHT. TGD individuals treated with testosterone may also have increased adverse cardiovascular risks and events, such as increased myocardial infarction, blood pressure, decreased HDL-cholesterol, and excess weight. [p. S112]

During adolescence, whether a child is receiving hormone treatments or not, WPATH (V. 8) recommends these “reversible” but potentially harmful “cosmetic” procedures: “binding” a girl’s breasts and “tucking” a boy’s genitals. (See section on “[social transitioning](#)” above.) Both practices carry their own health risks.

We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including review of the benefits and risks. [p. S54]

BCH also links to the National LGBTQIA+ Health Education Center (at the Fenway Institute) as a reliable resource. That group has [posted](#) webinars on “gender-affirming hormone therapy” for adolescents.

These hormone treatments are easy to obtain. “On average, hormone replacement therapy (HRT) for gender affirmation can cost anywhere from \$30-\$100 a month for individuals without health insurance,” in 2022, according to a pro-transgender [source](#).

## Eligibility for Surgery at BCH

A 2022 report at the [Journal of Clinical Medicine](#) compiled by BCH personnel states:

... The Center for Gender Surgery (CfGS) at Boston Children’s Hospital (BCH) was the first pediatric center in the United States to offer **gender-affirming chest surgeries for individuals over 15 years old and genital surgeries for those over 17 years of age**. In the four years [2017- 2020] since its inception, CfGS has completed over 300 gender-affirming surgeries. [bold added]

The BCH Center for Gender Surgery web page [now states](#),

... we help young people with **gender identity concerns** transfer seamlessly to surgical care if and when they are ready.... All genital surgeries are only performed on patients age 18 and older.

This means surgery is done for self-declared mental distress over a “gender identity concern.” Might a youth’s “readiness” override BCH’s stated age guidelines? How is readiness known by the patient or confirmed by the practitioner? To recall the words from GeMS’s [2007 press release](#), these surgeries are performed on “children and young adults who *present as transgendered* — those who have *no known anatomic or biochemical disorder, yet feel like a member of the opposite sex.*”



Some of the surgical procedure pages (see below) note that the hospital treats patients *up to the age of 35*. Why are those patients being served at a children's hospital? Are they follow-up patients for ongoing problems due to their earlier treatments? Has the hospital extended its age eligibility upward because these surgeries are so lucrative?

In an [archived video](#), social worker/researcher Elizabeth Boskey at the BCH Center for Gender Surgery, explains that the hospital follows WPATH's (suggested) guidelines in determining who is eligible for transition surgeries, as do other hospitals in the U.S.



Elizabeth Boskey, BCH social worker & researcher, on eligibility for surgery in [archived video](#).

The 2022 report at the [Journal of Clinical Medicine](#) compiled by BCH personnel (focused on developing "specialty anesthesia" for the younger patients) states:

**We identified 204 gender affirmation surgical cases, 177 chests/top surgeries, and 27 genital/bottom surgeries.** These findings indicate gender-diverse individuals who underwent life-changing surgery at our institution had a **median age of 18 years old, with many patients identifying as transmen [females]**. Our data suggests that **postoperative pain was significant**, but adverse events were minimal. [bold added]

The general section on "[Eligibility for Surgery](#)" reads in part:

Surgery is never the first step in a gender transition. It is something that happens after you have already explored social and medical transition options. People who choose to undergo surgery usually do so after taking other steps in the gender affirmation process, such as taking supplemental hormones....

To qualify for gender affirmation at Boston Children's Hospital, you **must be at least 18 years old for phalloplasty or metoidioplasty and for vaginoplasty**.

You must also have the following:

- A letter from a medical doctor or nurse practitioner stating that you have "persistent, well documented, gender dysphoria" and specifying the length of hormone therapy.
- A letter from your regular therapist stating that you have "persistent, well documented, gender dysphoria," that any significant mental health concerns are well controlled and that you have been living full time in your identified gender for at least 12 months.

- A second letter, from a mental health professional familiar with the procedure you are seeking, stating you are ready for surgery. This should include your understanding of the surgery procedure and recovery needs, fertility implications of surgery, and risks of surgery. It should also state that you are able to consent for surgery and include an assessment of your support systems.

Patients who want to pursue **chest surgery must be at least 15 years old** and have the following:

- A letter from a medical doctor or nurse practitioner stating that you have "persistent, well documented, gender dysphoria" and specifying either the length of hormone therapy or why you are not taking hormone therapy.
- A letter from a mental health provider stating that you have the **capacity to consent** and that any significant mental health issues are being addressed. [bold added]

The GeMS Center for Gender Surgery even provides [letter templates](#) for doctors and mental health providers to speed the process of surgical interventions.

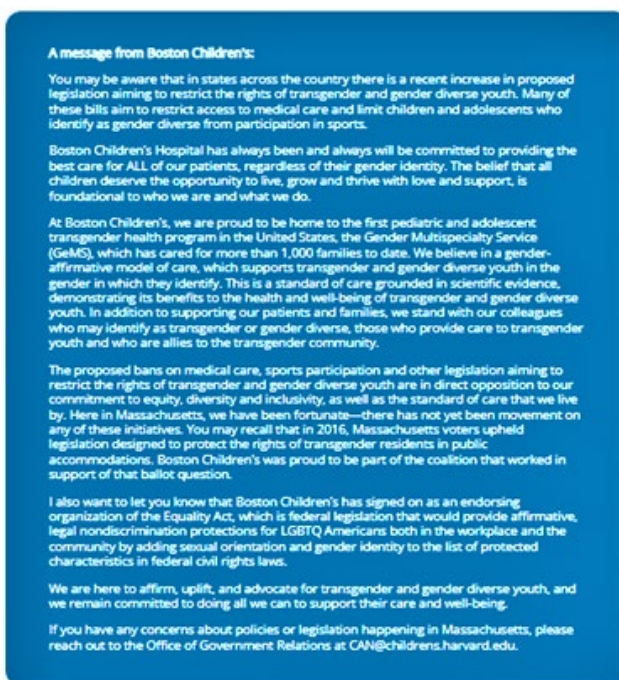
As noted above, WPATH, the World Professional Association for Transgender Health (comprised of *activists* from inside and outside the medical community) – which BCH cites as an authoritative resource – argues in its [Version 7](#) for *flexibility on age standards* for surgery. This vagueness continues in its recent Version 8. (See detail below for specific surgeries.)



This medallion appears on every page discussing the gruesome gender surgeries performed at Boston Children's Hospital.

Boston Children's – aware of growing concern around the country over these ghoulish surgeries – argues that their transgender “medical care” cannot be challenged because that would be criminal discrimination under Massachusetts law. Here is the statement on the [Center for Gender Surgery home page](#):

The proposed bans on medical care, sports participation and other legislation aiming to restrict the rights of transgender and gender diverse youth are in direct opposition to our commitment to equity, diversity and inclusivity, as well as the standard of care that we live by. Here in Massachusetts, we have been fortunate—there has not yet been movement on any of these initiatives. You may recall that in 2016, Massachusetts voters upheld legislation designed to protect the rights of transgender residents in public accommodations. Boston Children’s was proud to be part of the coalition that worked in support of that ballot question.



Center for Gender Surgery [home page](#)

## Mutilating surgeries performed at BCH

“Gender-affirming” treatments create lifelong patients. After children transition socially, many (or most) will proceed to puberty blockers &/or cross-sex hormones. The next step (if they choose or are pressured to continue) is disfiguring, *irreversible* surgeries. The need for ongoing hormonal treatment and follow-up care after these problematic surgeries means the trans-identified can never rest; their transition is an ongoing process.

The 2023 [web page](#) for the Center for Gender Surgery lists the procedures offered:

**Breast Augmentation** [creating breasts on boys]

**Chest Reconstruction** [double mastectomies on girls]

**Facial Harmonization** [surgeries to make features appear female or male]

**Metoidioplasty** [using female’s genital tissue to create small fake penis]

**Phalloplasty** [using female’s tissue usually from forearm to create fake penis closer to size of a male’s penis]

**Vaginoplasty** [deconstructing male's penis, using tissue to form fake labia around carved out fake vaginal cavity/wound]

**Voice training** [can involve Adam's apple and vocal cord surgeries for males]

[Gender dysphoria](#) occurs when there is a conflict between the gender you were assigned at birth and the gender with which you identify. This can create significant distress, and you may feel uncomfortable in your body. The Center for Gender Surgery at Boston Children's Hospital offers gender affirmation surgery services to eligible adolescents and young adults who are ready to take this step in their [journey](#). It is the first center of its kind in the U.S. in a major pediatric hospital setting.

## Our approach to gender surgery

As the first pediatric center in the country dedicated to the surgical care of transgender patients, we take an interdisciplinary approach from the start to ensure exceptional patient care. Our skilled team includes specialists in plastic surgery, urology, endocrinology, nursing, gender management, and social work, who collaborate to provide a full suite of surgical options for transgender teens and young adults. Our experienced [anesthesia team](#) works to provide culturally sensitive care to the gender-diverse community. By partnering with the hospital's nationally recognized [Gender Management Service \(GeMS\)](#), which provides a range of medical options for transgender youth, we help young people with gender identity concerns transfer seamlessly to surgical care if and when they are ready.

The center currently offers [vaginoplasty](#), [metoidioplasty](#), [phalloplasty](#), [chest reconstruction](#), [breast augmentation](#), [facial harmonization](#) and other gender affirmation surgeries to eligible patients. We are guided by the World Professional Association for Transgender Health (WPATH) standards and other criteria to surgically treat people who are stable in their gender identity and have [documentation](#) of persistent gender dysphoria. You do not need to be a GeMS patient to have surgery at the center. All genital surgeries are only performed on patients age 18 and older.

## Our areas of innovation in gender surgery

The Center's setting in an academic medical center means that our clinicians are able to benefit from Boston Children's rich community of scientific and clinical resources. As the Center grows, we hope to further expand our understanding of gender concerns and surgical techniques by leading and participating in various [research](#) projects. Our areas of interest include access improvements to gender-affirming surgery, fertility intentions and concerns of transgender young adults, and educational interventions regarding post-surgical self-care.

Center for Gender Surgery [home page](#)

Specifically at Boston Children's Hospital, the *Journal of Clinical Medicine* [reported](#) 204 "gender" surgeries on "adolescents and young adults" with "median age of 18" from January 2017 to August 2020. Patient ages ranged from 15 to 34. Notably, **32% of the surgical patients were minors, and 91% were females**. About 5% of the patients were males, 4% identified as "non-binary" (possibly biological females), and only one patient identified as a biological ("cis") female. "Our data suggests that postoperative pain was significant, but [immediate?] adverse events were minimal."

During that period, 87% of the "chest surgeries" were mastectomies performed on females. Girls and young women were also the main target for "bottom" surgeries. This included on female patients: nine phalloplasties, nine vaginectomies, three combined vaginectomies-phalloplasties, and one combined vaginectomy-metoidioplasty. There were five vaginoplasties (removal of male genitals and construction of pseudo vagina) performed on males.



But even if such surgical procedures are performed after a child turns 18, BCH's GeMS clinic should be held responsible for *encouraging* patients to make this horrific choice. The children were led by these doctors step by step, from social transitioning, to puberty blocking, to cross-sex hormones, and finally to surgeries.

## **Mastectomies, aka “Chest Reconstruction”**

**Females, age 15 & up**

<https://www.childrenshospital.org/treatments/chest-reconstruction>

BCH social worker [Elizabeth Boskey](#) confirmed in an [archived video](#) that “top surgery” is available for both females and males from age 15.

BCH employs the euphemism “*chest reconstruction*” instead of the correct (but evocative) term “mastectomy.” Healthy female breasts are referred to as “*excess breast tissue*.” Such tissue is apparently “highly upsetting” to trans-identifying adolescent girls. The 2022 *Journal of Clinical Medicine* [report](#) by BCH staff states:

The operative goals for chest reconstruction surgery involve producing a masculine chest contour by **removing excess breast tissue** and altering the nipple and areola with **minimal chest wall scars**. For transmasculine gender-diverse youth, **the existence of breast tissue and its growth during puberty can be highly upsetting and cause further gender dysphoria**. The anesthesia management goals for chest reconstruction surgery are to mitigate PONV [postoperative nausea and vomiting], decrease opioid consumption, and prevent the formation of postoperative hematomas. [bold added]

This surgery leaves disfiguring scars. It is irreversible. Obviously, silicone breast implants to “reverse” this procedure would be only cosmetic and can never be functioning female breasts for nursing a child. Nor will a survivor of this abuse ever be able to have normal erotic breast sensation.

