# Exhibit 4

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA

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|---|---|---|
| C.P., by and through his parents, PATRICIA PRITCHARD AND NOLLE PRITCHARD; and PATRICIA PRITCHARD, | ) | |
| Plaintiffs, | ) | No. 3:20-cv-06145-RJB |
| vs. | ) | |
| BLUE CROSS BLUE SHIELD OF ILLINOIS, | ) | |
| Defendant. | ) | |

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REMOTE
VIDEOTAPED DEPOSITION UPON ORAL EXAMINATION OF
LOREN S. SCHECHTER, M.D.
August 2, 2022

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Taken remotely
Witness location: Highland Park, Illinois

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You may answer.

THE WITNESS: Thank you. I'm a licensed physician and surgeon.

Q. (By Ms. Bedard) So what training have you received related to mental health care?

MR. GONZALEZ-PAGAN: Objection; form.

THE WITNESS: My board certification and expertise is in surgery. Mental health care is a part of medical education. I also routinely teach and attend and lecture at multidisciplinary conferences which involve and include an interdisciplinary and multidisciplinary team, which involves mental health and behavioral health professionals.

Q. (By Ms. Bedard) And where are you currently employed?

A. Rush University Medical Center.

Q. How long have you been employed there?

A. Started April of this year.

Q. And what is your role at Rush University Medical Center?

A. I'm director of gender affirmation surgery. I'm within the division of plastic surgery with -- my pending appointment is professor of surgery.

Q. So two different roles technically: You're the director of gender affirmation surgery and you also have a

A. So I would refer to that type of care as either gender-affirming or gender-confirming care. I also continue to perform genitourinary reconstruction for a variety of conditions that are not related to gender dysphoria, and I also have no limitation on my privileges within the division of plastic surgery in terms of performing general plastic surgery and reconstructive microsurgery.

Q. Understood. Okay. So perhaps the best way for me to say it then to encompass all those different types of treatments would be surgeries for the treatment of gender dysphoria. Does that make sense?

A. Yes.

Q. Okay. So how many surgeries do you perform per year related to the treatment of gender dysphoria?

A. Between 150 and 250.

Q. So 150 to 250 of the surgeries you perform per year are related to the treatment of gender dysphoria.

How many surgeries are you performing per year then that are not related to the treatment of gender dysphoria?

A. Probably 25 to 50.

Q. And how many of your patients, current patients identify as transgender?

A. Approximately 85 to 90 percent.

Q. And how many of your current transgender patients are minors?

A. I would estimate perhaps somewhere between 10 to 20 percent.

Q. All right. So I'm going to try to do some math here again and you tell me if I'm wrong.

So if you perform between 150 and 200 surgeries per year related to the treatment of gender dysphoria and approximately 10 to 20 percent of those are for minors, then we're looking at approximately 20 to 25 surgeries per year for transgender minors?

A. Yeah. So I think you said 150 to 200. I believe I said 150 to 250.

Q. Thank you --

A. Those are surgery --

Q. -- for clarifying.

A. Not all patients I see are patients of -- upon whom I perform surgery, so I see more patients per year than I do perform surgery. In terms of surgical procedures on individuals under the age of 18, that would probably be 10 to 25 people per year depending on the year.

Q. That's 10 to 25 surgeries performed per year on transgender minors?

A. That would be 10 to 25 people upon whom I would perform surgery. I suppose if we get into the weeds, there may be staged procedures, so they may not be distinct individuals. In other words, someone may have a secondary

A. I've been ending my two-year term as treasurer now. Prior to that, it may have been four or six years -- I don't recall specifically -- as a member of the board.

Q. Prior to your current role on executive committee and as treasurer, did you hold any other positions within WPATH?

A. I have -- I serve on several committees and have had several roles. Dating back to 2007, I was the local host, one of the local hosts for the biennial meeting when it was hosted in Chicago. I began the -- what's called the Surgeons Only Program beginning in 2007. I've been the director of multiple different educational offerings including the global education institute and various other educational conferences. I serve as a member on the ethics committee. There may have been some others, but I'd have to look at my CV.

Q. And are you involved with the preparation or production of various versions of the WPATH standards of care?

A. I serve as colead for the surgery and after-care chapter for the forthcoming Standard of Care 8. Prior to that, I was one of the authors for Standards of Care 7 as well.

Q. For the same sections?

A. The sections have -- we combined surgery and after

care for Standard of Care 8. In Standard of Care 7, my focus was on the relationship of the surgeon with the mental health professional and the professional providing -- prescribing hormones.

