EXHIBIT 129

Affidavit of Jamie Reed

Jamie Reed, being sworn, states:

1. I am an adult, I am under no mental incapacity or disability, and I know that the facts set forth in this affidavit are true because I have personal knowledge of them.

2. I hold a Bachelors of Arts in Cultural Anthropology from the University of Missouri St. Louis and a Master's of Science in Clinical Research Management from Washington University.

3. I have been working at Washington University for seven years. Initially at Washington University, I worked with HIV-positive patients, caring for many transgender individuals.

4. From 2018 until November 2022, I worked as a case manager at the Washington University Pediatric Transgender Center ("the Center") at St. Louis Children's Hospital. My duties included meeting with patients two to three days a week and completing the screening triage intake of patients who were referred to the Center.

5. I was offered and accepted the job as case manager for the Center because I had experience and expertise in working with transgender individuals and pediatric populations.

6. I took the job because I support trans rights and firmly believed I would be able to provide good care for children at the Center who are appropriate candidates to be receiving medical transition. Instead, I witnessed the Center cause permanent harm to many of the patients.

7. During my time at the Center, I personally witnessed Center healthcare providers lie to the public and to parents of patients about the treatment, or lack of treatment, and the effects of treatment provided to children at the Center. I witnessed staff at the Center provide puberty blockers and cross-sex hormones to children without complete informed parental consent and without an appropriate or accurate assessment of the needs of the child. I witnessed children experience shocking injuries from the medication the Center prescribed. And I saw the Center make no attempt or effort to track adverse outcomes of patients after they left the Center.

8. I raised concerns internally for years. But the doctors at the Center told me to stop raising these concerns. Last fall, the Center and the University Administration told me to "get with the program or get out." Because the Center was unwilling to make any changes in response to my concerns, I left the Center in November 2022 and accepted employment elsewhere within Washington University.

The Center Misleads the Public and Parents About What Care it Provides

9. The Center tells the public and parents that it provides multidisciplinary care. The Center says that you can come to the clinic and get transition hormones, if that is needed, but you can also get psychological and psychiatric care.

10. That is not true. The Center says that it has four practice areas: Endocrinology, Adolescent Medicine, Psychiatry, and Psychology. But the Center placed such strict limits on Psychiatry and Psychology that I was almost never allowed to schedule patients for those practices. Those practices were advertised as available, but most of the time they were not in fact available. Even when psychology was available, it was only to write

a letter of support for the medical transition treatments and never for ongoing therapy. And psychiatry was allowed, but only on an extremely limited basis.

11. Instead, I was required to schedule children for Endocrinology or Adolescent Medicine. Rather than provide psychiatric or psychological therapy, these practices (Endocrinology and Adolescent Medicine) would medically transition patients' gender. Endocrinology would prescribe puberty blockers and cross-sex hormones. Adolescent Medicine, which was for children after puberty, prescribed cross-sex hormones. Children were sent to one practice or the other based on their age and stage of puberty or prepuberty. There was no continuing or ongoing mental health evaluation or treatment required or provided by the Center for patients.

12. The Center also claims that it is a multidisciplinary team approach. The benefit of that approach is supposed to be that patients and their parents can feel more confident that all aspects of their care options have been considered and that their treatment plan has the input of all of the team. This Center did have members who would advocate for different options for the patients with concerning gender histories, concerning comorbidities, and attempt to raise the serious concerns regarding patient care. Patients and their parents, however, were never informed that the team did not have consensus on the treatment. The staff members on the team that were not universally in support of immediate cross sex hormones were not supported and were told to stop questioning the prevailing narrative of immediate cross sex hormones for all by the prescribing physicians. The administration at the university did not actively support the multidisciplinary model of care and did not provide any oversight, and instead the administration told those raising

concerns and questions to stop raising them. The public has been led to believe that a 'team' has considered their child's care and that the 'team' had ruled it best for the cross sex hormones to be initiated, but the public was not told the truth.

13. Medical transition practice for children and adolescents is based on a study from the Netherlands. That study, the "Dutch study," excluded participants who presented underlying mental health issues.

14. But nearly all children who came to the Center here presented with very serious mental health problems. Despite claiming to be a place where children could receive multidisciplinary care, the Center would not treat these mental health issues. Instead, children were automatically given puberty blockers or cross-sex hormones even though the Dutch study excluded persons experiencing mental health issues.

15. One patient came to the Center identifying as a "communist, attack helicopter, human, female, maybe non binary." The child was in very poor mental health and early on reported that they had no idea their gender identity. Rather than treat the child for their serious mental health problems, the Center put the child on cross-sex hormones and ignored the child's obvious mental health problems. The child subsequently reported that their mental health actually was worsening once they started the cross-sex hormones.

16. Most children who come into the Center were assigned female at birth. Nearly all of them have serious comorbidities including, autism, ADHD, depression, anxiety, PTSD, trauma histories, OCD, and serious eating disorders. Rather than treat these conditions, the doctors prescribe puberty blockers or cross-sex hormones. Some examples include:

a. Patient was in a residential sex offender treatment facility in state custody. Patient had previously sexually abused animals and had stated when they were released that they would do so again. There were questions about consistency of gender history. The Center did not treat this underlying condition, but instead started the patient on hormones.

b. Patient who has severe Obsessive Compulsive Disorder and had threatened to self-harm their genitals. The Patient did not have a trans or other incongruent gender identity. The patient was placed on hormones not even to treat any gender dysphoria but to chemically reduce libido and sexual arousal.

c. Patient had history of sexual abuse and notified the psychologist of this. It was even documented in the letter of support that the patient had concerns about the changes that testosterone would cause to their genitals. Instead of treating the underlying trauma the patient was started on testosterone.

d. Patient had serious mental health concerns and was prescribed mental health medications directly before being prescribed hormones, yet didn't take the mental health medications. Nevertheless, the patient was placed on hormones.

e. Patient had significant autism with unrealistic expectations, struggled to answer questions, and wanted questions to be provided ahead of time. Yet the patient was started on feminizing hormones.

f. Patient had a mental health history that included being violent. In addition, the parent was forcing the patient to cross dress. The patient was put on feminizing hormones.