BCH follows WPATH’s mastectomy guidelines, which are flexible. The [Boskey video](#) confirms, “You are requested, but not required, to be on [opposite-sex] hormones for at least one year.” Here is the WPATH wording:

### **Irreversible Interventions**

**Chest surgery in FtM [female-to-male] patients *could* be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment.** The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, ***different approaches may be more suitable, depending on an adolescent’s specific clinical situation and goals for gender identity expression.***

**Refusing timely medical interventions for adolescents *might* prolong gender dysphoria and contribute to an appearance that *could* provoke abuse and stigmatization.** As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during



adolescence..., **withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.** [[Version 7](#), p. 21; bold and italics added]

The article in the *Journal of Clinical Medicine* by BCH staff (March 2022) [noted](#) that “177 chest/top surgeries” were performed at BCH on mostly female patients with a “median age of 18” between January 2017 and August 2020. *More than a third were under 18:*

Over the 3-year study period, a total of 204 gender affirmation surgical cases were identified: 177 chest/top and 27 genital/bottom surgeries (Table 1). **Most cases were masculinizing chest reconstructions 177/204 (86.8%) with 65/177 (36.7%) of those patients being less than 18 years of age.** Patient characteristics included a median age of 18 years old, with the overwhelming majority of the [gender-affirmation] patients **(90.7%) identifying as transmen [females].** [bold added]

Here is how BCH soft-pedals mastectomy surgery:

**Chest reconstruction surgery is a procedure in which physicians remove excess [sic] breast tissue** and create a more masculine appearance for your chest. Patients who want to pursue chest surgery **must be at least 15 years old** and have the following:

- A letter from a medical doctor or nurse practitioner stating that you have "persistent, well documented, gender dysphoria" and specifying either the length of hormone therapy or why you are not taking hormone therapy.
- A letter from a mental health provider stating that you have the **capacity to consent and that any significant mental health issues are being addressed.** [bold added]

How can a 15-year-old girl have “the capacity to consent”?

“Gender dysphoria” is no longer considered a mental illness, but just “distress” that needs to be addressed. WPATH ([Version 8](#)) states that “*chest dysphoria*” in girls

... is associated with **higher rates of anxiety, depression, and distress and can lead to functional limitations, such as avoiding exercising or bathing....** Testosterone unfortunately does little to alleviate this distress, although chest masculinization is an option for some individuals to address this distress long-term. [p. S66; bold added]

This seems to be an admission that there *are* [underlying mental health issues](#) for these girls (who don’t want to take a bath because they don’t like seeing their breasts). But the therapists involved in gender clinics just want to end the girls’ anxiety and depression – by removing their breasts (when the vaunted cross-sex hormones don’t fix the problem).

Here is the [current BCH web page](#) on mastectomies (removal of “excess breast tissue”):

## What is chest reconstruction surgery?

Chest reconstruction surgery is a procedure in which physicians remove excess breast tissue and create a more masculine appearance for your chest. Chest reconstruction can allow transmasculine people to live more easily in their affirmed gender. It is often the only surgical step in the gender affirmation process.

The clinicians in the [Center for Gender Surgery](#) at Boston Children's Hospital offer chest reconstruction surgery as a gender affirmation procedure to eligible patients who have documented and persistent [gender dysphoria](#) and who are over age 18 (or over age 15 with parental consent). Our skilled team includes specialists in plastic surgery, urology, gender management and social work, who work together to provide a full suite of options for transgender teens and young adults.

Gender affirmation surgeries are a group of surgical procedures that some transgender and gender diverse people use to help affirm their gender identity. Chest reconstruction surgery is a type of "top surgery" in which physicians remove excess breast tissue and create a more masculine appearance for your chest.

## Who is eligible for chest reconstruction surgery?

People who choose to undergo chest reconstruction usually do so after taking other steps in the gender affirmation process, such as taking supplemental hormones. However, it isn't necessary to take hormones to qualify for chest reconstruction surgery. To be eligible for chest reconstruction surgery at Boston Children's Hospital, you must be at least 15 years old and meet certain [criteria](#).

## What happens during chest reconstruction surgery?

The specific technique used in this procedure can vary depending on your breast size and skin elasticity. In general, chest reconstruction surgery involves removal of most of the breast tissue and excess skin. The surgeon will also create a more masculine looking chest contour, including repositioning and reshaping your nipples, if necessary.

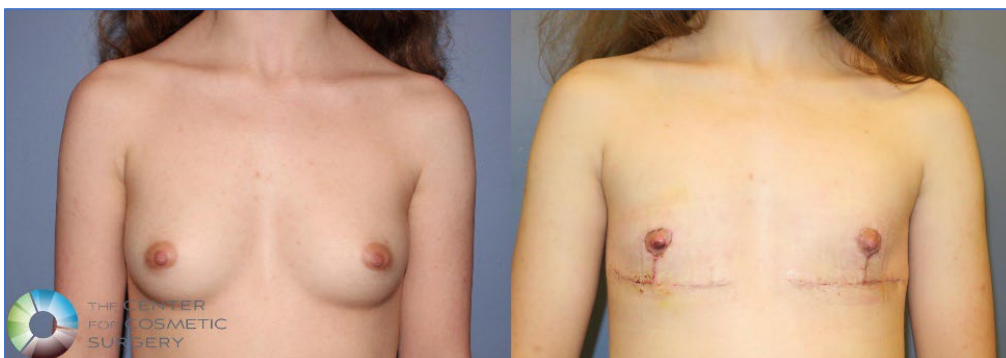
## What happens after surgery?

You should be able to return to school or work about a week after surgery. Because the healing process can take time, you shouldn't engage in strenuous physical activity or heavy lifting in the first four to six weeks after chest reconstruction surgery. You'll need to follow up with your care team within three to seven days of the procedure. Your clinician will explain in detail how to care for your incisions and how to look for signs of infection.

Another [description](#) of "chest reconstruction" (still online) refers to the WPATH standards for required letters confirming a patient's "behavioral health" and names Oren Ganor, MD, at the BCH Center for Gender Surgery as the intended recipient of the patient's health letter.

The BCH Center for Gender Surgery website links to the UCSF Transgender Care clinic as authoritative. Its section on "[postoperative care and common issues after masculinizing chest surgery](#)" includes this, plus details on other post-op issues:

**Early reoperation is required in 4-9% of patients, usually for hematoma evacuation and infection, with a 12% overall complication rate.** Postsurgical complications are divided into those presenting early (within 2 weeks postoperatively) and late (after two to four weeks). **Limited data specific to transgender masculinizing chest surgery are not as robust** as data published for reduction mammoplasty and male gynecomastia surgery, so data on surgical complications are supplemented with data abstracted from the more extensive literature available in these fields. [bold added]



Young female before and after “gender-affirming chest” surgery.  
(Photo: Center for Cosmetic Surgery, Denver)

At the national level, [MedPageToday](#) reported in 2022 on the huge increase in numbers of “gender-affirming chest surgeries among transgender adolescents [ages 12 to 17]: *Gender-Affirming Chest Surgeries Increase by Nearly 5x in Teens*; Researchers compared number of annual surgeries in 2016 to 2019.” That’s a 389% increase in three years, from 100 in 2016 to 489 in 2019. Nearly all of these “chest surgeries” were “masculinizing” (mastectomies on girls), and only 1.4% were “feminizing” (breast implants on boys). The *MedPageToday* report continued:

Only 19.9% of adolescents who underwent gender-affirming chest surgeries in this sample also used gender-affirming hormone therapy. As for psychiatric comorbidities, 21.1% had anxiety and 16.2% had depression -- the two most commonly reported.... The median inflation-adjusted total cost of gender-affirming chest surgeries largely held steady during this time period, at about \$30,000...

The Internet and social media are flooded with photos of young women and teen girls showing off their post-operative scars. How long will they be happy with what they’ve had done to their bodies? If they change their minds and want to become mothers, breast feeding will be impossible. And it will be hard, if not impossible, to remove the hair on their chests due to their testosterone treatments, without extensive and expensive electrolysis.



A young woman’s or girl’s chest after a double mastectomy to affirm her “gender transition.” ([Image source](#)) Are these considered “minimal chest wall scars”?

## Male chest surgeries, aka “Breast Augmentation”

Males, age 15 & up

<https://www.childrenshospital.org/treatments/breast-augmentation>

The Center for Gender Surgery refers to male imitation of female breasts as “breast augmentation.” It can be achieved through cross-sex hormones and/or surgical implants. BCH explains:

People [males] who choose to undergo breast augmentation surgery usually do so after taking other steps in the gender affirmation process, such as taking supplemental hormones. We typically recommend that you take estrogen for at least a year before pursuing surgery. This allows time for as much breast growth as possible through hormone treatment.... During breast augmentation surgery, your physician will make an incision under each breast or around the areola. They will then insert implants (usually saline-filled implants) sub-muscularly, or behind your pectoral muscles.

(An [older pdf on breast augmentation](#) from the Center for Gender Surgery was last saved at Internet Archive on Sept. 2, 2022.)

BCH social worker Elizabeth Boskey calls the small estrogen-induced breasts “*natural breast growth*” for a male (in an [archived video](#)). But it is *unnaturally* induced growth via cross-sex hormones.



BCH social worker Boskey explains recommendation before a male has breast implant surgery. (Archived [video](#))

The *Journal of Clinical Medicine* (March 2022, Table 2) [revealed](#) that “177 chest/top surgeries” were performed at BCH on mostly female patients with a “median age of 18” between January 2017 and August 2020. There were five males (“transwomen”) of unknown age who received “chest surgeries.” In addition, some of the eight “non-binary” patients may have been male. Overall, about 37% of the gender surgery patients in this study were younger than 18.

At the national level, [MedPageToday](#) reported in 2022 on “gender-affirming chest surgeries among transgender adolescents [ages 12 to 17]: “Gender-Affirming Chest Surgeries Increase by Nearly 5x in Teens; Researchers compared number of annual surgeries in 2016 to 2019.” Only 1.4% of those surgeries were “feminizing” (i.e., breast implants on boys).



“She-male” showing typical small and narrow breasts following time on female hormones, but before implants. [Image: anonymous social media post]

A male-to-female [transgender website](#) notes common problems with males’ results from use of female hormones:

**It may take two years to achieve full [breast] growth [via hormones] so patience is essential.** Dissatisfied girls [sic; transgender males] rushing to seek breast implants after one year may then experienced [sic] complications and misshaped breasts when another spurt of breast tissue growth sets in. It should also be expected that the breasts will grow unevenly, e.g. the right may become much fuller than the left. In the long term the differences will mostly even out...

... many transsexual women, particularly those starting hormones over about the age of 25, suffer from under-developed or hypoplastic breasts. Such breasts are very small or narrow, lack normal fullness, and may seem bulbous or swollen at the tip due to an over-prominent nipple-areolar complex – their narrow elongated appearance leads them to be termed “tubular breasts”, and nicknamed “snoopy breasts”. The shape is caused by a failure to sufficiently develop the glands and lobules which help fill out the breast. [bold added]

A plastic surgery [website](#) explains that male implant surgery may require two phases:

**Transgender male to female breast surgery recognizes the constraints of the male chest anatomy which includes tight overlying chest skin.** This constraint must be overcome when attempting to increase the overall fullness of the chest to appear more feminine. Additionally, the male breast perimeter must be converted from a straight line appearance to a more rounded appearance. Finally, the nipple-areola positioning and size must be



altered to create a more feminine representation.... **transgender male to female breast surgery requires utilization of a more modest implant that then encourages the tight male chest skin to stretch out. Our transgender male to female patients will then be asked to delay their second stage of breast augmentation implant replacement for a minimum of 6 to 12 months following their initial augmentation surgery.** [bold added]

That [website](#) has this image of a male before and after breast implants:



(Photo: Cosmetic Plastic Surgery Institute)

Our research shows that many men who seek female-imitating breasts retain their male genitals. So-called “she-males” are a part of a homosexual fetish culture that some medical practitioners are all too happy to support – including the gender doctors at Boston Children’s Hospital.

### **Male bottom surgery – Vaginoplasty (removal of genitals, construction of pseudo-vagina, clitoris, and labia)**

**Males – Eligibility now age 18 to 35, was formerly age 17 & up**

<https://www.childrenshospital.org/treatments/vaginoplasty>

An article in the *Journal of Clinical Medicine* (March 2022) by BCH researchers revealed that “27 genital-bottom surgeries” were performed at BCH with a “median age of 18” between January 2017 and August 2020. The article noted that five of those surgeries were vaginoplasties on male patients. It gave 17 as the earliest age for “genital surgeries”:

The Center for Gender Surgery (CfGS) at Boston Children’s Hospital (BCH) was the first pediatric center in the United States to offer gender-affirming chest surgeries for individuals over 15 years old and **genital surgeries for those over 17 years of age.** In the four years since its inception, CfGS has completed over 300 gender-affirming surgeries.... [bold added]

(It’s unlikely the researchers made a mistake regarding the age qualification.)

The BCH Center for Gender Surgery “Overview” standards page was recently changed. The older [August 12, 2022 page](#) (at Internet Archive) confirms that the hospital *formerly* allowed vaginoplasty surgery on male patients as young as 17:

To qualify for gender affirmation at Boston Children's Hospital, you must be at least 18 years old for phalloplasty or metoidioplasty and **at least 17 years old for vaginoplasty**. [bold added]

The screenshot shows the website for the Center for Gender Surgery at Boston Children's Hospital. The page is titled "Center for Gender Surgery Eligibility for Surgery". It features a navigation menu, a contact section, and an "Overview" section. The "Overview" section includes a disclaimer, a paragraph about surgery being a step in a gender transition, and specific eligibility requirements. A "BEST CHILDREN'S HOSPITALS" award badge is visible at the bottom left.