Q. And has Standard of Care 8 been released to the public yet?

A. There was a version released for public comment, I believe, around December. I may have that date a little bit off. It has not been otherwise released as of yet.

Q. And, Dr. Schechter, are you also familiar with The Endocrine Society?

A. With The Endocrine Society?

Q. Yes.

A. I believe there are several different endocrine societies. There's clinical -- I think they have several different societies.

Q. When you say "they" have several different societies, what do you mean exactly?

A. Endocrinologists.

Q. So are you a member of any of the endocrine societies?

A. I am not.

Q. In addition to WPATH, are you involved in any other societies or professional organizations that relate to the treatment of gender dysphoria?

A. It's possible, again, in the sense that the academic work would mirror my clinical work, so in the sense that there have been publications accepted and I have presentations that have discussed clinical care of individuals under the age of 18.

Q. So I was actually asking more broadly about treatment of gender dysphoria on the whole, not just for those under the age of 18, although that's helpful to know as well.

So what would the updates be from the past few months to your CV related to the provision of care for the treatment of those with gender dysphoria?

A. So I've had a publication accepted to the Journal of Plastic and Reconstructive Surgery regarding the relationship between the surgeon and mental health professional. That article explores the issue of informed consent. I don't believe we specifically highlight -- there may be references to adolescent care, but looks at the topic of surgery for gender incongruence or gender dysphoria more broadly.

There would be presentations including grand rounds. I was a visiting professor at Georgetown within the last several weeks. There were discussions regarding provision of care adolescents, so in that sense, there would be updates to my CV.

Q. Could you read me that paragraph, please?

A. "Currently, the local Medicare Administrative Contractors determine coverage of gender reassignment surgery on a case-by-case basis. We have received a complete, formal request to make a national coverage determination on surgical remedies for gender identity disorder, parentheses, (GID), now known as gender dysphoria. The Centers for Medicare and Medicaid Services, parentheses, (CMS), is not issuing a national coverage determination, parentheses, (NCD), at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population."

Q. So, Dr. Schechter, CMS in 2016 made a determination not to issue a national coverage determination because the clinical evidence was inconclusive to the Medicare population, right?

A. To the Medicare population, that is correct.

Q. And I'm going to turn now to Page 46 of that decision memo.

And on Page 46, do you see the paragraph beginning with, "Of the 33 studies reviewed"?

A. Yes.

Q. Could you read me that paragraph as well, please?

A. Sure. Hold on. Just trying to move this

So in this CMS decision memo, they indicated that CMS reviewed 33 studies, right?

A. Yes.

Q. And CMS determined that the published results of those studies were conflicting; that some were positive and some were negative, right?

A. Yes. So Medicare looked at -- or CMS looked at the data with regard to the Medicare population, and as we know, it wasn't until 2014 when Medicare removed their across-the-board ban on gender affirm- -- on reimbursement for gender-affirming surgeries. So the issue that evidence is limited is not surprising when people have been denied medically necessary care. That's one issue.

Also our issue or our indication for surgery is for the medical condition of gender incongruence or gender dysphoria. So while psychometric studies may be one assessment or one review, in most of the studies, the overwhelming majority of the studies demonstrate improvement in health outcomes. This does not speak to the primary indication for surgery, which is treatment of gender incongruence or gender dysphoria.

Q. And why -- why is that? Why does it not speak to the provision of treatment for gender incongruence or gender dysphoria?

A. It does not specifically indicate that it

evaluates -- that this -- the 33 studies who look at gender -- I'm sorry. I'm getting an echo again.

MS. BEDARD: I am too.

MR. GONZALEZ-PAGAN: It might be me --

MS. BEDARD: Okay.

MR. GONZALEZ-PAGAN: -- it gave me a warning slow resources, I'll mute.

MS. BEDARD: I think it's yours.

THE WITNESS: This paragraph looks at psychometric studies, does not look at the effect on gender incongruence specifically, the alignment of one's body with their identity.

Q. (By Ms. Bedard) And what is your response, Dr. Schechter, to this decision memo?

A. Well, first of all, in plastic surgery, most of the surgeries we performed do not have a national coverage determination. So once again, it's completely unsurprising to me because most often patients, upon -- who we -- patients who we care for aren't or have conditions that aren't covered under national coverage determination, so this is very much consistent with the overall practice of plastic surgery.

Q. And do you reference this decision memo in your expert report in this case?

A. I do not believe so.

Q. And why not?

A. Well, as I just said, because it's entirely unsurprising and consistent with plastic surgery in general. Most of our procedures don't have national coverage determinations, so it's really the norm.