17. These serious comorbidities were not treated by the Center, and doctors would prescribe puberty blockers or cross-sex hormones while patients were struggling with these comorbidities.

18. The psychiatry services were limited and could only serve patients who were 'not too severe,' which meant that many patients were being sent to the already overburdened emergency rooms for suicidal ideations, for self-harm, and for inpatient eating disorder treatment.

19. Many patients had depression and anxiety symptoms before starting cross sex hormones but it was only after starting these medications that they became more severe and required starting mental health medications. Many patients were also suspected of having autism and were not even required to be formally assessed for this condition before starting cross sex hormones.

20. Toward the end of my time at the Center, it became clear that many children coming to the Center had gender identities that were likely the result of social contagion. When I first started in 2018, the Center would receive between 5 and 10 calls a month. By the time I left, that number was more than 40 calls a month.

21. Social media is at least partly responsible for this large increase in children seeking gender transition treatment from the Center. Many children themselves would say that

they learned of their gender identities from TikTok. Children would arrive at the Center identifying not only as transgender, but also as having tic disorders (Tourette Syndrome) or multiple personality disorders (dissociative identity disorder). Doctors at the Center would ignore and dismiss as social contagion the claims about the tics and multiple personalities; but then those doctors would uncritically accept the children's statements about gender identity and place these children on puberty blockers and cross-sex hormones.

22. In one case, a child came into the Center identifying as "blind," even though the child could in fact see (after vision tests were performed). The child also identified as transgender. The Center dismissed the child's assertion about blindness as a somatization disorder but uncritically accepted the child's statement about gender and prescribed that child with drugs for medical transition without confirming the length or persistence of the condition. No concurrent mental health care was provided.

23. The Center tells the public and parents of patients that the point of puberty blockers is to give children time to figure out their gender identity. But the Center does not use puberty blockers for this purpose. Instead, the Center uses puberty blockers just until children are old enough to be put on cross-sex hormones. Doctors at the Center *always* prescribe cross-sex hormones for children who have been taking puberty blockers.

24. The Center also tells parents, children, and the public that puberty blockers are fully reversible. They are not. In children going through normal puberty, puberty blockers do

lasting damage. They cause children to go through menopause early, they reduce bone density, and they worsen mental health.

25. Doctors at the Center also have publicly claimed that they do not do any gender transition surgeries on minors. For example, last year Dr. Lewis and Dr. Garwood told the Missouri legislature, "at no point are surgeries on the table for anyone under 18" and also, "surgeries are not an option for anyone under 18 years of age." This was a lie. The Center regularly refers minors for gender transition surgery. The Center routinely gives out the names and contact information of surgeons to those under the age of 18. At least one gender transition surgery was performed by Dr. Allison Snyder-Warwick at St. Louis Children's Hospital in the last few years.

26. During medical visits with patients, I have personally heard providers report that they examined results of gender transition surgeries on minors. This includes examining the scar tissue and healing of sutures of breast surgeries.

27. At one point, Dr Chris Lewis and Dr Sarah Garwood reported that the Endocrine division leadership didn't want us referring minors for surgery. Yet, the Center continued referring minors for surgery. We claimed that the referrals were only "for educational purposes" for when children turned 18. But these referrals were in fact referrals. And patients we referred did in fact obtain transition surgeries as minors.

The Center Does Not Assess Children or Obtain Consent Before Placing them on Puberty Blockers and Hormones

28. The Center has four criteria that must be met before a child is placed on puberty blockers or cross-sex hormones. Although these criteria are supposed to enable the doctors to make case-by-case decisions, in practice everybody who meets these minimum criteria are prescribed cross-sex hormones or puberty blockers.

(1) Age

29. First, the child must be at a certain age or stage of puberty. Puberty stages are measured according to the Tanner Stage system.

30. The World Professional Association for Transgender Health ("WPATH") is an organization that drafts what it believes to be the best medical standard of care. WPATH is controversial. It is considered an activist organization, and its standards of care (or "guidelines") are much more lenient than the standards of care created by other organizations.

31. During the time, I was at the clinic, the WPATH Standard of Care Version 7 stated that children be at least 16 years old to start using cross-sex hormones. The Center deviated even from this most lenient standard and routinely prescribed cross-sex hormones to children as young as 13.

(2) Therapist Letter

32. The second criteria for a person to receive puberty blockers or cross-sex hormones is that the child have a letter of referral from a therapist. This requirement is supposed to ensure that two independent professional clinicians agree that medical transition is appropriate

before a child is given medication that causes irreversible change. But nothing about this process at the Center involved independent judgment.

33. The Center steered children toward therapists that the Center knew would refer these children back to the Center with a letter supporting medical transition. The Center had a list of therapists we would send children to, and a therapist could be on that list only if the Center "knew they would say yes" to medical transition. The Center had two in-house psychologists. They were Dr. Alex Maixner and Dr. Sarah Girresch-Ward as well as several outside therapists. Nobody on our list was required to be licensed in psychology or psychiatry.

