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The Evidence Speaks: A Response to 'The Trans Myth'

Jason Masters, Sydney, Australia

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Abstract

This article responds to claims made in *The Spectator Australia* (November 2025) regarding gender-affirming care for transgender youth. The original article cited the UK Cass Review to argue against providing healthcare to this population in the Australia. This response examines these claims against peer-reviewed evidence.

The Cass Review did not recommend banning gender-affirming care. Three independent peer-reviewed analyses have identified methodological concerns in the review. The Utah Department of Health and Human Services systematic review (2025), commissioned by conservative legislators, examined 277 studies involving over 28,000 transgender minors and found evidence supporting the effectiveness of treatment. Research documents the harms of the UK puberty blocker ban, including deteriorating mental health and increased suicidal ideation among affected young people.

Australian medical bodies, including the Australian Medical Association and the Royal Australasian College of Physicians, support gender-affirming care as an evidence-based practice. Systematic evidence indicates treatment satisfaction rates exceeding 94% and regret rates of approximately 1%. Policy decisions affecting vulnerable young people should be based on evidence rather than ideological opposition. This article provides citations that enable the independent verification of all claims.

Keywords: gender-affirming care, transgender youth, Cass Review, evidence-based medicine, health policy, Australia, Queensland puberty blocker withdrawal

Introduction

Edie Wyatt's article 'The trans myth' (*The Spectator Australia*, 29 November 2025) presents a collection of claims about gender-affirming care that demand scrutiny. The article cites the UK Cass Review and related documents to argue against providing healthcare to transgender youth. This response examines Wyatt's claims against peer-reviewed evidence.

The stakes are high. Policy decisions based on misinformation can harm vulnerable young people. Australian health ministers and clinicians require accurate information to make informed decisions. This article provides this information with full citations.

The timing of this debate is significant. In the United States, 25 states have enacted bans on gender-affirming care for minors between 2022 and 2024. The UK implemented a puberty-blocker ban in 2024. New Zealand followed in November 2024. Queensland remains the only Australian state with restrictions. Political pressure on other Australian jurisdictions is increasing. Evidence-based responses are essential to address these issues.

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What the Cass Review Says

Wyatt's article relies on the Cass Review as its primary authority. The Cass Review did not recommend banning gender-affirming care. This fact is central to understanding how the Review has been misused in public debates.

The Review states: 'The Review does not recommend that gender-affirming care be withheld from young people.' This calls for individualised assessment, improved research, and better clinical pathways. Dr Hilary Cass herself stated in her April 2024 press conference: 'I am not saying that they should not get treatment.'

The claim that the evidence is 'weak' requires context. The Cass Review's assessment of evidence quality refers to formal grading under the GRADE framework, where Randomised Controlled Trials receive the highest ratings. This methodology rates most paediatric medicines as 'low quality' because RCTs are often unethical or impractical with children. The same evidence standard would exclude most established paediatric treatments.

The Review's own systematic reviews found moderate-quality evidence of mental health benefits from gender-affirming medical treatment. The reviews found GnRHa (puberty blockers) to be effective in suppressing puberty. The reviews found no evidence of serious harm sufficient to justify the withholding of treatment.

Contrary to claims that 98% of studies were excluded, the York University systematic reviews commissioned by the Cass Review included approximately 60% of the identified studies. The remaining 40% were excluded for methodological reasons common to all systematic reviews. This 98% figure derives from a misunderstanding of how systematic review methodology functions.

Peer-Reviewed Critiques of the Cass Review

Multiple independent analyses have identified methodological concerns in the Cass Review. Three distinct critiques merit our attention.

Yale Integrity Project (July 2024)

In July 2024, Yale Law School researchers published a detailed critique of the Cass Review. The 39-page analysis, authored by eight legal scholars and scientists, including MDs and PhDs, identified significant methodological concerns. Lead author Dr Meredithe McNamara was joined by Dr Johanna Olson-Kennedy, Dr Jack Turban, Dr Kellan Baker, Dr Anne Alstott, and Dr Aron Janssen.

The Yale analysis found that the Review's recommendations contradict its own findings. The Review acknowledged that some young people benefit

from puberty suppression, yet made such treatment inaccessible. The Review found no evidence that psychological treatments improve gender dysphoria, yet recommended expanding their provision. The Review found that NHS services were already restrictive (only 22% of 3,306 patients received any gender-affirming medical treatment after assessment), yet recommended increased barriers (McNamara et al., 2024).

The Yale critique noted that the review should not be cited as supporting bans on gender-affirming care. The Review's recommendations differ from the policy positions adopted by jurisdictions claiming to implement its findings.