**Contact Us**

- Contact the Center for Gender Surgery  
617-355-2740
- International  
+1-617-355-5209
- Email  
Email us

[Request an Appointment](#)

[Request a Second Opinion](#)

**Overview**

*\*Please note: Scheduling of patient procedures depends on a number of factors, including your health, the insurance authorization process, when you were initially seen, and other individual needs. We strive to schedule patients equitably and ethically to maximize efficiency and provide the best possible care to everyone. Center staff cannot discuss any information about other patients, including scheduling of procedures.\**

Surgery is never the first step in a gender transition. It is something that happens after you have already explored social and medical transition options. People who choose to undergo surgery usually do so after taking other steps in the gender affirmation process, such as taking supplemental hormones.

Please note: You cannot smoke or vape (cigarettes, marijuana or other substances) or have any other nicotine exposure for 60 days before surgery and cannot smoke, vape or use any other nicotine products for six weeks after the surgery. Doing so may delay your procedure and increase the risk of serious complications.

To qualify for gender affirmation at Boston Children's Hospital, you must be at least 18 years old for [phalloplasty](#), or [metoidioplasty](#), and at least 17 years old for [vaginoplasty](#).

You must also have the following:

- A letter from a medical doctor or nurse practitioner stating that you have "persistent, well documented, gender dysphoria" and specifying the length of hormone therapy.
- A letter from your regular therapist stating that you have "persistent, well documented, gender dysphoria," that any significant mental health concerns are well controlled and that you have been living full time in your identified gender for at least 12 months.
- A second letter, from a mental health professional familiar with the procedure you are seeking, stating you are ready for surgery. This should include your understanding of the surgery procedure and recovery needs, fertility implications of surgery, and risks of surgery. It should also state that you are able to consent for surgery and include an assessment of your support systems.

Patients who want to pursue chest surgery must be at least 15 years old and have the following:

- A letter from a medical doctor or nurse practitioner stating that you have "persistent, well documented, gender dysphoria" and specifying either the length of hormone therapy or why you are not taking hormone therapy.
- A letter from a mental health provider stating that you have the capacity to consent and that any significant mental health issues are being addressed.

Read the specific eligibility requirements for each procedure in these downloadable PDFs:

- [Breast Augmentation](#)
- [Chest Reconstruction](#)
- [Metoidioplasty](#)
- [Phalloplasty](#)
  - [Hair Removal for Phalloplasty](#)
- [Vaginoplasty](#)
  - [Hair Removal for Vaginoplasty](#)

**BEST CHILDREN'S HOSPITALS**  
USNews  
HONOR ROLL  
2022-23

Earlier eligibility page (saved Aug. 12, 2022) states, “at least 17 years old for vaginoplasty.”

Yet another [page](#) (at Internet Archive) describing vaginoplasty (captured August 19, 2022) confirms that the surgery was being offered to patients between ages 17 and 35. It included this reminder, just in case the patient would want to become a father some day:

**Fertility preservation** – If you are interested in gamete preservation, you will need to complete this prior to your surgery.

WPATH, Version 7, states this about bottom surgery:

**Irreversible Interventions**

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

[Version 7, p. 21]

WPATH ([Version 8](#), 2022) floats the idea of performing this surgery on “youth under 18 years of age” even though there is “limited data” on the outcomes:

**A 2017 study of 20 WPATH-affiliated surgeons in the US reported slightly more than half had performed vaginoplasty in minors. Limited data are available on the outcomes for youth undergoing vaginoplasty....** Small studies have reported improved psychosocial functioning and decreased gender dysphoria in adolescents who have undergone vaginoplasty....

**While the sample sizes are small, these studies suggest there may be a benefit for some adolescents to having these procedures performed before the age of 18.** Factors that may support pursuing these procedures for youth under 18 years of age include the increased availability of support from family members, greater ease of managing postoperative care prior to transitioning to tasks of early adulthood (e.g., entering university or the workforce), and safety concerns in public spaces (i.e., to reduce transphobic violence). Given the complexity and irreversibility of these procedures, an assessment of the adolescent’s ability to adhere to postsurgical care recommendations and to comprehend the long-term impacts of these procedures on reproductive and sexual function is crucial. [p. S66; bold added]

This surgery involves carving out a cavity (essentially a deep wound) for a pseudo-vagina constructed from penis and scrotum tissue. Testicles are usually removed at the same time that the penis is dismantled. BCH describes the procedure on its [current web page](#):

Vaginoplasty is a procedure in which surgeons create a vagina from your existing genital tissue. Vaginoplasty requires a lifetime commitment to aftercare, because women [sic] who have a vaginoplasty will have to [painfully] dilate their vagina [wound] regularly to keep it open....

**Vaginoplasty is the creation of a [pseudo] vagina and vulva (clitoris, labia minora and labia majora) from your existing genital tissue, including the penis and scrotum. Orchiectomy (surgical removal of the testicles) is often performed at the same time as vaginoplasty but can also be performed at an earlier time in transition....**

**Vaginoplasty requires a significant recovery time and ongoing self-care....** You will also likely need to urinate through a catheter for one to two weeks after surgery. Your clinical team will give you detailed instructions on how to care for the catheter, and how to check for signs of infection at the surgical site, such as redness and swelling. You will likely be able to walk around and engage in light activity within a week after surgery, and healed enough to go back to all activities at around six weeks. **This surgery has a very long healing process that can take 12 to 18 months.**

**Unlike other gender affirmation surgeries, vaginoplasty requires a lifetime commitment to aftercare.** If you have a vaginoplasty, you will initially have to dilate your vagina multiple times a day to keep it open. **Eventually, that can be reduced to several times a week, depending on a variety of factors.** [bold added]



A post-op [photo](#) from a plastic surgery site MozaicCare.net of the opening to a man's "neo-vagina" and neo-labia (with catheter)

Hair removal must precede the surgery. BCH no longer posts a separate page on this. [This BCH page](#) was captured on Internet Archive on April 9, 2022. It explains:

Before you undergo vaginoplasty, you will need to have **all hair removed from your perineum, the shaft of the penis, and the inner two-thirds of the scrotum.** You can taper hair removal to a point one inch above the anus. **Hair can be removed with either laser or electrolysis. This will likely take multiple sessions over a period of four to eight months.** You should leave the hair that is above your penile shaft and on the outer one-third of the scrotum. Hair in these locations will help to contribute to the natural appearance of your vagina. The outer area of the scrotum is used to create the labia. Hair is expected there and can help to disguise scars. You can find a list of trans-affirming hair removal providers in your area at [transcaresite.org](http://transcaresite.org). [bold added]



PROCEDURES AND CARE

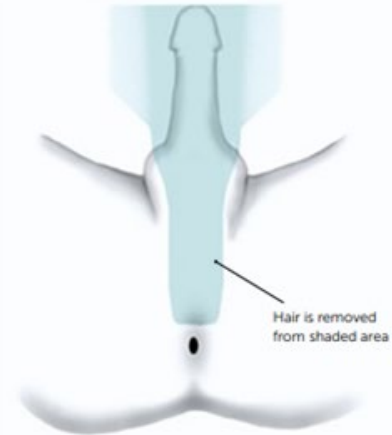
**Hair Removal for Vaginoplasty**

Boston Children's Hospital  
Center for Gender Surgery  
bostonchildrens.org/gendersurgery | 617-355-2740

Before you undergo vaginoplasty, you will need to have all hair removed from your perineum, the shaft of the penis, and the inner two-thirds of the scrotum. You can taper hair removal to a point one inch above the anus. Hair can be removed with either laser or electrolysis. This will likely take multiple sessions over a period of four to eight months.

You should leave the hair that is above your penile shaft and on the outer one-third of the scrotum. Hair in these locations will help to contribute to the natural appearance of your vagina. The outer area of the scrotum is used to create the labia. Hair is expected there and can help to disguise scars.

You can find a list of trans-affirming hair removal providers in your area at [transcaresite.org](http://transcaresite.org).



The [illustration below](#) shows the steps in this gruesome surgery.

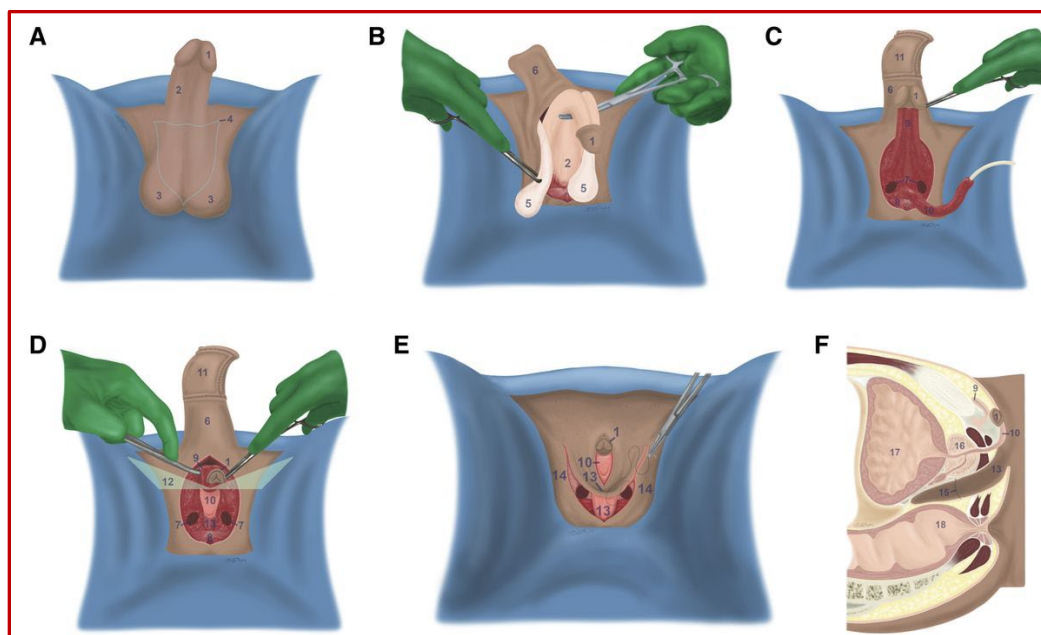


Illustration from [American Journal of Obstetrics & Gynecology](#):  
“[penile inversion](#)” technique for creating a pseudo-vagina

The Center for Gender Surgery links to the UCSF Transgender Care clinic as an authoritative source. Its page, “[Vaginoplasty procedures, complications and aftercare](#)” has much detail. Excerpts:

**The most common vaginoplasty technique is some variation of the penile inversion procedure. In this technique, a vaginal vault is created between the rectum and the**



urethra, in the same location as a non-transgender female between the pelvic floor (Kegel) muscles, and the vaginal lining is created from penile skin. An orchiectomy is performed, the labia majora are created using scrotal skin, and the clitoris is created from a portion of the glans penis. The prostate is left in place to avoid complications such as incontinence and urethral strictures. Furthermore, the prostate has erogenous sensation and is the anatomic equivalent to the "g-spot." Great care is taken to limit the external scars from a vaginoplasty by locating the incisions appropriately and with meticulous closure. **Typical depth is 15 cm (6 inches), with a range of 12-16cm (5-6.5 inches); in comparison, typical vaginal depth in non-transgender females is between 9-12cm (3.5 to 5 inches).**

**In the case of prior circumcision a skin graft, typically scrotal in origin, may be required. If there is insufficient skin between the penis and the scrotum to achieve 12cm (5 inches) of depth, a skin graft from the hip, lower abdomen or inner thigh may be used.** Resultant scarring at the donor site may be minimized or hidden using standard techniques. Because the penile inversion approach does not create a vaginal mucosa, the vagina does not self-lubricate and requires the use of an external lubricant for dilation or penetrative sex.

Scrotal skin has abundant hair follicles and it is possible to transfer skin with sparse hair growth into the vagina unless hair is removed in advance. Some surgeons rely on treating all the visible hair with aggressive thinning of the skin and cauterization of visible hair follicles at the time of surgery. However, since hair grows in stages this approach might not adequately address dormant follicles. **The most reliable method of preventing hair growth in the vagina is to perform scrotal electrolysis, at least three full clearings 8-12 weeks apart,** depending on electrologist preference and hair type and distribution. Surgeons should provide a diagram of the specific area for clearance....

Gauze packing or a stenting device is placed in the vagina intraoperatively and remains in place for 5-7 days. Once removed, **the patient is instructed in vaginal dilation,** with dilators generally provided by the surgeon; dilation schedules vary between surgeons. [Detailed dilation instructions follow.]

**Immediate risks include bleeding, infection, skin or clitoral necrosis, suture line dehiscence, urinary retention or vaginal prolapse. Fistulas from the rectum, urethra or bladder usually present early on. [Many other adverse outcomes described.] ... Adherence to the dilation regimen is critical to healing and maintaining vaginal depth and girth....**

The vagina is skin-lined and under normal conditions is colonized with a combination of skin flora as well as some vaginal species; a study of vaginal flora in a mix of transgender women with and without symptoms of odor and discharge found Staphylococcus, Streptococcus, Enterococcus, Corynebacterium, Mobiluncus, and Bacteroides species to be most common.