34. If we did not receive a letter from an outside therapist that would let us prescribe puberty blockers or cross-sex hormones, we would then just send the patient to the in-house therapists: Dr. Alex Maixner and Dr. Sarah Girresch-Ward.

35. We also instructed the therapists what to say in their letters to us. I was instructed to draft and send language to the therapists for them to use in letters they then sent to us, and most therapists on the list had a template letter drafted by the Center that they could fill out to return to the Center.

36. The WPATH guidelines require a full psychological assessment of the child before recommending puberty blockers or cross-sex hormones. A full assessment typically requires 10 to 12 hours of time with the child. Therapists on the Center's list would send us letters after just 1-2 hours with a patient.

(3) Consent

37. The third criteria was parental consent. The Center routinely issued puberty blockers or cross-sex hormones without parental consent.

38. Doctors at the Center routinely pressured parents into "consenting" by pushing those parents, threatening them, and bullying them.

39. A common tactic was for doctors to tell the parent of a child assigned female at birth, "You can either have a living son or a dead daughter." The clinicians would tell parents of a child assigned male at birth, "You can either have a living daughter or dead son." The clinicians would say this to parents in front of their children. That introduced the idea of suicide to the children. The suicide assertion was also based on false statistics. The clinicians would also malign any parent that was not on board with medicalizing their children. They would speak disparaging of those parents.

40. I was present during the visits with many parents when this happened.

41. Parents would come into the Center wanting to discuss research and ask questions. The clinicians would dismiss the research that the parents had found and speak down to the parents.

42. When parents suggested that they wanted only therapy treatment, not cross-sex hormones or puberty blockers, doctors treated those parents as if the parents were abusive, uneducated, and willing to harm their own children.

43. These assertions about abuse and suicide were used as tools to stop parents from asking questions and to pressure parents into consenting.

44. The Center has a team culture of supporting the affirming parent and maligning the non-affirming parent.

45. Parents routinely said they felt they were being pressured to consent. Often parents would give "consent" but say they were only doing so because "you guys are going to do this anyway."

46. The Center was also intentionally blind about who had legal authority to consent. I wanted the Center to ask parents before the first visits about and request copies of custody agreements because custody agreements often spell out who among divorced parents must consent to medical procedures. I was told not to ask for custody agreements because "if we have the custody agreement, we have to follow it."

47. At one point, a child's father said no to cross-sex hormones. The child later arrived with an adult male (step parent) who said the child could receive cross-sex hormones. The Center did not check to see if this adult male was a legal parent or guardian who had any legal right to consent to treatment.

48. Other centers who prescribe cross-sex hormones and puberty blockers require parents to issue written consent. Several times, I asked the doctors to require written consent. They repeatedly refused. The entire time I worked there the Center had no written informed consent, and none that was provided to or signed by patients.

49. On several occasions, the doctors have continued prescribing medical transition even when a parent stated that they were revoking consent.

50. Before placing children on cross-sex hormones or puberty blockers, the Center also did not inform parents or children of the very serious side effects.

51. Doctors know that cross-sex hormones (immediately after puberty blockers) make children permanently sterile. The doctors did not share this information with parents or children.

52. For example, the Center nurse and I expressed concerns about a patient's intellectual function and ability to provide informed consent. The patient had a history of attending a school district for special education needs, couldn't identify where they lived, and couldn't explain what kind of legal documents (ID) they had. Our concerns were dismissed by the provider, and hormones were given. Patient then stated in a follow up appointment that they wanted to potentially have biological children and had not been seen by the fertility department. When the nurse and I asked the Center provider if they had covered the fertility questions, the Center provider became livid and adamantly disagreed that treatment could "potentially render the patient sterile."

53. Doctors knew that many of our former patients had stopped taking cross-sex hormones and were detransitioning. Doctors did not share this information with parents or children.

(4) Clinical Visit

54. The fourth criteria for prescribing cross-sex hormones or puberty blockers is that the child must have a one-hour consultation with Endocrinology or Adolescent Medicine.

55. This is little more than a box-checking exercise. One hour is not sufficient time to fully assess these children. I witnessed doctors on several occasions' mention that they did not have time in the meeting to discuss everything they wanted to discuss. The Center decided to give these children cross-sex hormones and puberty blockers anyway.

56. The WPATH standard of care in effect when I was at the Center required a full assessment of a child's situation. That typically cannot be done in less than 10 or 12 hours. The Center ignored this standard and gave children puberty blockers and cross-sex hormones after just two 1-hour visits (one with a therapist and one with a doctor at the Center).

Cross-Sex Hormones and Puberty Blockers Are Automatic

57. The Center tells the public and parents that it makes individualized decisions. That is not true. Doctors at the Center believe that every child who meets four basic criteria—age or puberty stage, therapist letter, parental consent, and a one-hour visit with a doctor—is a good candidate for irreversible medical intervention. When a child meets these four simple criteria, the doctors always decide to move forward with puberty blockers or cross-sex hormones. There were no objective medical test or criteria or individualized assessments.

58. The doctors do this even though many children coming to the Center are either experiencing social contagion or have very serious mental health issues that should be addressed first. The standard of care in studies says a center should resolve mental health

issues before sending children through medical transition. The Center is not following that standard.

59. Children come into the clinic using pronouns of inanimate objects like "mushroom," "rock," or "helicopter." Children come into the clinic saying they want hormones because they do not want to be gay. Children come in changing their identities on a day-to-day basis. Children come in under clear pressure by a parent to identify in a way inconsistent with the child's actual identity. In all these cases, the doctors decide to issue puberty blockers or cross-sex hormones.