York University Systematic Reviews Critique (May 2025)

A separate peer-reviewed critique published in *BMC Medical Research Methodology* applied the Risk of Bias in Systematic Reviews (ROBIS) tool to all seven York University systematic reviews commissioned by the Cass Review. ROBIS is the standard instrument for evaluating systematic review methodology.

The researchers found a 'high risk of bias' in all seven reviews, citing 'unexplained protocol deviations, ambiguous eligibility criteria, inadequate study identification' (Noone et al., 2025). This critique is distinct from that of the Yale analysis. It focuses on the technical methodology of the underlying evidence synthesis, not policy interpretation.

Australian Medical Journal Critiques (October 2025)

In October 2025, the *Medical Journal of Australia* published two significant articles addressing the Cass Review and gender-affirming care in Australia.

Moore et al. (2025) brought together 16 Australian clinical experts across adolescent medicine, endocrinology, psychiatry, paediatrics, and epidemiology. Their analysis documented the internal contradictions within the Cass Review. They noted: 'Few treatments for any condition meet this criterion [high certainty evidence of very long-term efficacy and safety], and it is difficult to name another field in which regulators impose such a benchmark.'

Moore et al. highlighted the aspects of the review’s development. One-third of health professionals in the Review's clinical engagement agreed with the statement 'there is no such thing as a trans child.' The Review team was selected based on the absence of trans healthcare experience. No transgender authors contributed to this review. This article includes a positionality statement acknowledging the authors' clinical experience and professional roles in transgender healthcare.

McFadyen et al. (2025) provided an autoethnographic account comparing a 1987 MJA case series documenting psychiatric treatment for gender diverse children to the author's own medical records and adult recollections. McFadyen, identified as 'Case 5' in the historical case series from Stubbs Terrace Hospital in Western Australia, documented the harms of historical conversion approaches: 'sharply declining mental health, increased

depression, social isolation, anxiety, stress, self-harm, school avoidance and suicide ideation.'

The McFadyen article provides first-person evidence that efforts to suppress or change gender identity are 'ineffective and harmful.' The Stubbs Terrace Hospital is no longer operational. The treatment approaches documented in the 1987 case series would now be classified as conversion therapy and are prohibited in multiple Australian jurisdictions.

The Utah Study: Conservative Legislators' Own Evidence

In 2023, the Republican-controlled legislature of Utah banned gender-affirming care for transgender youth. The same legislation required the Utah Department of Health and Human Services to conduct a systematic review of medical evidence. Conservative lawmakers anticipated that the review would validate their policy decisions. The Utah DHHS engaged the University of Utah to conduct the required study.

The University of Utah Drug Regimen Review Center delivered a 1,051-page report in May 2025. Researchers examined 277 clinical studies involving over 28,000 transgender minors over two and a half years of analysis (Utah DHHS, 2025). This review represents one of the most comprehensive evidence reviews on gender-affirming care for young people.

These findings contradict the legislature's expectations. The report concluded that the evidence supports the treatment effectiveness for mental health outcomes, psychosocial functioning, and physical development consistent with affirmed gender. Evidence supports a lower suicide risk with access to care. Evidence supports quality-of-life improvements.

Utah's Republican legislators responded by dismissing their own commissioned study. This reaction demonstrates how ideological opposition to gender-affirming care persists, regardless of the evidence. When evidence contradicts predetermined conclusions, proponents of restrictions discard the evidence rather than revise their positions.

Documented Harms from the UK Puberty Blocker Ban

Kennedy (2025), published in the *Journal of Gender Studies*, provides direct evidence of harms from the UK puberty blocker ban implemented following the Cass Review. This research documented the experiences of trans children and their parents through qualitative interviews.

Participants reported deteriorating mental health, increased suicidal ideation, loss of hope for the future, forced medical tourism to access care abroad, family financial hardship from seeking treatment in other countries and social

withdrawal. The study reached empirical saturation, meaning that no new information emerged from the additional interviews (Kennedy, 2025).

Kennedy concluded: 'The evidence presented here of the very significant harm it is causing to children and young people presents an overwhelming case for ending it immediately.' The research was conducted by a lecturer at Goldsmiths College, University of London with expertise in organised transphobia and trans youth.

The UK's ban created a natural experiment. Before the ban, young trans people in the UK had access to puberty blockers through NHS gender identity services. After the ban, access was removed. Kennedy documented these consequences. Policymakers considering similar restrictions should examine these documented outcomes.