**A far less common approach to vaginoplasty is the use of either colon or small bowel to line the vaginal vault. This technique has the advantages of diminished need for dilation, greater depth and is naturally self-lubricating. However, this approach requires abdominal surgery with a risk of serious or even life-threatening complications.** The primary indication for an intestinal approach is the revision of prior penile-inversion vaginoplasties. **Since the secretion is digestive there is a risk of malodor and frequent secretions, and secretions are constant rather than only with arousal. Wearing panty liners or pads may be necessary for the long term.** Bacterial overgrowth (diversion colitis) is common and may present with a greenish discharge.... The bowel lining is also not as durable as skin. **Use of intestinal tissue also places the vagina at risk of diseases of the bowel including inflammatory bowel disease, arterio-venous malformations (AVM) or neoplasms;** screening or diagnostic evaluations for these conditions should be performed as indicated.

**Urinary tract infections are not uncommon, since the urethra is shortened during a vaginoplasty....** [bold added]

A recent Canadian [study](#) showed, “Patients experience numerous symptoms and concerns [following vaginoplasty] that often correlate with clinical findings and require multiple follow-up appointments.”

Many patients (22.5%) accessed care in the first 3 months after surgery, with the majority (55%) seeking care within the first perioperative year. Most patients (61.3%) were seen for more than one visit and presented with more than two symptoms or concerns. Common patient-reported symptoms during clinical visit included pain (53.8%), dilation concerns (46.3%), and surgical site/vaginal bleeding (42.5%). Sexual function concerns were also common (33.8%) with anorgasmia (11.3%) and dyspareunia [painful intercourse] (11.3%) being the most frequent complications. The most common adverse outcomes identified by health care providers included hypergranulation [excessive capillary growth at wound] (38.8%), urinary dysfunction (18.8%), and wound healing issues (12.5%).

Since few vaginoplasties are performed at BCH, one might ask how skilled the surgeons are in the particular techniques needed. Does BCH bring in outside surgeons?

## Female bottom surgery - Metoidioplasty (construction of pseudo mini-penis and scrotum)

Females, Age 18 up to 35

<https://www.childrenshospital.org/treatments/metoidioplasty>

WPATH, Version 7, states this about bottom surgery:

### Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

[Version 7, p. 21]

An article in the *Journal of Clinical Medicine* (March 2022) by BCH staffers [noted](#) that “27 genital/bottom surgeries” were performed at BCH with “median age of 18” between January 2017 and August 2020. This included only one combined vaginectomy-metoidioplasty. (Most females opting for bottom surgery chose the more extreme phalloplasty, according to this study.)

This surgery uses the female’s clitoral tissue to form a “mini” penis. BCH explains it ...

... is performed after the clitoris has been enlarged through the use of testosterone therapy.... Our skilled team includes specialists in plastic surgery, urology, gender management and social work, who work together to provide a full suite of options for transgender teens [sic] and young adults. [Did BCH forget to remove that phrase?] ... Often, a scrotoplasty (surgical creation of a scrotum from the labia majora) is performed at the same time.... If you undergo urethral lengthening as part of metoidioplasty, you will also

likely need to urinate through a catheter for three to four weeks after surgery.... **This surgery has a very long healing process that can take 12 to 18 months.**

## What is metoidioplasty?

Metoidioplasty is the surgical creation of a penis using your existing genital tissue. It is a less-extensive procedure than [phalloplasty](#) and is performed after the clitoris has been enlarged through the use of testosterone therapy. It is possible to undergo phalloplasty after a metoidioplasty, but the reverse is not true.

The clinicians in the [Center for Gender Surgery](#) at Boston Children's Hospital offer metoidioplasty as a gender affirmation procedure to eligible patients age 18 and over who have been living in their identified gender full time for at least 12 months. Our skilled team includes specialists in plastic surgery, urology, gender management and social work, who work together to provide a full suite of options for transgender teens and young adults.

Gender affirmation surgeries are a group of surgical procedures that some transgender and gender diverse people use to help affirm their gender identity. Metoidioplasty is a type of "bottom surgery" (surgery on the genitals) available to transgender men, or those who identify as transmasculine. It involves the surgical creation of a penis from your existing genital tissue.

## Who is eligible for metoidioplasty?

Surgery is never the first step in a gender transition. It is something that happens after you have already explored social and medical transition options. People who choose to undergo metoidioplasty usually do so after taking other steps in the gender affirmation process, such as taking supplemental hormones and undergoing chest surgery. To qualify for metoidioplasty at Boston Children's Hospital, you must be at least 18 years old and meet certain [criteria](#).

## What happens during metoidioplasty?

Although they have different functions, the clitoris and penis are both derived from the same tissue. Metoidioplasty takes advantage of this fact by creating a penis from the clitoris after it has been enlarged through the use of testosterone therapy. Often, a scrotoplasty (surgical creation of a scrotum from the labia majora) is performed at the same time.

Metoidioplasty may also include surgical construction of a glans and lengthening of the urethra. The first option improves the resemblance to a cisgender male's penis. The second makes it possible for you to urinate while standing up. It is possible to have a phalloplasty after a metoidioplasty but the reverse is not true.

## What happens after metoidioplasty?

Metoidioplasty can take between two and five hours, and you may need to stay in the hospital for a day or two. Because the healing process can take time, you shouldn't engage in strenuous physical activity or heavy lifting in the first six weeks after metoidioplasty.

If you undergo urethral lengthening as part of metoidioplasty, you will also likely need to urinate through a catheter for three to four weeks after surgery. Your clinical team will give you detailed instructions on how to care for the catheter and how to check for signs of infection at the surgical site, such as redness and swelling. You will likely be able to walk around and engage in light activity within a week after surgery, and healed enough to go back to all activities at around six weeks. This surgery has a very long healing process that can take 12 to 18 months.

Current [BCH page](#) on Metoidioplasty

An [earlier web page](#) was captured on Internet Archive on August 29, 2022.

A [research paper](#) explained why some women want a pseudo mini-penis and pseudo scrotum:

Metoidioplasty is a gender-affirming surgical option for individuals who desire masculine genitalia while **preserving erogenous sensation and avoiding the morbidity [diseased state] of phalloplasty**. Concurrent urethral lengthening offers patients the potential to **stand to urinate**. [bold added]

This acknowledges the many reported painful complications, follow-up surgeries, and outright failures accompanying phalloplasty. But (as stated below), with metoidioplasty, erections are “possible” (though the shaft is small) and it is possible for the girl or woman to stand to urinate.

The BCH Center for Gender Surgery website links to the UCSF Transgender Care clinic as an authoritative source. It says of [metoidioplasty](#):

Metoidioplasty (metaoidioplasty) is a Greek word that means "towards male genitalia." **Testosterone causes growth of the clitoris; metoidioplasty uses only local tissue (no grafting) to create a smaller, 1 to 3 inch phallus with girth approximately the size of someone's thumb. Patients may opt to have a urethra placed in the phallus, but not all patients choose to do this. A scrotum can also be created from the labia majora and a vaginectomy may be performed.**

**Because metoidioplasty is a shorter procedure, occasionally hysterectomy is performed at the same time as metoidioplasty. Some surgeons may use tissue expanders to create the scrotum, while others do not find this necessary. Testicular implants are typically placed at a second stage approximately 4 months later.** While the phallus is not large enough to accept a penile implant, **erections are possible since the procedure involves the use of natal clitoral and other genital tissues.**

**Complications** associated with metoidioplasty are very similar to free flap phalloplasty, except for flap loss since no flap is used. **Wound breakdown, infection, urethral stricture and fistula are all seen** in similar anatomic sites to that of free flap phalloplasty, although the incidence is lower in metoidioplasty. Risks such as coronal flattening do not occur in metoidioplasty, as the corona does not require sculpting in metoidioplasty. Management of complications similar to as is detailed in the phalloplasty section. [bold added]

This image of a typical surgical outcome comes from a [plastic surgery site](#):



(Photo: metoidioplasty.net, Dr. Curtis Crane)

## Female bottom surgery - Phalloplasty (construction of pseudo penis and testicles)

Females, Age 18 & up to 35

<https://www.childrenshospital.org/treatments/phalloplasty>

WPATH, Version 7, states this about bottom surgery:

### Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

[Version 7, p. 21]

An article in the *Journal of Clinical Medicine* (March 2022) by BCH staffers [stated](#) that “27 genital/bottom surgeries” were performed at BCH “median age of 18” between January 2017 and August 2020. This included 22 female patients: nine phalloplasties, nine vaginectomies, three combined vaginectomies-phalloplasties, and one combined vaginectomy-metoidioplasty. It describes the phalloplasty and vaginectomy procedures:

For transmasculine patients, the surgical goals of bottom surgery depend on patient specific desires. These include the removal of female genitalia, the formation of male genitalia, standing to void [urinate], the consolidation of erogenous feeling to the [fake] phallus, and future erectile prosthesis and testicular implants. The more extensive phalloplasty procedures consist of several steps, including vaginectomy, urethral lengthening, scrotoplasty, and creation of the neophallus, which is most commonly performed with a free tissue transfer from the radial forearm.

Here is how the Center for Gender Surgery [describes phalloplasty](#). Note the long healing time of 12-18 months (not counting later complications which are common):

Phalloplasty is the surgical creation of a [pseudo] penis.... **Phalloplasty involves the harvesting of one or more "flaps" of skin and other tissues from your forearm** [to form a pseudo-penis and urethra], although several other options may be available, such as the thigh. Prior to surgery, you will need to undergo permanent laser hair removal or electrolysis on your arm or other donor site.... **In order to be ready for phalloplasty, patients also need to undergo uterus removal (hysterectomy), which needs to be completed at least 3 months before the phalloplasty**.... Your [arm] donor site will be covered with a skin graft from your thigh, which will heal on its own.... **The vagina may also be removed at this time**.... You will also likely need to urinate through a catheter for the first three to four weeks after surgery.... **This surgery has a very long healing process that can take 12 to 18 months.** [bold added]



## What is phalloplasty?

Phalloplasty is the surgical creation of a penis. In this procedure, surgeons harvest one or more "flaps" of skin and other tissues from a donor site on your body (usually your forearm) and use it to form a penis and urethra.

The clinicians in the [Center for Gender Surgery](#) at Boston Children's Hospital offer phalloplasty as a gender affirmation procedure to eligible patients age 18 and over who have been living in their identified gender full time for at least 12 months. Our skilled team includes specialists in plastic surgery, urology, gender management and social work, who work together to provide a full suite of options for transgender teens and young adults.

Gender affirmation surgeries are a group of surgical procedures that some transgender and gender diverse people use to help affirm their gender identity. Phalloplasty is a type of "bottom surgery" (surgery on the genitals) available to transgender men, or those who identify as transmasculine. It involves the surgical creation of a penis from skin and other tissue harvested from another part of your body.

## Who is eligible for phalloplasty?

Surgery is never the first step in a gender transition. It is something that happens after you have already explored social and medical transition options. People who choose to undergo phalloplasty usually do so after taking other steps in the gender affirmation process, such as taking supplemental hormones and undergoing chest surgery. **To qualify for phalloplasty at Boston Children's Hospital, you must be at least 18 years old and meet certain [criteria](#).**

## What happens before and during phalloplasty?

Phalloplasty involves the harvesting of one or more "flaps" of skin and other tissues from your forearm, although several other options may be available, such as the thigh. Prior to surgery, you will need to undergo permanent laser hair removal or electrolysis on your arm or other donor site. It is also crucial that you stop smoking of any kind at least 3 months prior to your operation. In order to be ready for phalloplasty, patients also need to undergo uterus removal (hysterectomy), which needs to be completed at least 3 months before the phalloplasty. During phalloplasty, the surgeon removes the flaps and then uses them to create a penis and urethra. Your donor site will be covered with a skin graft from your thigh, which will heal on its own. At Boston Children's, this procedure usually takes place during a single, long surgery, which can last between 8 and 12 hours. The vagina may also be removed at this time.

## What happens after phalloplasty?

Phalloplasty is a complex surgical procedure that requires a significant recovery time and ongoing self-care. You should expect to spend about a week in hospital following your surgery and to return for follow-up appointments after you are discharged. Because the healing process can take time, you shouldn't engage in strenuous physical activity or heavy lifting in the first 6 weeks after phalloplasty. You will also likely need to urinate through a catheter for the first three to four weeks after surgery. Your clinical team will give you detailed instructions on how to care for the catheter, as well as the surgical wounds on your donor site and graft site, and how to check for signs of infection, such as redness and swelling.

You will likely be able to walk around and engage in light activity within a week after surgery, and healed enough to go back to all activities at around 6 weeks. This surgery has a very long healing process that can take 12 to 18 months.

A previous BCH [web page](#) (captured August 26, 2022) is available on Internet Archive. It includes these procedures needed or recommended before the phalloplasty:

**Hysterectomy** – You can see our gynecologist for a consult for a hysterectomy. If you choose to go elsewhere, it **must be done 90 days before your phalloplasty /metoidioplasty.**


**Hair removal** – **Depending on the type of procedure, you must have a minimum of 4 cm of complete hair removal from the underside of your forearm (electrolysis). Most patients will want to clear the entire forearm of hair** (laser or electrolysis). A list of trans-affirming hair removal providers can be found at [transcaresite.org](http://transcaresite.org).