60. In one case where a girl was placed on cross-sex hormones, I found out later that the girl desired cross-sex hormones only because she wanted to avoid becoming pregnant. There was no need for this girl to be prescribed cross-sex hormones. What she needed was basic sex education and maybe contraception. An adequate assessment before prescribing hormones would have revealed this fact. But because the doctors automatically prescribe cross-sex hormones or puberty blockers for children meeting the bare minimum criteria, this girl was unnecessarily placed on drugs that cause irreversible change to the body.

61. On another occasion, a patient had their breasts removed. Although the patient had turned 18, this surgery was performed at St. Louis Children's Hospital. Three months later, the patient contacted the surgeon and asked for their breasts to be "put back on." Had a requisite and adequate assessment been performed before the procedure, the doctors could have prevented this patient from undergoing irreversible surgical change.

62. In July 2022, the FDA issued a "black box warning" for puberty blockers, the strictest kind of warning the FDA can give a medication. It issued the warning following evidence in patients of brain swelling and loss of vision. Despite this warning, doctors at the Center continued their automatic practice of giving kids these drugs.

63. In more than four years working at the clinic, I witnessed only two examples of the doctors deciding not to prescribe cross-sex hormones or puberty blockers for a child who met the four basic criteria. Both cases involved patients with severe developmental delays. And in one of those cases, the doctors in fact said that they would prescribe cross-sex hormones or puberty blockers. The only reason the doctor did not prescribe those medications was that the parents would not agree to monitor administration of the medication.

64. In hundreds of other cases, Center doctors automatically issued puberty blockers or cross-sex hormones without considering the child's individual circumstances or mental health.

65. In one case, a psychiatrist called the Center's endocrinologist and explained that a child, who had already tried to commit suicide by threatening to jump off a roof, should not be given cross-sex hormones because the child was struggling with serious mental health issues. I witnessed the endocrinologist yell at the psychiatrist on the phone and speak down to this provider.

66. Because I was concerned that the doctors were giving cross-sex hormones and puberty blockers to children who should not be on them, I created a "red flag" list of children

where other staff and I had concerns. The doctors told me I had to stop raising these concerns. I was not allowed to maintain the red flag list after that.

67. During the time I was creating the red flag list, noting my concern that these children were not good candidates for permanent, irreversible medication treatment, the doctors would simply send these children to our in-house therapists. Those therapists would inevitably provide letters to the doctors, and then the doctors would say there can't be any concern over these children because another therapist was fine with prescribing puberty blockers or cross-sex hormones.

Children Are Experiencing Serious Harm, and the Center Will Not Do Any Follow Up

68. It is my professional opinion that cross-sex hormones and puberty blockers should only be used where the benefits outweigh the harms. These drugs have imposed and are imposing serious harms on the children who have been patients at the Center.

69. The doctors at the Center tell the public and tell parents of patients that puberty blockers are fully reversible. They really are not. They do lasting damage to the body.

70. I have seen puberty blockers worsen the mental health outcomes of children. Children who have not contemplated suicide before being put on puberty blockers have attempted suicide after. Puberty blockers force children to go through premature menopause. Puberty blockers decrease bone density.

71. Cross-sex hormones (after puberty blockers) in almost all cases will permanently sterilize children. Children on cross-sex hormones also experience substantial gain in blood

pressure, cholesterol, and weight. All of these have significant negative health effects. One patient started hormones and took one dose and then started having symptoms that they believed was indicative of a blood clot.

72. Children who take testosterone as a cross-sex hormone experience severe atrophy of vaginal tissue. One patient on cross-sex hormones called the Center after having sexual intercourse. The patient experienced vaginal lacerations so severe that the patient bled through a pad, through pants, and through a towel wrapped around their waist, and had to have the vaginal lacerations surgically treated in St. Louis Children's Hospital emergency room.

73. Most patients who have taken cross-sex hormones have experienced near-constant abdominal pain.

74. One doctor at the Center, Dr. Chris Lewis, is giving patients a drug called Bicalutamide. The drug has a legitimate use for treating pancreatic cancer, but it has a side effect of causing breasts to grow, and it can poison the liver. There are no clinical studies for using this drug for gender transitions, and there are no established standards of care for using this drug.

75. Because of these risks and the lack of scientific studies, other centers that do gender transitions will not use Bicalutamide. The adult center affiliated with Washington University will not use this medication for this reason. But the Center treating children does.

76. I know of at least one patient at the Center who was advised by the renal department to stop taking Bicalutamide because the child was experiencing liver damage. The child's parent reported this to the Center through the patient's online self-reporting medical chart (MyChart). The parent said they were not the type to sue, but "this could be a huge PR problem for you."

77. I have heard from patients given testosterone that their clitorises have grown so large that they now constantly chafe against the child's pants, causing them pain when they walk.