Puberty Blockers: 45 Years of Clinical Use

Gonadotropin-releasing hormone agonists (GnRHa), known as puberty blockers, have been used in medicine since 1980 to treat precocious puberty. The Mayo Clinic states that their effects are 'fully reversible' and that they provide 'time to explore gender identity' (Mayo Clinic, 2024). These medications suppress puberty by reducing the production of sex hormones.

These medications are used to treat central precocious puberty in cisgender children. This use is uncontroversial. Parents of cisgender children with precocious puberty are not accused of child abuse for seeking treatment for their children. The same medications prescribed to transgender adolescents for the same physiological purpose attract political opposition despite their equivalent safety profiles.

In October 2025, the Italian Medicines Agency (AIFA) completed its review of puberty blockers used for gender dysphoria. The agency found no evidence to alter the risk-benefit ratio and maintained its approval for continued prescription. This decision followed a comprehensive review of the evidence conducted at the request of the Italian government. Italy has a conservative coalition government. The decision to maintain access to puberty blockers was based on the evidence.

Chen et al. (2023), a multisite US study of 315 transgender and nonbinary youth, followed participants for two years after initiating gender-affirming hormones. The research documented decreases in depression and anxiety symptoms, alongside increases in life satisfaction and positive affect. This study represents the largest prospective cohort with the longest follow-up period reported for this population.

Bone Density: A Manageable Clinical Concern

Critics cite bone density effects as evidence that puberty blockers are harmful to patients. However, the evidence requires a proper clinical context. The effects of bone density are real, documented, and clinically manageable.

Van der Loos et al. (2023), published in *JAMA Pediatrics*, followed 75 participants over 15 years. This represents the longest follow-up period for bone health in this population. Bone mineral density z-scores decreased during puberty suppression with GnRH treatment. After long-term gender-affirming hormone treatment (nine or more years), pretreatment z-scores were not fully restored, but bone mineral density was maintained.

Ciancia et al. (2022), reviewing the evidence, stated: 'Results consistently indicate a negative impact of long-term puberty suppression on bone mineral density, especially at the lumbar spine, which is only partially restored after sex steroid administration.' The same review recommends weight-bearing exercise and calcium and vitamin D supplementation during puberty suppression. Trans girls appear to be more vulnerable than trans boys to compromised bone health.

Fighera et al. (2019) conducted a systematic review and meta-analysis, finding statistically significant increases in lumbar spine bone mineral density in trans women at 12 and 24 months of hormone therapy. Trans men showed no statistically significant differences in bone mineral density at any of the measured sites. Single cohort data showed no fracture events at 12 months follow-up.

Bone density monitoring is a standard clinical practice. General practitioners routinely manage bone density in patients on corticosteroids, those with coeliac disease, postmenopausal women, and many other populations. The protocols are well established. DXA scanning, vitamin D supplementation, calcium intake monitoring, and weight-bearing exercise recommendations are part of the standard care. Any competent GP can monitor and manage bone density in transgender patients.

Framing manageable side effects as a justification for denying treatment reflects a double standard not applied elsewhere in medicine. Chemotherapy has severe side effects. We do not deny treatment to patients with cancer because chemotherapy affects their health. We managed the side effects. The same principle applies to gender-affirming care.

The WPATH Files: Context and Corrections

Anti-transgender advocacy groups have cited leaked internal communications from the World Professional Association for Transgender Health (WPATH) as evidence of misconduct. An independent analysis by journalist Erin Reed

identified 216 factual inaccuracies in the initial reporting of these communications.

The communications show medical professionals discussing complex cases and seeking peer consultations. This is a standard medical practice. Doctors of all specialties consult their colleagues regarding complex cases. Oncologists discuss the treatment decisions. Surgeons seek second opinions from other surgeons. Psychiatrists consult for complex presentations. Internal professional discussions are evidence of careful practice and not misconduct.

Framing routine peer consultation as scandalous reveals unfamiliarity with the functioning of medicine. Medical boards require documentation of clinical reasoning skills. Case conferences are specifically designed for collegial discussions. The WPATH communications demonstrate the careful deliberation that good medical practice requires.

Outcomes: What the Research Shows

Tordoff et al. (2022), published in *JAMA Network Open*, followed transgender and nonbinary youth receiving gender-affirming care. Participants showed 60% lower odds of moderate or severe depression and 73% lower odds of suicidality than baseline after 12 months of treatment. This study used a prospective cohort design with standardised outcome measures.

Bustos et al. (2021) conducted a systematic review and meta-analysis of gender-affirming surgery outcomes. The regret rate was approximately 1%. This compares favourably with the regret rates for other elective procedures. Thornton et al. (2024) found that gender-affirming surgery regret rates were 6 to 100 times lower than those for common elective procedures, including knee replacement, bariatric surgery, and laser eye surgery.