**Fertility preservation** – If you are interested in gamete preservation, you will need to complete this prior to your surgery, or discuss whether it makes sense **to retain your ovaries when your uterus is removed.** [bold added]

Earlier there was a [separate page on hair removal](#) to be done prior to the phalloplasty, with a drawing of the arm “donor site.” (It was last posted on August 18, 2022.)

PROCEDURES AND CARE

## Hair Removal for Phalloplasty



**Boston Children's Hospital  
Center for Gender Surgery**  
bostonchildrens.org/gendersurgery | 617-355-2740

Before you have a phalloplasty, you will need to undergo hair removal at the donor site (typically the arm). All hair should be removed from the crease of the wrist to a minimum of 15 cm up the arm. Ideally 18 cm of hair or more will be removed.

**On the underside side of your arm**  
The hair in this area should be removed by electrolysis rather than laser to ensure full hair removal. This hair should be removed in a strip that is 4 cm at the base and 5.5 cm at the top. This section of your arm will be used to create a urethra, and hair increases the risk of complications.

**On the remainder of the forearm**  
Hair in this area can be removed with laser, electrolysis, or a combination.

You can find a list of trans-affirming hair removal providers in your area at [transcaresite.org](http://transcaresite.org).

Notes

---

---

---

---

---

---

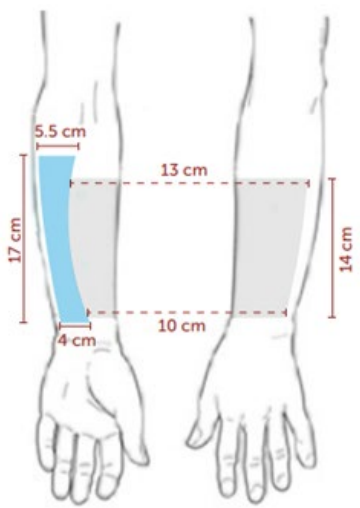
---

---

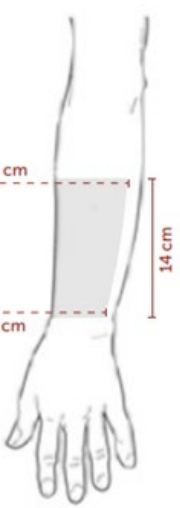
---

---

**Front view  
(supine)**



**Back view  
(prone)**



Skin from the pinky side of the arm, focused on its under side, used to form the urethra. Hair in this area must be removed by electrolysis.

Skin used to form the outside of the phallus. A laser may be used to remove hair in this area.

[Hair removal required](#) prior to skin removal for phalloplasty surgery

The page explains the procedure on the forearm:

**Before you have a phalloplasty, you will need to undergo hair removal at the donor site (typically the arm).** All hair should be removed from the crease of the wrist to a minimum of 15 cm up the arm. Ideally 18 cm of hair or more will be removed.

**On the underside side of your arm:** The hair in this area should be removed by electrolysis rather than laser to ensure full hair removal. This hair should be removed in a strip that is 4 cm at the base and 5.5 cm at the top. **This section of your arm will be used to create a urethra, and hair increases the risk of complications.**

On the remainder of the forearm: Hair in this area can be removed with laser, electrolysis, or a combination. ...

[blue area] Skin from the pinky side of the arm, focused on its under side, used to form the urethra. Hair in this area must be removed by electrolysis.

[gray area] **Skin used to form the outside of the phallus.** A laser may be used to remove hair in this area. [bold added]

If the hair is not removed properly, the woman could experience painful hair *inside* her urethra. And who wants a penis that's hairy on the outside?



[Here](#) is what happens to the “donor” forearm. Her thigh will also be damaged, because skin is taken from there and grafted onto the forearm.



Flesh from arm used to create pseudo-phallus & urethra. Skin is taken from thigh to patch the forearm. (Photo: UroToday.com)

In the end, here's what the (“transman”) woman gets for her fake penis and testicles. This is where the BCH “gender” clinicians have pushed her. Pain and more pain. Dying flesh. The pseudo penis may or may not be functional for normal urinating. Many follow-up procedures are often required. But as for “normal” sexual functioning, it's reportedly a zero.



The Frankenstein pseudo-phallus takes shape. (These and more photos of this procedure [here.](#))

The site posting the above photos [adds](#):

Male genital aesthetics and urinary function can be achieved in a single stage via phalloplasty with urethroplasty, vaginectomy, scrotoplasty, and perineal reconstruction. **Sexual function via prosthetic surgery [“erectile implants” to stiffen pseudo penis] is offered after patients develop protective tactile sensation in their neophallus and are voiding reliably.** Patients with *urethral complications* require repair prior to the insertion of implants [to stiffen the pseudo penis]. [bold added]

The BCH Center for Gender Surgery website links to the UCSF Transgender Care clinic as an authoritative source. It says [regarding phalloplasty](#):

#### **Risks associated with phalloplasty**

There are general risks associated with any surgery, including infection, bleeding, damage to surrounding tissues, and pain. Specific to phalloplasty in transgender men, there is risk of flap loss, urethral complications, wound breakdown, pelvic bleeding or pain, bladder or rectal injury, lack of sensation, prolonged need for drainage, or need for further procedures. Donor site risks include unsightly scarring, wound breakdown, granulation tissue formation, decreased mobility, hematoma, pain and decreased sensation. If patients are discharged from their surgeon's care and are not local, they should see their primary care provider every three months during the first year.

#### **Wound infections ...**

**Wound breakdown is common** and typically occurs at points where multiple suture lines meet (i.e. perineal-scrotal junction and base of phallus)....

#### **Urinary catheter difficulties ...**

#### **Flap loss ...**

#### **Pelvic or groin hematoma ...**

#### **Rectal injury ...**

**Urethral** strictures typically present 6-12 months after surgery with symptoms of a weak stream, straining with urination, and sometimes concomitant fistulas secondary to distal obstruction from the stricture. This will require surgical intervention with either dilation or urethroplasty.

#### **Scars ...**

#### **Granulation tissue ...**

**Erectile Implants** Roughly nine months after the penis is created, the patient can have a penile implant placed to allow rigidity for penetration. **Currently there are no FDA approved implants specifically created for transgender patients.** As such, implants created for non-transgender males with erectile dysfunction are rigidly fixed to the pubic bone. Complications can include infection and erosion....

**Infection is the most common complication of the penile implant.** Pre and post op antibiotics reduce the risk, as well as intraoperative sterile technique. If an implant becomes infected, it typically has to be removed. A new implant may be replaced six months later.

**Erosion** is when the implant protrudes through the skin of the phallus or the urethra. The presence of sensation in the phallus, and avoiding an excessively large implant reduce the risk of erosion. As with infection, erosion of an implant necessitates surgical removal.

[bold added]

In other words, results are far from guaranteed. There is a lot of agony over failed phalloplasty procedures reported on the Internet. And it's irreversible.

Amir Taghinia, MD, MPH at BCH explains the phalloplasty surgery in an [archived video](#). (He does not seem very confident with the terminology, hesitating frequently.)

A phalloplasty is a procedure to basically create uh, uh, a penis or a phallus for, uh, an individual who was born biological female and who seeks transition to, uh, a male, uh, gender. The procedure is done with plastic surgeons and urologists. The urologists manipulate the tissues in the surrounding area to lengthen the urethra. A new scrotum is created. And, uh, some of the anatomical parts of, uh, the female anatomy are removed. The plastic surgeons are in charge of creating the new tissue that will ultimately meet the lengthened urethra and the additional tissue that's been moved to, uh, create, uh, the n... neo-phallus. We typically utilize tissue from elsewhere, for example, the forearm or the thigh is used. The plastic surgeons are also responsible for providing sensation by doing the nerve [unclear] so that the new phallus will have sensations, and also responsible for re-establishing the blood supply, and also to shape it in a way that appears more, um, physiologically and anatomically, um, like a natural one. [transcript by author]



BCH Dr. Taghinia explains the surgical creation of a fake penis in [archived video](#).

## **“Gender-affirming” hysterectomy & vaginectomy**

**Females, Age 18 & up**

<https://www.childrenshospital.org/programs/transgender-reproductive-health-service>

Hysterectomies (removal of the uterus) and vaginectomies (removal of the vagina) are done in connection with a metoidioplasty or phalloplasty. (See sections above.) BCH’s web page on [Transgender Reproductive Health](#) notes the hospital offers “gender-affirming hysterectomies”:

... gender-affirming hysterectomies (including ovarian-sparing hysterectomies and hysterectomies done in coordination with [phalloplasty/metoidioplasty](#)). **We only perform gender-affirming hysterectomies on patients who are age 18 or older.** [bold in original]



This apparently means that some women will be able to have their ovaries preserved in case they decide they want to become mothers. But that could only happen with advanced techniques at fertility clinics (requiring donor wombs).

*Note:* The BCH website as it appeared on August 12, 2022 gave no eligibility age for specifically for hysterectomies, though noted the procedure is “done in coordination with phalloplasty/metoidioplasty” which require the patient be at least 18.

The [BCH website](#) now states, “We only perform gender-affirming hysterectomies on patients who are age 18 or older.”

While not appearing as an offered surgery at BCH on the public website, the hospital earlier posted this [archived video](#) by Frances Grimstad, MD, MS, Attending Physician in Gynecology. The doctor seems almost giddy as she describes “gender-affirming hysterectomies” while speaking over strangely upbeat background music.



BCH [archived video](#): gynecologist Grimstad on “gender-affirming hysterectomy”

Dr. Grimstad says:

Gender-affirming hysterectomy is very similar to most hysterectomies that occur. Hysterectomy itself is removal of the uterus, the cervix (which is the opening of the uterus), and the fallopian tubes (which are attached to the sides of the uterus. Some gender-affirming hysterectomies will also include the removal of the ovaries. But that’s technically a separate procedure called bilateral oophorectomy and not every gender-affirming hysterectomy includes that. And people who are getting gender-affirming hysterectomies do not have to have their ovaries removed. [transcript by author]

Hysterectomies have to be completed before phalloplasty or metoidioplasty surgeries.

The [Cleveland Clinic](#) matter-of-factly describes vaginectomy, a procedure developed for cancer treatment that is now also offered to “transgender men”:

Part of the [female reproductive system](#), the vagina is a tube made of muscle. It starts at the vulva (the external genitals) and extends to the cervix (the opening of the uterus). Depending on the location and size of the tumors, the stage of cancer and whether it has spread, your provider may recommend:

**Partial vaginectomy**, to remove the upper portion of the vagina.

**Total vaginectomy**, to remove the entire vagina.

**Radical vaginectomy**, which removes the entire vagina as well as the tissue around it.

Some transgender men get vaginectomy as part of [gender affirmation surgery](#). Providers also call this female-to-male (FTM) “bottom surgery.” The procedure usually happens before [metoidioplasty](#) or [phalloplasty](#). These are surgeries to create a penis.

## Facial Harmonization (plastic surgeries on face, skull, jaw, throat)

### Females & Males, Age 18 & up

An archived BCH [page](#) states:

**Facial harmonization involves the use of surgical techniques to modify facial features** so they appear more traditionally feminine or masculine. It is sometimes used as part of a person’s transition to align more with their gender identity. To be eligible, you must at least 18 years of age and have reached full facial maturity.

Facial feminization surgery (also known as FFS) is offered to transgender women **[males]** to address facial features that are masculine. **It can include reduction of a prominent brow, feminizing the hairline, feminizing rhinoplasty, upper lip lift, cheek augmentation, procedures to round the jaw line, narrow, and refine the chin and to reduce prominent trachea (Adam’s apple).**

To be ready for facial feminization, you need to have completed facial growth. This can be determined by a radiograph (x-ray) of your wrist. Prior to surgery, we will obtain a facial CT scan to evaluate your skeletal structures.

You should discuss your specific objectives with your surgeon. **Procedures for the forehead, cheeks, nose, jawline, and trachea are tailored to your facial anatomy and goals.** These may be done at once or in stages, depending on the type of procedure.

**Facial masculinization** - This type of surgery is offered to transgender men [women] to create a more masculine appearance. It often includes augmentation of the jawline with mandibular implants.

At Boston Children’s Hospital, we offer facial harmonization to transgender and gender-diverse **patients over 18** in the [Center for Gender Surgery](#). **Our skilled [plastic surgeons](#) are experienced in performing both facial feminization and facial masculine procedures.**

[bold added]

## Transgender Reproductive Health Service

The BCH website has a section devoted to [transgender reproductive health](#).

Everyone has reproductive anatomy, and everyone can have reproductive health concerns. The Transgender Reproductive Health Service at Boston Children’s Hospital provides inclusive reproductive health care for people of all gender identities and anatomies. We recognize that your reproductive health needs may be as unique as you are. Our goal is to help you address your reproductive health needs in a way that aligns with your gender identity and your

relationship to your anatomy. That's why we provide a variety of reproductive health services to our patients. These include:

- management of bleeding, pelvic pain, or other gynecologic concerns for people on gender-affirming testosterone therapy
- menstrual suppression
- contraception counseling
- gender-affirming hysterectomies (including ovarian-sparing hysterectomies and hysterectomies done in coordination with phalloplasty/metoidioplasty). **We only perform gender-affirming hysterectomies on patients who are age 18 or older.**
- dilation therapy and care of neovaginas for people who have undergone gender-affirming **vaginoplasty** [Bold in original]

It is strange that side effects following "gender-affirming" surgeries are considered part of *reproductive* health. This list above, in fact, confirms that some of these patients have had their reproductive systems destroyed and they would not be having these specific health issues if they had not had "gender-affirming" procedures. Note that their hormone treatments and fake reproductive organs are creating serious issues for them: females suffering pain and bleeding due to testosterone; males needing "dilation therapy" for their fake vagina wounds that tend to shrink and seal up (making penetration painful or impossible).