78. Despite telling the public and parents that the Center offers multidisciplinary, complete care, the Center makes no attempt to provide care after prescribing cross-sex hormones or puberty blockers. The Center does not provide mental health care or refer children for mental health care even though nearly all children who come to the Center are experiencing serious mental health issues. The Center does not require children to continue with mental health care after they prescribe cross-sex hormones or puberty blockers and even continues those medications when the patients directly report worsening mental health after initiating those medications. Some additional examples to those discussed above include:

a. Patient was on hormones and had decompensating mental health, outlandish name changes, self-diagnosis of multiple personalities (DID). The patient was continued on hormones.

b. Patient believed that they were being poisoned by the testosterone and stopped for a period. They had significant serious mental health issues, but were put back on testosterone.

c. Patient was brought to the Center at the age of 17 by a man who was not related to them yet with whom the patient had been living. They were started on hormones as soon as they turned 18. Patient's mental health subsequently got worse and it was disclosed in an Emergency Department visit that the man that had brought them to the clinic had been sexually and physically abusing them. The medical transition treatment was not stopped and the Center provider did not require trauma therapy, mental health care or an assessment.

d. Patient was in residential facility, in foster care. We convinced the staff that it was ok for patient to start testosterone. Patient ran away numerous times from facility and was having unprotected intercourse while on testosterone (which causes birth defects). The patient was continued on the testosterone.

e. Patient admits that they were started on testosterone when they were very young- age 11- and only because they were moving to a state (Florida) that the parent was concerned wouldn't prescribe later. Patient has desisted in male identity to a vague non binary with their own self-diagnosis of autism. Patient has changed their name numerous times and is clearly struggling with thoughts about desistence, even saying they wanted breast development. The Center continued the testosterone.

f. Patient who was on hormones was being evaluated for OCD and having somatization disorder with 'seizure' activity. Patient was kept on hormones.

g. Patient who was on hormones stopped taking their schizophrenia medications without consulting a doctor. Patient was continued on hormones.

h. Patient changed to non-binary identity, then changed preferred name and stated that their identity was shifting day to day. Patient was continued on hormones.

79. The Center also refuses to track complications and adverse events among its patients. There is no standard protocol for tracking patients who have received treatment. And the Center actively avoids trying to learn about these adverse events.

80. On my own initiative, I have tracked some patients on a case-by-case basis, but the Center discouraged me from doing so. I wanted to track the number of our patients who detransition. I wanted to track the number of our patients who have attempted suicide or committed suicide. The Center would not make either of these tracking systems a priority.

81. It is my belief that the Center does not track these outcomes because they do not want to have to report them to new patients and because they do not want to discontinue cross-sex hormone prescriptions. The Center never discontinues cross-sex hormones, no matter the outcome.

82. In just a two-year period from 2020 to 2022, the Center initiated medical transition for more than 600 children. About 74% of these children were assigned female at birth. These procedures were paid for mostly by private insurance, but during this time, it is my understanding that the Center also billed the cost for these procedures to state and federal publicly funded insurance programs.

83. I have personally witnessed staff say they were uncomfortable with how the Center has told them they have to code bills sent to publicly funded insurance programs. I have witnessed staff directly ask the providers for clarification on billing questions and have providers dismiss the concerns and work to have the patients have this care covered as the priority.

84. I have personally witnessed staff report that they were aware that patients had been coded incorrectly (coding for precocious puberty for puberty blockers when the child does not in fact have that condition).

85. Based on my observation that the Center has prescribed puberty blockers or cross-sex hormones hundreds of times where they should not have, the Center is billing private and public insurance for unnecessary procedures.

86. Even when it is clear that the cross-sex hormones or puberty blockers are harming the child, the Center continues that treatment and continues billing public and private insurance.

Jamie Reed

2/7/2023
Date

State of Missouri)
)
City of St. Louis)

On this day, Jamie Reed personally appeared before me, a notary public in Missouri. I know her to be the individual who signed this document, and she acknowledged to me that she signed it for the purposes stated in it.

Katie R Keeven
Notary Public

2/7/2023
Date

KATIE R. KEEVEN
Notary Public, Notary Seal
State of Missouri
St. Louis County
Commission # 21767059
My Commission Expires 11-15-2025

EXHIBIT 130

THE FREEPRESS

FOR FREE PEOPLE

Jamie Reed at home in Missouri. (Theo R. Welling.)

I Thought I Was Saving Trans Kids. Now I'm Blowing the Whistle.

There are more than 100 pediatric gender clinics across the U.S. I worked at one. What's happening to children is morally and medically appalling.

By Jamie Reed
February 9, 2023

I am a 42-year-old St. Louis native, a queer woman, and politically to the left of Bernie Sanders. My worldview has deeply shaped my career. I have spent my professional life providing counseling to vulnerable populations: children in foster care, sexual minorities, the poor.

For almost four years, I worked at The Washington University School of Medicine Division of Infectious Diseases with teens and young adults who were HIV positive. Many of them were trans or otherwise gender nonconforming, and I could relate: Through childhood and adolescence, I did a lot of gender questioning myself. I'm now married to a transman, and together we are raising my two biological children from a previous marriage and three foster children we hope to adopt.

All that led me to a job in 2018 as a case manager at The Washington University Transgender Center at St. Louis Children's Hospital, which had been established a year earlier.

The center's working assumption was that the earlier you treat kids with gender dysphoria, the more anguish you can prevent later on. This premise was shared by the center's doctors and therapists. Given their expertise, I assumed that abundant evidence backed this consensus.

During the four years I worked at the clinic as a case manager—I was responsible for patient intake and oversight—around a thousand distressed young people came through our doors. The majority of them received hormone prescriptions that can have life-altering consequences—including sterility.

I left the clinic in November of last year because I could no longer participate in what was happening there. By the time I departed, I was certain that the way the American medical system is treating these patients is the opposite of the promise we make to "do no harm." Instead, we are permanently harming the vulnerable patients in our care.

Today I am speaking out. I am doing so knowing how toxic the public conversation is around this highly contentious issue—and the ways that my testimony might be misused. I am doing so knowing that I am putting myself at serious personal and professional risk.