The Australian Private Lives 3 survey (2020) found that 75.3% of transgender respondents who had accessed gender-affirming hormone treatment reported improved mental health. The survey documented the experiences of 6,835 LGBTIQ+ Australians. The 2022 US Transgender Survey, the largest survey of transgender people globally with over 92,000 respondents, found that 94% of respondents who had received gender-affirming hormone therapy were satisfied or very satisfied with the results.

However, individual cases of regret exist. Systematic evidence shows that these cases represent approximately 1% of those who receive treatment. Media coverage of individual regret cases creates a misleading impression of regret frequency. Selecting unrepresentative cases to characterise a medical intervention is a recognised technique for spreading misinformation. Notwithstanding this, those who detransition should be provided with all the medical support they require and be respected by all in the community.

Australian Medical Authority Positions

Australian medical bodies support gender-affirming care as an evidence-based practice. The Australian Medical Association, the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists, and AusPATH (the Australian Professional Association for Trans Health) have all issued statements supporting access to gender-affirming care for transgender youth.

In every country, there are small non-mainstream bodies, many of which are either directly religious or have a membership that is religious or against the LGBTIQA+ community. In the US, one example is the so-called 'American College of Pediatrics', which, despite its name, is not the leading professional body in this field (the American Academy of Pediatrics holds that position). The 'College' has approximately 500 to 700 members compared to the AAP's 67,000+ (roughly 1%), and the Southern Poverty Law Center has designated it a 'hate group' because of its history of anti-LGBTQ advocacy. The organisation was founded in 2002 specifically to oppose same-sex adoption (Southern Poverty Law Center, 2023).

In Australia, the organisations that fall into this category include:

- National Association of Practising Psychiatrists (NAPP)
- Australian Doctors Federation (ADF)
- Australian Catholic Medical Association (CMAA)
- Nurses' Professional Association of Australia (NPAA)
- Australian Medical Professional Society (AMPS)

None of these bodies appears to represent anywhere close to 10% of the workforce in their sector, and the proportion is generally much lower than that.

The latter two organisations are part of the broader Red Union Support Hub network, which was established by individuals with Liberal National Party connections, including Graeme Haycroft (a former supporter of ultra-right Queensland Premier Joh Bjelke-Petersen's failed Prime Minister campaign). These organisations initially grew by recruiting members opposed to COVID-19 vaccination mandates. The Australian Council of Trade Unions described them as 'fake unions run by LNP members and their associates set up to try and divide working people' (McManus, 2021).

Another theme across most of these organisations is that Dr Jillian Spencer, the terminated Queensland Children's Hospital psychiatrist who opposes gender-affirming care, appears as a connecting figure across these organisations, a speaker at many of those organisations' events, suggesting a coordinated network of smaller organisations with overlapping leadership and advocacy goals to create the appearance of broader professional support than exists.

Queensland is the only Australian state to implement restrictions on gender-affirming care. The NHMRC is currently reviewing the Australian guidelines. No other state has followed Queensland's approach, and major medical bodies have not revised their positions.

Australian law recognises young people's capacity to consent to medical treatment through the Gillick Competence Framework. The 2017 Family Court decision in Re Kelvin removed the requirement for court authorisation for stage two gender-affirming treatment, where the young person and their parents consent. The UK Bell v. The Tavistock decision (2020), which briefly imposed restrictions, was overturned on appeal in 2021. The Australian legal framework recognises the adolescent capacity for medical decision-making.

The Australian Bureau of Statistics estimated that approximately 1.2% of Australians aged 18 and over identify as transgender or gender diverse (2022). This population requires appropriate healthcare services. Restricting access to evidence-based treatments harms a substantial number of Australians. Their treatment should be covered under Medicare. Even in the US, the only Western nation without universal health care, a significant number of corporate health care insurance providers include coverage.

Diagnostic Classifications

The American Psychiatric Association's DSM-5 states: 'gender nonconformity is not in itself a mental disorder.' Gender dysphoria refers to the distress that some transgender people experience due to the incongruence between their gender identity and assigned sex. Treatment aims to alleviate this distress. Being transgender is not a disorder that requires correction.

The World Health Organization’s ICD-11 (2019) moved gender identity conditions out of the mental disorders chapter entirely. The WHO placed 'gender incongruence' in a new chapter on conditions related to sexual health. This change reflects the international medical consensus that being transgender is a normal variation of the human experience and not a pathology requiring a cure.