## **BCH Center for Gender Surgery's "Research and Innovation"**

The Center for Gender Surgery classifies its horrific experiments on young people as "[research and innovation](#)." Such euphemisms cannot disguise the ghoulish nature of their activities, conducted under the cover of "transgender health." The current web page states:

Research is an integral part of the Center for Gender Surgery. As we continue to grow, we will be investigating various facets of gender identity and gender affirmation procedures. Our areas of interest include:

- improving access to gender-affirming surgical options for transgender and gender non-conforming people
- the intersection between fertility intentions among transgender and gender non-confirming young adults and their decision-making around surgical and medical gender affirmation procedures
- the extent of the unmet need for gender-affirming medical and surgical procedures among gender-diverse people in New England
- educational interventions to facilitate a patient's ability to effectively care for themselves after gender-affirming surgical procedures
- how experiences with medical providers affect the ways that transgender and gender non-conforming youth and their families engage with preventive care

Here are some of the topics in the [bibliography](#) at the web page from August 14, 2022, (via Internet Archive):

Insurance coverage for breast surgeries [on healthy breasts or chests]  
 Surgical priorities for female-to-male patients  
 Women's college admissions re: transgender students  
 Nipple grafts pro & con [re: chest surgery patients]  
 Ethical issues considered when establishing a pediatric gender surgery center  
 Masculinizing chest reconstruction: epidemiology, surgical technique, & post-op outcomes  
 Breast augmentation for males: patient demographics, post-op outcomes  
 Nipple grafts & antibiotics  
 Public accommodation laws & "gender panic" in inpatient settings

## Bonus Videos: Drs. Carswell, Spack, & Diamond

**Dr. Jeremi Carswell** was listed as Director of the GeMS clinic in 2019. In this undated [video](#), she welcomes people to the GeMS clinic and gives a broad overview of what the clinic provides. She ends by encouraging patients to become involved in one of their research projects.



Dr. Jeremi Carswell, BCH gender clinic director

**Dr. Norman Spack**, co-founder of the GeMS clinic, gave a [TEDx Talk in 2014](#) in Brookline, Massachusetts. The title: "New medical treatments for transgender adolescents: Norman Spack at TEDxBeaconStreet." He speaks of learning from the Dutch doctors who pioneered the technique of blocking puberty to make the child's later physical "transition" (including surgeries) easier and more convincing. Already by 2014, he had treated 150 children with this experimental "Dutch protocol." He discusses and includes photos of some of his patients (including the twin on p. 23 above). [Video](#) below:



Dr. Norman Spack tells how he turns boys into girls.

Co-founder of the GeMS clinic along with Dr. Norman Spack, urologist Dr. David A. Diamond was listed as GeMS Co-Director for Gender Surgery in 2019. He is now professor and [physician](#) at the University of Rochester Medical Center. In his 2022 [video](#), he explains that his goal is to make transgender children “psychologically happy and healthy.” According to this video, he is now helping the U. of Rochester Medical Center develop a gender surgery clinic there.



Dr. David Diamond took his BCH gender surgery know-how to U. of Rochester Medical Center.



## **BCH Gender Clinic Staff, Admin, and Trustees – Names, Contact info**

Simply put, any medical or mental health professional, social worker, administrator, or member of the support staff taking part in or supporting these treatments is committing what the American College of Pediatricians says is “child abuse.” They are misleading parents into supporting radical, unscientific medical interventions and the irrational “gender” ideology underlying it.

The BCH website is now hiding the identities of the Center for Gender Surgery team, with no doctors named at the current blank [web page](#). Internet Archive has preserved the staff names in 2021, 2019, and 2018. Note that all of these doctors are associated with Harvard Medical School.

### **Center for Gender Surgery – 2021**

Phone: 617-355-2740

scheduling: 617-919-7102

email [gendersurgery@childrens.harvard.edu](mailto:gendersurgery@childrens.harvard.edu)

#### **CO-DIRECTORS**

Oren Ganor, MD, Co-Director, 617-355-8390

Amir H. Taghinia, MD, Co-Director, 617-355-3421

#### **PHYSICIANS**

Daniel M. Balkin, MD, PhD, 617-355-2476

Joseph G. Borer, MD

Jeremi Carswell, MD, Director, GeMS clinic, 617-355-7476 & 617-355-4367

Ingrid Ganske, MD, 617-355-1463

Frances Grimstad, MD, MS, 617-355-7648

Anne F. Hseu, MD, 617-355-6462

John G. Meara, MD, DMD, MBA, Plastic Surgeon-in-Chief, 617-355-4401

Richard N. Yu, MD, PhD, 617-355-7796

#### **PA & NURSES**

Haley Chrisos, MPAS, PA-C

Maria Semnack, RN, BSN, 617-919-1245

Vivian Williams, MSN, RN, CPNP, 617-355-7796, [vivian.williams@childrens.harvard.edu](mailto:vivian.williams@childrens.harvard.edu)

#### **CLINICAL RESEARCHER**

Dee Jolly, 617-919-1490, [dee.jolly@childrens.harvard.edu](mailto:dee.jolly@childrens.harvard.edu)

#### **SOCIAL WORKER**

Elizabeth Boskey, PhD, MPH, LICSW, MSW, 617-919-6525

#### **ADMIN. STAFF**



Evelyn Ann Borucki, MHA, Program Coord., 617-355-2740, [evelyn.borucki@childrens.harvard.edu](mailto:evelyn.borucki@childrens.harvard.edu)

Samantha Tatro, Senior Patient Experience Rep., 781-216-2219









## Gender Surgery Staff – photo page, Sept. 2021

### Center for Gender Surgery | Meet Our Team


#### Co-Directors

 <p><b>Drew Gerber, MD</b>          Co-Director, Center for Gender Surgery, Training Program, Department of Plastic and Oral Surgery, Assistant Professor of Surgery, Harvard Medical School</p>	 <p><b>Amy H. Taghva, MD</b>          Associate Professor, Department of Plastic &amp; Oral Surgery, Associate Professor, Harvard Medical School</p>
---	---



#### Physicians

 <p><b>Goran M. Sakin, MD, PhD</b>          Visiting Physician, Department of Plastic &amp; Oral Surgery, Instructor of Surgery, Harvard Medical School</p>	 <p><b>Joseph G. Sorel, MD</b>          Director, Resident Training Program, Co-Director, Research and Innovation, Oral, Reconstructive and Gender Surgery, Associate Professor of Surgery, Harvard Medical School</p>
 <p><b>Janet Caswell, MD</b>          Director, Gender Multispecialty Service (MGS), Visiting Physician, Division of Plastic Surgery, Associate Professor of Pediatrics, Harvard Medical School</p>	 <p><b>Ingrid Garcia, MD</b>          Visiting Physician, Department of Plastic &amp; Oral Surgery, Associate Professor, Harvard Medical School</p>
 <p><b>Francis Grissold, MD, MS</b>          Visiting, Division of Spine Surgery, Associate Professor, Harvard Medical School</p>	 <p><b>Anne F. Jhau, MD</b>          Associate, Department of Biotechnology and Gene-Diagnostic Personalized Medicine, Associate of Otolaryngology, Harvard Medical School</p>
 <p><b>John G. Vikers, MD, DVM, MBA</b>          Plastic Surgeon-in-Chief, Visiting Professor of Plastic Surgery, Harvard Medical School, Professor of Surgery, Harvard Medical School, University of Medicine</p>	 <p><b>Richard N. Yu, MD, PhD</b>          Director, Reside Surgery Program, Faculty of Plastic, Reconstructive, and Gender Surgery, Program Director, Reside Plastic Program, Associate Professor of Surgery, Harvard Medical School</p>


#### Physician Assistant

 <p><b>Haley Christy, MEd, PA-C</b>          Physician Assistant, Center for Gender Surgery</p>
--


#### Nurses

 <p><b>Maria Semraoui, RN, BSN</b>          Registered Nurse, Center for Gender Surgery</p>	 <p><b>Vivian Williams, MSN, RN, CNP</b>          Adult Registered Nurse Practitioner, Registered Nurse for B, Department of Surgery</p>
--	---



#### Clinical Researchers

 <p><b>Deer Jolly</b>          Clinical Research Specialist, Center for Gender Surgery</p>
---

#### Social Workers

 <p><b>Elizabeth Binkley, PhD, MPH, LICSW, MSW</b>          Social Worker, Center for Gender Surgery</p>
---

#### Administrative Staff

 <p><b>Evelyn Ann Bonetto, MBA</b>          Program Coordinator, Center for Gender Surgery</p>	 <p><b>Samantha Tarr</b>          Nurse Patient Experience Representative, Head Nurse of Plastic Surgery Program, Coordinator, Center for Gender Surgery</p>
---	---

## [GeMS clinic staff – early 2019](#)

Here is a listing of [GeMS clinic staff](#) from early 2019 (via Internet Archive). Most of them show affiliation with [Harvard Medical School](#).

[Jeremi Carswell](#), MD, Director GeMS, Attending Physician, Div. of Endocrinology  
[David A. Diamond](#), MD, Urologist-in-Chief, Co-Director, Center for Gender Surgery  
Ingrid Holm, MD, MPH, Attending Physician, Div. of Endocrinology  
Jessica Kremen, MD, Attending Physician, Div. of Endocrinology  
Sarah Pilcher, MSN, RN, CPNP; Cert. Pediatric NP, Dept. of Urology  
[Amy Tishelman](#), PhD, Director of Psychology, Dept. of Urology; Director, Clinical Research  
Yee-Min Chan, MD, PhD, Director, Disorders of Sexual Dev. Program, Attending Physician, Div. of Endocrinology  
Jennifer Gentile, PsyD, Attending Psychologist, Div. of Endocrinology  
Peter Hunt, PhD, Attending Psychologist, Div. of Endocrinology  
Francie Mandel, MSW, LICSW, Clinical Social Worker, Dept. of Pediatrics; Director of Mental Health Services GeMS  
Stephanie Roberts, MD, Attending Physician, Div. of Endocrinology  
Ellen Mitchell, Senior Patient Experience Rep., Div. of Endocrinology

## GeMS Clinic photo page – 2019

### Meet Our Team | Gender Management Service (GeMS) and Behavioral Health, Endocrinology, Urology (BE-U) Programs



**Jeremi Carswell, MD**  
Director, Gender Management Service; Attending Physician, Division of Endocrinology, Instructor in Pediatrics, Harvard Medical School



**Yee-Ming Chan, MD, PhD**  
Director, Disorders of Sexual Development Program; Attending Physician, Division of Endocrinology, Assistant Professor of Pediatrics, Harvard Medical School



**David A. Diamond, MD**  
Urologist-in-Chief; Co-Director, Center for Gender Surgery; Associate Clinical Ethicist, Senior Associate, Department of Urology, Professor of Surgery (Urology), Harvard Medical School; Alan B. Retik Chair & Professor of Surgery, Harvard Medical School



**Jennifer Gentile, PsyD**  
Attending Psychologist, Division of Endocrinology, Instructor in Psychology, Harvard Medical School



**Ingrid Holm, MD, MPH**  
Attending Physician, Division of Endocrinology, Associate Professor of Pediatrics, Harvard Medical School



**Peter Hunt, PhD**  
Attending Psychologist, Division of Endocrinology, Assistant Professor of Psychology, Harvard Medical School



**Jessica Kremen, MD**  
Attending Physician, Division of Endocrinology, Instructor in Pediatrics, Harvard Medical School



**Francie Mandel, MSW, LICSW**  
Clinical Social Worker, Department of Pediatrics; Director of Mental Health Services, DSD/GeMS Programs



**Sarah Plicher, MSN, RN, CPNP**  
Certified Pediatric Nurse Practitioner, Department of Urology



**Stephanie Roberts, MD**  
Attending Physician, Division of Endocrinology, Instructor in Pediatrics, Harvard Medical School



**Amy Tishelman, PhD**  
Director of Psychology, Department of Urology; Director, Clinical Research, DSD-GeMS, Assistant Professor of Psychology, Harvard Medical School



**Ellen Mitchell,**  
Senior Patient Experience Representative, Division of Endocrinology

## GeMS Surgery Staff – late 2018

### Center for Gender Surgery | Meet Our Team

#### Co-Directors



**David A. Diamond, MD**  
Urologist-in-Chief; Co-Director, Center for Gender Surgery; Associate Clinical Professor, Senior Associate, Department of Urology; Professor of Surgery (Urology), Harvard Medical School; Alan B. Retik Chair & Professor of Surgery, Harvard Medical School



**Oren Ganor, MD**  
Co-Director, Center for Gender Surgery; Attending Physician, Department of Plastic and Oral Surgery; Clinical Instructor, Harvard Medical School