Q. And, Dr. Schechter, are you aware that in 2020, the Council for Choices in Health Care in Finland, which I understand is known as COHERE Finland -- are you aware that they adopted a recommendation on medical treatment methods for gender dysphoria in minors?

A. I've heard of -- of treatments or -- or treatment policies in Finland.

Q. Have you reviewed any of those treatment policies prior to today?

A. I have never received a full translated copy of the decision for their policy.

Q. And Dr. Schechter, are you aware that in 2021, Sweden's largest adolescent gender clinic announced that it was no longer going to prescribe puberty blockers or hormones to youths under 18 outside of clinical trials?

A. I've heard of issues in Sweden at -- at one hospital, yes. Again, I haven't seen the full translated policy.

Q. Dr. Schechter, I'm going to show you what has been marked as Defendant's Exhibit 6.

# Exhibit

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

# Standards of Care

## for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

## The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

## Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

# Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

# Exhibit

INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH
2022, VOL. 23, NO. S1, S1–S258
https://doi.org/10.1080/26895269.2022.2100644

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REPORT

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

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†Deceased.

## INTRODUCTION

### *Purpose and use of the Standards of Care*

The overall goal of the World Professional Association for Transgender Health's (WPATH) Standards of Care—Eighth Edition (SOC-8) is to provide clinical guidance to health care professionals to assist transgender and gender diverse (TGD) people in accessing safe and effective pathways to achieving lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological well-being, and self-fulfillment. This assistance may include but is not limited to hormonal and surgical treatments, voice and communication therapy, primary care, hair removal, reproductive and sexual health, and mental health care. Healthcare systems should provide medically necessary gender-affirming health care for TGD people: See Chapter 2—Global Applicability, Statement 2.1.

WPATH is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, public policy, and respect in transgender health. Founded in 1979, the organization currently has over 3,000 health care professionals, social scientists, and legal professionals, all of whom are engaged in clinical practice, research, education and advocacy that affects the lives of TGD people. WPATH envisions a world wherein people of all gender identities and gender expressions have access to evidence-based health care, social services, justice, and equality.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the Standards of Care (SOC) for the health of TGD people. The SOC-8 is based on the best available science and expert professional consensus. The SOC was initially developed in 1979, and the last version was published in 2012.

Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the SOC-8 to other parts of the world are necessary. Suggestions for approaches to cultural relativity and cultural competence are included in this version of the SOC.

WPATH recognizes that health is not only dependent upon high-quality clinical care but also relies on social and political climates that ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that advance tolerance and equity for gender diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these policy and legal changes. Thus, health care professionals who provide care to TGD people are called upon to advocate for improved access to safe and licensed gender-affirming care while respecting the autonomy of individuals.

While this is primarily a document for health care professionals, individuals, their families, and social institutions may also use the SOC-8 to understand how it can assist with promoting optimal health for members of this diverse population.

The SOC-8 has 18 chapters containing recommendations for health care professionals working with TGD people. Each of the recommendations is followed by explanatory text with relevant references. The recommendations for the initiation of gender-affirming medical and/or surgical treatments (GAMSTs) for adults and adolescents are contained in their respective chapters (see Assessment for Adults and Adolescent chapters). A summary of the recommendations and criteria for GAMST can be found in Appendix D.

### *Populations included in the SOC-8*

In this document, we use the phrase transgender and gender diverse (TGD) to be as broad and comprehensive as possible in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth. This includes people who have culturally specific and/or language-specific experiences, identities or expressions, which may or may not be based on or encompassed by Western conceptualizations of gender or the language used to describe it.

WPATH SOC-8 expands who is included under the TGD umbrella, and the settings in which these guidelines should be applied to promote equity and human rights.

Globally, TGD people encompass a diverse array of gender identities and expressions and have differing needs for gender-affirming care across their lifespan that is related to individual goals and characteristics, available health care resources, and sociocultural and political contexts. When standards of care are absent for certain groups this vacuum can result in a multiplicity of therapeutic approaches, including those that may be counterproductive or harmful. The SOC-8 includes recommendations to promote health and well-being for gender diverse groups that have often been neglected and/or marginalized, including nonbinary people, eunuch, and intersex individuals.

The SOC-8 continues to outline the appropriate care of TGD youth, which includes, when indicated, the use of puberty suppression and, when indicated, the use of gender-affirming hormones.