These diagnostic classifications are important for policy-making. If being transgender were a mental disorder, approaches aimed at changing gender identity might be appropriate for treatment. Major diagnostic systems explicitly reject this framing. Gender-affirming care aligns with the understanding that gender identity is innate and worthy of support rather than elimination. The attempt to frame transgender people as living with mental illness is a repeat of the 'being gay is a mental illness' construct prior to the late 1970s.

Neurobiological Evidence

Neuroimaging research provides evidence for the biological basis of gender identity. Mueller et al. (2021), analysing MRI data from multiple international sites, found that transgender individuals showed a unique brain phenotype

distinct from both cisgender males and females. This study involved the largest neuroimaging sample of transgender individuals to date.

Multiple studies have documented structural and functional brain differences. These include differences in white matter microstructure (Rametti et al., 2011), cortical thickness patterns (Luders et al., 2012), and subcortical gray matter volumes (Hoekzema et al., 2015). The consistency of the findings across independent research groups supports the biological contributions to gender identity development.

No 'brain scan test' for gender identity exists. This study demonstrated population-level differences, not diagnostic criteria. Individual brains vary. The evidence refutes claims that gender identity is purely psychological, socially constructed, or a product of social contagion. Neurobiological research supports the understanding that gender identity has developmental origins in the brain structure and function.

Rhetorical Strategies in 'The Trans Myth'

Wyatt employed rhetorical strategies that merit identification. Recognising these techniques helps readers evaluate the merits of the arguments.

The article presents gender-affirming care as 'experimental.' PolitiFact rated this claim as FALSE in 2023, noting that puberty blockers have been used in paediatric medicine for over four decades. Hormone therapy has been prescribed to transgender individuals since the 1960s. Referring to established treatments as ‘experimental' misrepresents their history. The same medications prescribed for other conditions and purposes cannot be reasonably called experimental.

The article uses anecdotal accounts of regret. Individual cases exist. Systematic evidence indicates regret rates of approximately 1%. Media coverage of individual regret cases creates a misleading impression of regret frequency. In contrast, Jazz Jennings, who received puberty blockers from age 11 and has publicly documented her transition since childhood, reported positive wellbeing in 2024-2025 interviews. Individual cases do not prove anything about population outcomes. However, systematic evidence is required.

The article implies that children undergo surgery. Genital surgery on minors is extremely rare globally and requires extensive multi-year assessments. Most gender-affirming care for young people involves social transition (name, pronouns, presentation), psychological support, and, in some cases, reversible puberty suppression. In Australia, hormone therapy typically begins only after the age of 16 years, following rigorous assessment protocols.

The article positions itself as defending children while advocating for policies that are demonstrated to harm them. Kennedy (2025) documented the harms of the UK ban. The Utah study documented positive outcomes from access to care. McFadyen (2025) documents the historical harms of attempts

to suppress gender identity. Framing restrictions as protection inverts the evidence. Restrictions can cause harm. Access to care has positive outcomes.

Evidence-Based Policy

Australian health ministers face pressure from advocacy groups seeking to restrict gender-affirming care for minors. However, the evidence does not support this restriction.

The Cass Review itself does not recommend banning the treatment. Three independent peer-reviewed analyses have identified significant methodological problems in the Cass Review. The Utah DHHS study, commissioned by conservative legislators, found evidence supporting the treatment's effectiveness. The UK ban has resulted in documented harm. Italian regulators examined the evidence and maintained access to treatment.

Australian medical bodies support gender-affirming care for transgender individuals. International medical consensus supports gender-affirming care. The WHO and APA diagnostic systems do not classify being transgender as a disorder. This evidence supports gender-affirming care.

Policies should follow the evidence. **Transgender youth deserve healthcare based on science, not politics**. The evidence is clear. It is time for policymakers to listen.

Gender-affirming care for transgender youth is appropriate and usually necessary.

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Conflicts of Interest

The author is a transgender advocate and, at the time of writing this paper, a Co-convenor of Uniting Network Australia, an LGBTIQA+ advocacy group within the Uniting Church in Australia. The authors declare no financial conflicts of interest. This analysis was conducted independently using established research methods and publicly available data sources.

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Ethics Statement

This analytical response used publicly available data and documented policy information. No human subjects research was conducted, and ethical approval was not required.

AI Assistance Statement

The author used Claude (Anthropic) to assist with the literature synthesis, document formatting, and drafting. The author independently verified all sources. The author reviewed, edited, and takes full responsibility for the final content, analysis, and conclusions presented in this article.

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This article provides citations that enable the independent verification of all claims. Data is current as of December 2025.