**Amir H. Taghnia, MD**  
Attending Physician, Department of Plastic & Oral Surgery; Assistant Professor, Harvard Medical School

#### Support Team



**Joseph G. Borer, MD**  
Director, Bladder Exstrophy Program; Co-Director, Neurourology and Urodynamics, Chair, Reconstructive Urologic Surgery; Associate Professor of Surgery (Urology), Harvard Medical School



**Elizabeth Boskey**  
Social Worker, Center for Gender Surgery



**Jeremi Carswell, MD**  
Director, Gender Management Service; Attending Physician, Division of Endocrinology; Instructor in Pediatrics, Harvard Medical School



**John G. Meara, MD, DMD, MBA**  
Plastic Surgeon-in-Chief, Kleijman Professor of Global Surgery, Harvard Medical School; Professor of Surgery, Harvard Medical School; Professor of Paediatrics, University of Melbourne



**Haley Chrisos, MPAS, PA-C**  
Physician Assistant, Center for Gender Surgery



**Marta Semnack, RN, BSN**  
Registered Nurse, Center for Gender Surgery



**Samantha Tatro**  
Senior Patient Experience Representative, Department of Plastic Surgery; Program Coordinator, Center for Gender Surgery



## Contact Info for BCH Admin, Gender Clinic, & Trustees

Tell them: *Shut down the “Gender Multispecialty Clinic” and Center for Gender Surgery.*

### **Boston Children’s Hospital – main office**

300 Longwood Ave., Boston, MA 02115  
ph 617-355-6000

### **BCH Gender Multispecialty Clinic – GeMS**

300 Longwood Ave., Boston, MA 02115  
ph 617-355-4367

### **BCH Center for Gender Surgery**

ph 617-355-4367 or 617-355-2740  
email: [gendersurgery@childrens.harvard.edu](mailto:gendersurgery@childrens.harvard.edu)  
Fax: 617-738-1657  
Waltham office: 9 Hope Ave., Waltham, MA 02453

### **BCH Administration**

Kevin B. Churchwell, MD, President and Chief Executive Officer,  
[CEO@childrens.harvard.edu](mailto:CEO@childrens.harvard.edu)  
[Gary R. Fleisher, MD](mailto:gary.fleisher@childrens.harvard.edu), Physician-in-Chief, Pediatrician-in-Chief,  
[gary.fleisher@childrens.harvard.edu](mailto:gary.fleisher@childrens.harvard.edu)  
[Vincent W. Chiang, MD](mailto:vincent.chiang@childrens.harvard.edu), Vice Chair for Finance,  
[vincent.chiang@childrens.harvard.edu](mailto:vincent.chiang@childrens.harvard.edu)  
Sandra Fenwick, Former CEO (during expansion of gender clinic)

### **Trustees**

Board of Trustees, Boston Children’s Hospital  
300 Longwood Ave., Boston, MA 02115  
ph 617-355-6000

<https://www.childrenshospital.org/about-us/our-leadership/board-trustees>

- [Douglas A. Berthiaume](#), Chairman, Boston Children’s Hospital Board of Trustees; Retired Chairman and President and Chief Executive Officer, Waters Corporation
- [Allan S. Bufferd](#), Treasurer Emeritus, Massachusetts Institute of Technology
- [Kevin B. Churchwell, MD](#), President and Chief Executive Officer, Boston Children’s Hospital; Robert and Dana Smith Associate Professor of Anesthesia, Harvard Medical School
- [Steven J. Fishman, MD](#), Surgeon-in-Chief, Chief, Department of Surgery; Stuart and Jane Weitzman Family Chair in Surgery; Co-Director, Vascular Anomalies

Center, Boston Children's Hospital; Professor of Surgery, Harvard Medical School

- [Gary R. Fleisher, MD](#), Physician-in-Chief, Pediatrician-in-Chief, and Chairman, Department of Medicine, Boston Children's Hospital; Egan Family Foundation Professor, Department of Pediatrics, Harvard Medical School
- [Winston Henderson](#), Vice President, General Counsel at Clear Scientific Inc.
- [Ivor Braden Horn, MD](#), Director of Health Equity and Product Inclusion at Google; Board Director, Care Academy
- [Stephen R. Karp](#), Immediate Past Chair, Boston Children's Hospital Board of Trustees; Chairman and Chief Executive Officer, New England Development
- [Steven D. Krichmar](#), Former Chief of Operations, Putnam Investments
- [Robert S. Langer](#), David H. Koch Institute Professor, Koch Institute of Integrative Cancer Research, Massachusetts Institute of Technology
- [Peter Laussen, MBBS, FANZCA, FCICM](#), Executive Vice President of Health Affairs, Boston Children's Hospital
- [Vivian S. Lee](#), MD, PhD, MBA, President of Health Platforms at Verily Life Sciences; Senior Lecturer, Harvard Medical School
- [Harvey Lodish, PhD](#), Member, Whitehead Institute for Biomedical Research, Whitehead Institute; Professor of Biology and Professor of Bioengineering, Massachusetts Institute of Technology
- [Gary Loveman](#), Former Chairman, President, and Chief Executive Officer, Caesars Entertainment Corporation
- [Ralph C. Martin II](#), Senior Vice President and General Counsel, Northeastern University
- [Thomas Meléndez](#), Former Investment Officer, MFS Investment Management
- [William "Ted" Pappendick IV](#), Senior Advisor to Bain Capital
- [Mark Proctor, MD](#), Neurosurgeon-in-Chief; Director, Brain Injury Center, Boston Children's; Professor, Harvard Medical School
- [Kathleen Regan](#), Executive Vice President and Chief Operating Officer, The Commonwealth Fund
- [Alison Taunton-Rigby, PhD, OBE](#), Director and Trustee, Healthcare, Life Sciences and Financial Services
- [Robert Smith](#), Vice Chair, Boston Children's Hospital Board of Trustees; Founding Partner, Managing Partner, Castanea Partners
- [Lisa S. Wieland](#), Chief Executive Officer, Massachusetts Port Authority
- [Laura J. Wood, DNP, MS, RN](#), Senior Vice President, Patient Care Services and Chief Nursing Officer, Sporing Carpenter Chair for Nursing
- [Gregory Young, MD](#), President and Chief Executive Officer, Pediatric Physician's Organization at Children's Hospital, Boston Children's Hospital

## WPATH - World Professional Association for Transgender Health

The most appalling information in this document may be the lists below of the many “professionals” who are part of the anti-science [World Professional Association for Transgender Health \(WPATH\)](#) and their “[Standards of Care](#)” for “transgender and gender-diverse people.” This international organization of transgender activists and their allies – many of whom are neither medical doctors nor medical researchers – gives cover to hospitals and clinics that administer harmful treatments to minors (and adults), by providing (loose and evolving) “guidance.” Boston Children’s Hospital and other children’s hospitals around the country cite WPATH as authoritative.

### [Editorial Board for the \*International Journal of Transgender Care\*](#)

(WPATH “Standards of Care” publishers)

#### EDITOR

WALTER PIERRE BOUMAN, MD, PhD, National Centre for Transgender Health & University of Nottingham, Nottingham, UK

#### ASSOCIATE EDITORS

Y. GAVRIEL ANSARA, PhD, Ansara Psychotherapy, Sovereign Boon Wurrung land, Kulin Nations, VIC, Australia

JON ARCELUS, MD, PhD, University of Nottingham, Nottingham, UK

RACHEL BLUEBOND-LANGNER, MD, NYU Langone Health, New York, NY, USA

GRIET DE CUYPERE, MD, PhD, Ghent University Hospital, Ghent, Belgium

ELS ELAUT, PhD, Ghent University Hospital, Ghent, Belgium

M. PAZ GALUPO, PhD, Towson University, Towson, MD, USA

BAUDEWIJNTJE P.C. KREUKELS, PhD, VU University Medical Center, Amsterdam, the Netherlands

ASA RADIX, MD, PhD, Department of Medicine, NYU and Callen-Lorde Community Health Center, New York, NY, USA

DAMIEN W. RIGGS, PhD, Flinders University, Adelaide, Australia

SHOSHANA ROSENBERG, ScD, MPH, MSexol, Independent Researcher, unceded Wurundjeri land, Kulin Nations, Australia

LOREN S. SCHECHTER, MD, FACS, University Plastic Surgery, Morton Grove, IL, USA

THOMAS STEENSMA, PhD, VU University Medical Center, Amsterdam, the Netherlands

GUY T’SJOEN, MD, PhD, Ghent University Hospital, Ghent, Belgium

GARETH TREHARNE, PhD, Department of Psychology, University of Otago, Aotearoa/New Zealand

WOUTER VAN DER SLUIS, MD, PhD, VU University Medical Center, Amsterdam, the Netherlands

JAIMIE VEALE, PhD, University of Waikato, Hamilton, New Zealand

CHANTAL WIEPJES, MD, PhD, VU University Medical Center, Amsterdam, the Netherlands

#### FORMER EDITORS

FRIEDEMANN PFÄFFLIN, MD, University of Ulm, Ulm, Germany, *Founding Editor*

ELI COLEMAN, PhD, University of Minnesota Medical School, Minneapolis, MN, USA, *Founding Editor*

RICHARD EKINS, PhD, University of Ulster, Coleraine, UK

DAVID KING, PhD, University of Liverpool, Liverpool, UK

WALTER O BOCKTING, PhD, Program for the Study of LGBT Health, Division of Gender, Sexuality, and Health, New York State Psychiatric Institute/Columbia University Psychiatry with the Columbia University School of Nursing, New York, USA

**EDITORIAL BOARD**

STEWART ADELSON, MD, Columbia University, New York, NY  
 INÉZ ARÍSTEGUI, PhD, Fundacion Huesped and Universidad de Palermo, Buenos Aires, Argentina  
 SWAGATA BANIK, PhD, Baldwin Wallace University, Berea, Cleveland, OH  
 JAVIER BELINKY, MD, Department of Gender Surgery Hospital Carlos G. Durand, Guemes Clinic and School of Medicine, Buenos Aires University, Buenos Aires, Argentina  
 DIANNE BERG, PhD, University of Minnesota, Minneapolis, MN  
 JENS BERLI, MD, Oregon Health & Science University, Portland, OR  
 NOVA BRADFORD, Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School, Minnesota, USA  
 GEORGE BROWN, MD, East Tennessee State University, Bluff City, TN  
 STEPHANIE BUDGE, PhD, University of Wisconsin, Madison, WI  
 JOHN CAPOZUCA, PhD, Private Practice, New York, NY  
 PEGGY T. COHEN-KETTENIS, PhD, VU University Medical Center, Amsterdam, the Netherlands  
 CAROLINE DAVIDGE-PITTS, MBBCh, Mayo Clinic, Rochester, MN  
 MADELINE B. DEUTSCH, MD, Center of Excellence for Transgender Health, University of California, San Francisco, CA, and Los Angeles Gay & Lesbian Center, Los Angeles, CA  
 ANNELOU LC DE VRIES, MD, PhD, VU University Medical Center, Amsterdam, the Netherlands  
 DOMENICO DI CEGLIE, MD, Tavistock Gender Identity Development Service, London, UK  
 RICHARD DOCTER, PhD, California State University, Northridge, CA  
 RANDALL D. EHRBAR, PsyD, Whitman-Walker Health, Washington, DC  
 LAURA ERICKSON-SCHROTH, MD, Columbia University, New York, NY  
 FRED ETTNER, MD, Private Practice, Lincolnwood, IL  
 RANDI ETTNER, PhD, New Health Foundation, Evanston, IL  
 JAMIE FELDMAN, MD, PhD, University of Minnesota Medical School, Minneapolis, MN  
 ALDO FELICI, MD, Ospedale San Camillo, Roma, Italy  
 ALESSANDRA FISHER, MD, PhD, Andrology, Women's Endocrinology and Gender Incongruence Unity, Careggi University Hospital, Florence, Italy  
 LIN FRASER, EdD, Private Practice, San Francisco, CA  
 ROB GAROFALO, MD, Anne and Robert H. Lurie Children's Hospital, Chicago, IL  
 MELANIE GOLD, DO, Columbia University, New York, NY  
 CESAR GONZALEZ, PhD, University of Minnesota Medical School, Minneapolis, MN  
 LOUIS GOOREN, MD, PhD, VU University Medical Center, Amsterdam, the Netherlands  
 JAMISON GREEN, PhD, University of California, San Francisco, CA  
 UWE HARTMANN, MD, Medizinische Hochschule, Hannover, Germany  
 STEFAN HIRSCHAUER, PhD, Ludwig-Maximilian-Universität, Munich, Germany  
 TORVALD HOJERBACK, MD, University Hospital, Lund, Sweden  
 ALEX IANTAFFI, PhD, University of Minnesota, Minneapolis, MN  
 LAURA A. JACOBS, MSW, LCSW, Callen-Lorde Community Health Center, New York, NY  
 GAIL KNUDSON, MD, Vancouver Coastal Health, Vancouver, BC, Canada  
 BRUNHILD KRING, MD, Lincoln Medical & Mental Health Center, Bronx, NY  
 LAURA KUPER, PhD, Children's Health and University of Texas Southwestern Medical Center, Dallas, TX  
 DONALD LAUB, MD, Stanford University, Palo Alto, CA  
 SCOTT LEIBOWITZ, MD, Nationwide Children's Hospital, Columbus, OH, USA  
 ARLENE ISTAR LEV, LCSW, CASAC, Choices Counseling and Consulting, Albany, NY  
 STEVE LEVINE, PhD, Center for Marital & Sexual Health Inc., Beachwood, OH  
 ASHLEIGH LIN, PhD, Telethon Kids Institute, The University of Western Australia, Perth, Australia  
 XIMENA LOPEZ, MD, GENDER, Education and Care Interdisciplinary Support (GENECIS) Program, Dallas, TX  
 JEAN MALPAS, LMHC, LMFT, Ackerman Institute for the Family, New York, NY  
 JENNIFER MCGUIRE, PhD, University of Minnesota, Minneapolis, MN