Almost everyone in my life advised me to keep my head down. But I cannot in good conscience do so. Because what is happening to scores of children is far more important than my comfort. And what is happening to them is morally and medically appalling.

Reed in her office. (Theo R. Welling).

The Floodgates Open

Soon after my arrival at the Transgender Center, I was struck by the lack of formal protocols for treatment. The center's physician co-directors were essentially the sole authority.

At first, the patient population was tipped toward what used to be the "traditional" instance of a child with gender dysphoria: a boy, often quite young, who wanted to present as—who wanted to be—a girl.

Until 2015 or so, a very small number of these boys comprised the population of pediatric gender dysphoria cases. Then, across the Western world, there began to be a dramatic increase in a new population: Teenage girls, many with no previous history of gender distress, suddenly declared

they were transgender and demanded immediate treatment with testosterone.

I certainly saw this at the center. One of my jobs was to do intake for new patients and their families. When I started there were probably 10 such calls a month. When I left there were 50, and about 70 percent of the new patients were girls. Sometimes clusters of girls arrived from the same high school.

This concerned me, but didn't feel I was in the position to sound some kind of alarm back then. There was a team of about eight of us, and only one other person brought up the kinds of questions I had. Anyone who raised doubts ran the risk of being called a transphobe.

The girls who came to us had many comorbidities: depression, anxiety, ADHD, eating disorders, obesity. Many were diagnosed with autism, or had autism-like symptoms. A report last year on a British pediatric transgender center found that about one-third of the patients referred there were on the autism spectrum.

Frequently, our patients declared they had disorders that no one believed they had. We had patients who said they had Tourette syndrome (but they didn't); that they had tic disorders (but they didn't); that they had multiple personalities (but they didn't).

The doctors privately recognized these false self-diagnoses as a manifestation of social contagion. They even acknowledged that suicide has an element of social contagion. But when I said the clusters of girls streaming into our service looked as if their gender issues might be a

manifestation of social contagion, the doctors said gender identity reflected something innate.

To begin transitioning, the girls needed a letter of support from a therapist—usually one we recommended—who they had to see only once or twice for the green light. To make it more efficient for the therapists, we offered them a template for how to write a letter in support of transition. The next stop was a single visit to the endocrinologist for a testosterone prescription.

That's all it took.

When a female takes testosterone, the profound and permanent effects of the hormone can be seen in a matter of months. Voices drop, beards sprout, body fat is redistributed. Sexual interest explodes, aggression increases, and mood can be unpredictable. Our patients were told about some side effects, including sterility. But after working at the center, I came to believe that teenagers are simply not capable of fully grasping what it means to make the decision to become infertile while still a minor.

Side Effects

Many encounters with patients emphasized to me how little these young people understood the profound impacts changing gender would have on their bodies and minds. But the center downplayed the negative consequences, and emphasized the need for transition. As the center's website said, "Left untreated, gender dysphoria has any number of consequences, from self-harm to suicide. But when you take away the gender dysphoria by allowing a child to be who he or she is, we're noticing

that goes away. The studies we have show these kids often wind up functioning psychosocially as well as or better than their peers."

There are no reliable studies showing this. Indeed, the experiences of many of the center's patients prove how false these assertions are.

Here's an example. On Friday, May 1, 2020, a colleague emailed me about a 15-year-old male patient: "Oh dear. I am concerned that [the patient] does not understand what Bicalutamide does." I responded: "I don't think that we start anything honestly right now."

From: [redacted]>
Sent: Friday, May 1, 2020 11:58 AM
To: Reed, Jamie [redacted]
Subject: Re: Letter

Oh dear. I am concerned that [redacted] does not understand what Bicalutamide does. It's not
just a blocker, it will cause breast development.... the family seemed certain that was their first
choice of therapy to start with. The statement made in the letter that: "At times it seems scary,
so she wants to move slowly, but eventually sees herself as being on estrogen," is concerning....
and the wrote name at the end....

What do we do now?

From: Reed, Jamie
Sent: Friday, May 1, 2020 12:12 PM
To: [redacted]
Subject: RE: Letter

I don't think that we start anything honestly right now.
I think that this is a letter saying wait more time and yes I think that [redacted] does not understand what
Bicalutamide does.

Bicalutamide is a medication used to treat metastatic prostate cancer, and one of its side effects is that it feminizes the bodies of men who take it,

including the appearance of breasts. The center prescribed this cancer drug as a puberty blocker and feminizing agent for boys. As with most cancer drugs, bicalutamide has a long list of side effects, and this patient experienced one of them: liver toxicity. He was sent to another unit of the hospital for evaluation and immediately taken off the drug. Afterward, his mother sent an electronic message to the Transgender Center saying that we were lucky her family was not the type to sue.

How little patients understood what they were getting into was illustrated by a call we received at the center in 2020 from a 17-year-old biological female patient who was on testosterone. She said she was bleeding from the vagina. In less than an hour she had soaked through an extra heavy pad, her jeans, and a towel she had wrapped around her waist. The nurse at the center told her to go to the emergency room right away.

We found out later this girl had had intercourse, and because testosterone thins the vaginal tissues, her vaginal canal had ripped open. She had to be sedated and given surgery to repair the damage. She wasn't the only vaginal laceration case we heard about.

Other girls were disturbed by the effects of testosterone on their clitoris, which enlarges and grows into what looks like a microphallus, or a tiny penis. I counseled one patient whose enlarged clitoris now extended below her vulva, and it chafed and rubbed painfully in her jeans. I advised her to get the kind of compression undergarments worn by biological men who dress to pass as female. At the end of the call I thought to myself, "Wow, we hurt this kid."