Worldwide, TGD people commonly experience transphobia, stigmatization, ignorance, and refusal of care when seeking health care services, which contributes to significant health disparities. TGD people often report having to teach their medical providers how to care for them due to the latter's insufficient knowledge and training. Intersectional forms of discrimination, social marginalization, and hate crimes against TGD people lead to minority stress. Minority stress is associated with mental health disparities exemplified by increased rates of depression, suicidality, and non-suicidal self-injuries than rates in cisgender populations. Professionals from every discipline should consider the marked vulnerability of many TGD people. WPATH urges health care authorities, policymakers, and medical societies to discourage and combat transphobia among health care professionals and ensure every effort is made to refer TGD people to professionals with experience and willingness to provide gender-affirming care.

### *Flexibility in the SOC*

The SOC-8 guidelines are intended to be flexible to meet the diverse health care needs of TGD people globally. While adaptable, they offer standards for promoting optimal health care and for guiding treatment of people experiencing gender incongruence. As in all previous versions of the SOC, the criteria put forth in this document for gender-affirming interventions are clinical guidelines; individual health care professionals and programs may modify them in consultation with the TGD person. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health care professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care—and the SOC—to evolve.

The SOC-8 supports the role of informed decision-making and the value of harm reduction approaches. In addition, this version of the SOC recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Health care professionals can use the SOC to help patients consider the full range of health services open to them in accordance with their clinical needs for gender expression.

### *Diversity versus Diagnosis*

The expression of gender characteristics, including identities, that are not stereotypically associated with one's sex assigned at birth is a common and a culturally diverse human phenomenon that should not be seen as inherently negative or pathological. Unfortunately, gender nonconformity and diversity in gender identity and expression is stigmatized in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress." Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make TGD individuals more vulnerable to developing mental health concerns such as anxiety and depression. In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and

neglect in one's interpersonal relationships, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being TGD.

While Gender Dysphoria (GD) is still considered a mental health condition in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5-TR) of the American Psychiatric Association. Gender incongruence is no longer seen as pathological or a mental disorder in the world health community. Gender Incongruence is recognized as a condition in the International Classification of Diseases and Related Health Problems, 11th Version of the World Health Organization (ICD-11). Because of historical and current stigma, TGD people can experience distress or dysphoria that may be addressed with various gender-affirming treatment options. While nomenclature is subject to change and new terminology and classifications may be adopted by various health organizations or administrative bodies, the medical necessity of treatment and care is clearly recognized for the many people who experience dissonance between their sex assigned at birth and their gender identity.

Not all societies, countries, or health care systems require a diagnosis for treatment. However, in some countries these diagnoses may facilitate access to medically necessary health care and can guide further research into effective treatments.

### *Health care services*

The goal of gender-affirming care is to partner with TGD people to holistically address their social, mental, and medical health needs and well-being while respectfully affirming their gender identity. Gender-affirming care supports TGD people across the lifespan—from the very first signs of gender incongruence in childhood through adulthood and into older age—as well as people with concerns and uncertainty about their gender identity, either prior to or after transition.

Transgender health care is greater than the sum of its parts, involving holistic inter- and multidisciplinary care between endocrinology, surgery, voice and communication, primary care, reproductive health, sexual health and mental health disciplines to support gender-affirming interventions as well as preventive care and chronic disease management. Gender-affirming interventions include puberty suppression, hormone therapy, and gender-affirming surgeries among others. It should be emphasized there is no 'one-size-fits-all' approach and TGD people may need to undergo all, some, or none of these interventions to support their gender affirmation. These guidelines encourage the use of a patient-centered care model for initiation of gender- affirming interventions and update many previous requirements to reduce barriers to care.

Ideally, communication and coordination of care should occur between providers to optimize outcomes and the timing of gender-affirming interventions centered on the patient's needs and desires and to minimize harm. In well-resourced settings, multidisciplinary consultation and care coordination is often routine, but many regions worldwide lack facilities dedicated to transgender care. For these regions, if possible, it is strongly recommended that individual care providers create a network to facilitate transgender health care that is not available locally.

Worldwide, TGD people are sometime forced by family members or religious communities to undergo conversion therapy. WPATH strongly recommends against any use of reparative or conversion therapy (see statements 6.5 and 18.10).

### *Health care settings*

The SOC-8 are guidelines rooted in the fundamental rights of TGD people that apply to all settings in which health care is provided regardless of an individual's social or medical circumstances. This includes a recommendation to apply the standards of care for TGD people who are incarcerated or living in other institutional settings.

Due to a lack of knowledgeable providers, untimely access, cost barriers and/or previous stigmatizing health care experiences, many TGD people take non-prescribed hormone therapy. This poses health risks associated with the use of unmonitored therapy in potentially supratherapeutic doses and the potential exposure to blood-borne illnesses if needles are shared for administration. However, for many individuals, it is the only means of acquiring medically necessary