DANE MENKIN, MSN, CRNP, AAHIVM, LaSalle University, Philadelphia, PA  
WALTER J. MEYER III, MD, University of Texas Medical Branch, Galveston, TX  
HEINO MEYER-BAHLBURG, DrRerNat, Columbia University, New York, NY  
STAN MONSTREY, MD, PhD, University Hospital, Ghent, Belgium  
JOZ MOTMANS, PhD, Ghent University and Ghent University Hospital, Ghent, Belgium  
DON OPERARIO, PhD, Brown University, Providence, RI  
JOANNE PASHDAG, PhD, California School of Forensic Studies, Alliant International University, San Francisco, CA  
VERONICA PIMENOFF, MD, Helsinki University Central Hospital, Helsinki, Finland  
JAE A. PUCKETT, PhD, Department of Psychology, Michigan State University, East Lansing, Michigan, USA  
JACK PULA, MD, Columbia University, New York, NY  
KATHERINE RACHLIN, PhD, Private Practice, New York, NY  
BLAS RADI, Universidad de Buenos Aires/Instituto de Investigaciones Filosóficas SADAF/CONCIET, Buenos Aires, Argentina  
ANNA R. RAVENNA, PhD, Ospedale San Camillo, Roma, Italy  
CHRISTINA RICHARDS, DCPsych, Tavistock and Portman NHS Foundation Trust & Regents University, London, UK  
G NIC RIDER, PhD, Program in Human Sexuality, Univ. of Minnesota Medical School, Minneapolis, MN  
ELIZABETH RILEY, PhD, University of Tasmania, Hobart, Tasmania  
JISKA RISTORI, PhD, Andrology, Women's Endocrinology & Gender Incongruence Unit, University Hospital Careggi, Florence, Italy  
BEAN ROBINSON, PhD, University of Minnesota Medical School, Minneapolis, MN  
ALVARO RODRIGUEZ, MD, Centro Especializado en Cirugía Mamaria y Cirugía Transgénero, Cali, Columbia  
STEPHEN ROSENTHAL, MD, University of California, San Francisco, San Francisco, CA  
MICHAEL W. ROSS, PhD, DrMedSC, University of Texas Health Science Center, Houston, TX  
AYDEN SCHEIM, PhD, Drexel University, Philadelphia, PA  
JAE SEVELIUS, PhD, University of California, San Francisco, San Francisco, CA  
ALEX SHARPE, PhD, Keele University, Staffordshire, UK  
ANNELIESE SINGH, PhD, University of Georgia, Athens, GA  
MARIA SÖDERSTEN, SLP, PhD, Karolinska University Hospital and Karolinska Institutet, Stockholm, Sweden  
KATIE SPENCER, PhD, University of Minnesota, Minneapolis, MN  
PENELOPE STRAUSS, PhD, Telethon Kids Institute, The University of Western Australia, Perth, Australia  
AMETS SUESS SCHWEND, PhD, Research Group "Others. Feminist Perspectives in Social Research," University of Granada, Granada, Spain  
VIN TANGPRICHA, MD, PhD, Emory University, Atlanta, GA  
NAT THORNE, MSc, University of Nottingham, Nottingham, UK  
TIM VAN DE GRIFT, MD, PhD, VU University Medical Center, Amsterdam, the Netherlands  
ANNA VAN DER MIESEN, MD, VU University Medical Center, Amsterdam, the Netherlands  
AMY TISHELMAN, MD, Boston Children's Hospital and Harvard Medical School, Boston, MA  
BEN VINCENT, PhD, Open University, Milton Keynes, UK  
BARBARA E. WARREN, PsyD, CASAC, Beth Israel Medical Center, New York, NY  
STEPHEN WHITTLE, PhD, Manchester Metropolitan University, Manchester, UK  
MICHAEL WILL, RJCD, Wurzburg, Germany  
SAM WINTER, PhD, Curtin University, Perth, Western Australia  
GEMMA WITCOMB, PhD, Loughborough University, Loughborough, UK  
KEVAN R. WYLIE, MD, Porterbrook Clinic, Sheffield, UK  
EICHER WOLF, MD, Diakonissen-Krankenhaus, Manheim, Germany  
SAHIKA YUKSEL, MD, Istanbul Medical Facility, Istanbul, Turkey  
KEN ZUCKER, PhD, University of Toronto, Toronto, ON, Canada



[First page](#) of WPATH, “Standards of Care” Version 8, Sept. 2022. Contributors:



International Journal of Transgender Health



ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/wjht21>

## Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.-B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus

To cite this article: E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.-B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, *International Journal of Transgender Health*, 23:sup1, S1-S259, DOI: [10.1080/26895269.2022.2100644](https://doi.org/10.1080/26895269.2022.2100644)

## Reliable Sources

Society for Evidence Based Gender Medicine, <https://segm.org/studies>

American College of Pediatricians:

“Sex is a Biological Trait of Medical Significance,” March 2021;

<https://acpeds.org/position-statements/sex-is-a-biological-trait-of-medical-significance> and

[https://acpeds.org/assets/Sex-is-a-Biological-Trait-of-Medical-Significance-\(1\).pdf](https://acpeds.org/assets/Sex-is-a-Biological-Trait-of-Medical-Significance-(1).pdf)

Jane W. Robbins, Esq. and Vernadette Broyles, Esq., “The Myth about Suicide and Gender Dysphoric Children,” no date; <https://acpeds.org/assets/SUICIDE-MYTH-HANDOUT-1592593440.pdf>

“Gender Dysphoria in Children,” Nov. 2018; <https://acpeds.org/position-statements/gender-dysphoria-in-children>

“Transgender Interventions Harm Children: No Evidence that Transgender Interventions are Safe for Children,” no date, <https://acpeds.org/transgender-interventions-harm-children>

“Deconstructing Transgender Pediatrics,” no date;

<https://acpeds.org/topics/sexuality-issues-of-youth/gender-confusion-and-transgender-identity/deconstructing-transgender-pediatrics>

Articles referencing “gender”: <https://acpeds.org/search-results?q=gender>

William J. Malone, Paul W. Hruz, Julia W. Mason, Stephen Beck, “Proper Care of Transgender and Gender-diverse Persons in the Setting of Proposed Discrimination: A Policy Perspective,” Letter to the Editor, *The Journal of Clinical Endocrinology & Metabolism*, Volume 106, Issue 8, August 2021; <https://doi.org/10.1210/clinem/dgab205>

Michael K. Laidlaw, Quentin L. Van Meter, Paul W. Hruz, Andre Van Mol, William J. Malone, “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” Letter to the Editor, *The Journal of Clinical Endocrinology & Metabolism*, Volume 104, Issue 3, March 2019; <https://doi.org/10.1210/jc.2018-01925>

E. Abbruzzese, Stephen B. Levine, Julia W. Mason, “The Myth of ‘Reliable Research’ in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies-and research that has followed,” *J Sex Marital Ther.*, 2023 Jan 2;1-27. <https://pubmed.ncbi.nlm.nih.gov/36593754>

Christian Medical & Dental Associations, “CMDA Ethics Statement: Transgender Identification,” Medical, Ethical, and References sections; download link [bit.ly/41fMM5p](https://bit.ly/41fMM5p).

Sex Change Regret, <https://sexchangeregret.com>

Amicus brief filed by Attorneys General of AL, AK, AZ, GA, ID, IN, KS, KY, LA, MS, MO, MT, NE, SC, SD, TN, & TX, July 2021.

Section II, "The Experimental Gender Transition Procedures Prohibited By Arkansas Are Fraught With Medical And Scientific Uncertainties,"

<https://www.alabamaag.gov/Documents/news/Arkansas%20Transgender%20Brief%20Amicus.pdf>

Jennifer Bauwens, Ph.D., editor, "Do Not Sterilize Children: Why Physiological Gender Transition Procedures for Minors Should Be Prohibited," Family Research Council, July 2021, <https://downloads.frc.org/EF/EF20J34.pdf>

Jane Robbins, Esq., "Revisiting the Impossibility of Informed Consent for Transgender Interventions," *The Public Discourse*, July 19, 2022;

<https://www.thepublicdiscourse.com/2022/07/83503/> & [her other articles](#) at *Public Discourse*.

MassResistance, "Children's Hospital Boston Gender Clinic & Dr. Normal Spack: Barbaric, experimental medical procedures on children who think they're 'transgender'," index page, 2005-2011;

[https://www.massresistance.org/topics/reports/Childrens\\_Hosp\\_Bos.html](https://www.massresistance.org/topics/reports/Childrens_Hosp_Bos.html)

Susan Berry, PhD, "Dr. Quentin Van Meter: How Faulty Research by a 1950s 'Sexual Revolutionist' Guided the Modern Transgender Movement," *Breitbart*, Oct. 24, 2018;

<https://www.breitbart.com/politics/2018/10/24/dr-quentin-van-meter-transgenderism-invented-1950s-johns-hopkins-lab/>

Lisa Selin Davis, "How Young Is Too Young for Sterilization? An influential transgender advocacy group releases new recommendations based on politics—not science," *Common Sense*, Sept. 28, 2022; <https://www.commonsense.news/p/how-young-is-too-young-for-sterilization>

Jennifer Bilek, "The Billionaires behind the Transgender Movement," *First Things*, Jan. 21, 2020; <https://www.firstthings.com/web-exclusives/2020/01/the-billionaires-behind-the-lgbt-movement>

Jennifer Bilek, "Big Pharma, Big Tech, and Synthetic Sex Identities," *RealClearPolicy*, Sept. 20, 2022;

[https://www.realclearpolicy.com/2022/09/20/big\\_pharma\\_big\\_tech\\_and\\_synthetic\\_sex\\_identities\\_854505.html](https://www.realclearpolicy.com/2022/09/20/big_pharma_big_tech_and_synthetic_sex_identities_854505.html)

Abigail Shrier, "Top Trans Doctors Blow the Whistle on 'Sloppy' Care; In exclusive interviews, two prominent providers sound off on puberty blockers, 'affirmative' care, the inhibition of sexual pleasure, and the suppression of dissent in their field," Oct. 4, 2021; <https://www.commonsense.news/p/top-trans-doctors-blow-the-whistle>

Christina Buttons, “Boston Children's Hospital gleefully encourages surgical, pharmaceutical 'gender transition' for teens,” Aug. 10, 2022;  
<https://thepostmillennial.com/boston-childrens-hospital-gleefully-encourages-surgical-pharmaceutical-gender-transition-for-teens>

Laurel Duggan, “ ‘We Were Wrong’: Pioneer in Child Gender Dysphoria Treatment Says Trans Medical Industry Is Harming Kids,” *Daily Caller*, March 11, 2023,  
<https://dailycaller.com/2023/03/11/pioneer-in-child-gender-dysphoria-treatment-says-trans-medical-industry-is-harming-kids/>

Laurel Duggan, “ ‘Horrorifying’: Huge Proportion Of Children Pursuing Gender Transitions Are Actually Autistic, Experts Believe,” *Daily Caller*, March 12, 2023,  
<https://dailycaller.com/2023/03/12/horrifying-huge-proportion-of-children-pursuing-gender-transitions-are-actually-autistic-experts-believe/>

Spencer Lindquist, reports at *Breitbart* on statements by BCH Drs. Carswell and McGregor, Oct.-Nov. 2022,

<https://www.breitbart.com/health/2022/10/10/director-boston-childrens-gender-clinic-puberty-blockers-cause-infertility-given-like-candy/>

<https://www.breitbart.com/health/2022/10/15/boston-childrens-hospital-claims-puberty-blockers-completely-reversible/>

[70]

<https://www.breitbart.com/health/2022/11/28/14-pursuing-transgender-surgery-boston-childrens-hospital-admits/>

Samantha Kamman, “Trans health group removed age recommendations for gender surgeries to protect doctors,” *The Christian Post*, Sept. 23, 2022,

<https://www.christianpost.com/us/trans-health-group-removed-age-guideline-for-gender-surgeries-protect-doctors.html> (re: statements by BCH GeMS Dr. Amy Tishelman, author of section in WPATH V. 8 on hormone guidelines for children).

Gender Mapping Project, <https://www.gendermapper.org/>. Click through to directory of clinics: <https://www.gendermapper.org/name-and-shame-doctors>

“Transman” Scott Newgent, Interview, Gender Dysphoria Alliance, Dec. 18, 2021,  
<https://www.genderdysphoriaalliance.com/post/meet-scott-newgent> & TreVoices,  
<https://www.scottnewgent.com/>