There are rare conditions in which babies are born with atypical genitalia —cases that call for sophisticated care and compassion. But clinics like the

one where I worked are *creating* a whole cohort of kids with atypical genitals—and most of these teens haven't even had sex yet. They had no idea who they were going to be as adults. Yet all it took for them to permanently transform themselves was one or two short conversations with a therapist.

Being put on powerful doses of testosterone or estrogen—enough to try to trick your body into mimicking the opposite sex—-affects the rest of the body. I doubt that any parent who's ever consented to give their kid testosterone (a lifelong treatment) knows that they're also possibly signing their kid up for blood pressure medication, cholesterol medication, and perhaps sleep apnea and diabetes.

But sometimes the parents' understanding of what they had agreed to do to their children came forcefully:

On Thu, Jun 9, 2022 at 11:20 AM [redacted]> wrote:
Hello,

Please be advised that I'm revoking my consent for this course of medical treatment. Grades
have dropped, there's been an in-patient behavioral health visit and now he's on 5 different
medications. Lexipro, Trazadone, Buspar, etc.

[redacted] is a shell of his former self riddled with anxiety. Who knows if it's because the hormone
blockers or the other medications. I revoke my consent. I want the hormone blocker removed.
Thank you.

Neglected and Mentally Ill Patients

Besides teenage girls, another new group was referred to us: young people from the inpatient psychiatric unit, or the emergency department, of St. Louis Children's Hospital. The mental health of these kids was deeply concerning—there were diagnoses like schizophrenia, PTSD, bipolar disorder, and more. Often they were already on a fistful of pharmaceuticals.

This was tragic, but unsurprising given the profound trauma some had been through. Yet no matter how much suffering or pain a child had endured, or how little treatment and love they had received, our doctors viewed gender transition—even with all the expense and hardship it entailed—as the solution.

Some weeks it felt as though almost our entire caseload was nothing but disturbed young people.

For example, one teenager came to us in the summer of 2022 when he was 17 years old and living in a lockdown facility because he had been sexually abusing dogs. He'd had an awful childhood: His mother was a drug addict, his father was imprisoned, and he grew up in foster care. Whatever treatment he may have been getting, it wasn't working.

During our intake I learned from another caseworker that when he got out, he planned to reoffend because he believed the dogs had willingly submitted.

Somewhere along the way, he expressed a desire to become female, so he ended up being seen at our center. From there, he went to a psychologist at the hospital who was known to approve virtually everyone seeking

transition. Then our doctor recommended feminizing hormones. At the time, I wondered if this was being done as a form of chemical castration.

That same thought came up again with another case. This one was in spring of 2022 and concerned a young man who had intense obsessive-compulsive disorder that manifested as a desire to cut off his penis after he masturbated. This patient expressed no gender dysphoria, but he got hormones, too. I asked the doctor what protocol he was following, but I never got a straight answer.

In Loco Parentis

Another disturbing aspect of the center was its lack of regard for the rights of parents—and the extent to which doctors saw themselves as more informed decision-makers over the fate of these children.

In Missouri, only one parent's consent is required for treatment of their child. But when there was a dispute between the parents, it seemed the center always took the side of the affirming parent.

My concerns about this approach to dissenting parents grew in 2019 when one of our doctors actually testified in a custody hearing against a father who opposed a mother's wish to start their *11-year-old daughter* on puberty blockers.

I had done the original intake call, and I found the mother quite disturbing. She and the father were getting divorced, and the mother described the daughter as "kind of a tomboy." So now the mother was convinced her child was trans. But when I asked if her daughter had adopted a boy's name, if she was distressed about her body, if she was

saying she felt like a boy, the mother said no. I explained the girl just didn't meet the criteria for an evaluation.

Then a month later, the mother called back and said her daughter now used a boy's name, was in distress over her body, and wanted to transition. This time the mom and daughter were given an appointment. Our providers decided the girl was trans and prescribed a puberty blocker to prevent her normal development.

The father adamantly disagreed, said this was all coming from the mother, and a custody battle ensued. After the hearing where our doctor testified in favor of transition, the judge sided with the mother.

From: Reed, Jamie
Sent: Wednesday, June 23, 2021 10:55 AM
To: [redacted]
Subject: RE: Request Guidance

Thanks, I was not having any issue with interpreting or understanding the elements that she commented
on below. I was looking at the bigger question about how consent is now being determined.

My concerns are that the Judge is essentially removing the element of parental consent and placing it in
our hands.

The Judge could have awarded the medical decision making to the Dad or awarded the legal custody to
the Dad.
Instead the Judge put in the center's hands the decision making for medical transition. And this is a
patient who is not yet 16.

-Jamie

'I Want My Breasts Back'

Because I was the main intake person, I had the broadest perspective on our existing and prospective patients. In 2019, a new group of people

appeared on my radar: desisters and detransitioners. Desisters choose not to go through with a transition. Detransitioners are transgender people who decide to return to their birth gender.

The one colleague with whom I was able to share my concerns agreed with me that we should be tracking desistance and detransition. We thought the doctors would want to collect and understand this data in order to figure out what they had missed.

We were wrong. One doctor wondered aloud why he would spend time on someone who was no longer his patient.

But we created a document anyway and called it the Red Flag list. It was an Excel spreadsheet that tracked the kind of patients that kept my colleague and me up at night.

One of the saddest cases of detransition I witnessed was a teenage girl, who, like so many of our patients, came from an unstable family, was in an uncertain living situation, and had a history of drug use. The overwhelming majority of our patients are white, but this girl was black. She was put on hormones at the center when she was around 16. When she was 18, she went in for a double mastectomy, what's known as "top surgery."

Three months later she called the surgeon's office to say she was going back to her birth name and that her pronouns were "she" and "her." Heartbreakingly, she told the nurse, "I want my breasts back." The surgeon's office contacted our office because they didn't know what to say to this girl.

My colleague and I said that we would reach out. It took a while to track her down, and when we did we made sure that she was in decent mental health, that she was not actively suicidal, that she was not using substances. The last I heard, she was pregnant. Of course, she'll never be able to breastfeed her child.

'Get On Board, Or Get Out'

My concerns about what was going on at the center started to overtake my life. By spring 2020, I felt a medical and moral obligation to do something. So I spoke up in the office, and sent plenty of emails.

Here's just one example: On January 6, 2022, I received an email from a staff therapist asking me for help with a case of a 16-year-old transgender male living in another state. "Parents are open to having patient see a therapist but are not supportive of gender and patient does not want parents to be aware of gender identity. I am having a challenging time finding a gender affirming therapist."

I replied:

"I do not ethically agree with linking a minor patient to a therapist who would be gender affirming with gender as a focus of their work without that being discussed with the parents and the parent agreeing to that kind of care."

From: Reed, Jamie
Sent: Thursday, January 6, 2022 12:52 PM
To: [redacted]
Subject: RE: therapy resource
Attachments: [redacted]Mental Health Providers Updated Version 11_2021.docx

This might be best discussed on a call, but I do not ethically agree with linking a minor patient to a therapist who would be gender affirming with gender as a focus of their work without that being discussed with the parent and the parent agreeing to that kind of care.

Within the center we do not link minor patients to gender affirming care without the consent of at least one parent or legal guardian.

With that said we have a list of therapist for[redacted]attached.

Sincerely,

In all my years at the Washington University School of Medicine, I had received solidly positive performance reviews. But in 2021, that changed. I got a below-average mark for my "Judgment" and "Working Relationships/Cooperative Spirit." Although I was described as "responsible, conscientious, hard-working and productive" the evaluation also noted: "At times Jamie responds poorly to direction from management with defensiveness and hostility."

Things came to a head at a half-day retreat in summer of 2022. In front of the team, the doctors said that my colleague and I had to stop questioning the "medicine and the science" as well as their authority. Then an administrator told us we had to "Get on board, or get out." It became clear that the purpose of the retreat was to deliver these messages to us.

The Washington University system provides a generous college tuition payment program for long-standing employees. I live by my paycheck and

have no money to put aside for five college tuitions for my kids. I had to keep my job. I also feel a lot of loyalty to Washington University.

But I decided then and there that I had to get out of the Transgender Center, and to do so, I had to keep my head down and improve my next performance review.

I managed to get a decent evaluation, and I landed a job conducting research in another part of The Washington University School of Medicine. I gave my notice and left the Transgender Center in November of 2022.

(Theo R. Welling)

What I Want to See Happen

For a couple of weeks, I tried to put everything behind me and settled into my new job as a clinical research coordinator, managing studies regarding children undergoing bone marrow transplants.

Then I came across comments from Dr. Rachel Levine, a transgender woman who is a high official at the federal Department of Health and Human Services. The article read: "Levine, the U.S. assistant secretary for health, said that clinics are proceeding carefully and that no American children are receiving drugs or hormones for gender dysphoria who shouldn't."

I felt stunned and sickened. It wasn't true. And I know that from deep first-hand experience.

So I started writing down everything I could about my experience at the Transgender Center. Two weeks ago, I brought my concerns and documents to the attention of Missouri's attorney general. He is a Republican. I am a progressive. But the safety of children should not be a matter for our culture wars.

Click here to read Jamie Reed's letter to the Missouri AG.

Given the secrecy and lack of rigorous standards that characterize youth gender transition across the country, I believe that to ensure the safety of American children, we need a moratorium on the hormonal and surgical treatment of young people with gender dysphoria.

In the past 15 years, according to Reuters, the U.S. has gone from having no pediatric gender clinics to more than 100. A thorough analysis should

be undertaken to find out what has been done to their patients and why—and what the long-term consequences are.

There is a clear path for us to follow. Just last year England shut down the Tavistock Centre, the only youth gender clinic in the country, after an investigation revealed shoddy practices and poor patient treatment. Sweden and Finland, too, have investigated pediatric transition and greatly curbed the practice, finding there is insufficient evidence of help, and danger of great harm.

Some critics describe the kind of treatment offered at places like the Transgender Center where I worked as a kind of national experiment. But that's wrong.

Experiments are supposed to be carefully designed. Hypotheses are supposed to be tested ethically. The doctors I worked alongside at the Transgender Center said frequently about the treatment of our patients: "We are building the plane while we are flying it." No one should be a passenger on that kind of aircraft.

Tonight at 6:00 p.m. PST we are hosting a conversation with Jamie Reed. To join us (event details will be sent later today) become a subscriber now:

Thursday, February 9, 2023

EXHIBIT 131

THE FREE PRESS

FOR FREE PEOPLE

Monday, February 5, 2024

9:24 AM

Tamara Pietzke outside her home in Tacoma, Washington, on January 25, 2024. (Portraits by David Ryder for The Free Press)

I Was Told to Approve All Teen Gender Transitions. I Refused.

For six years I worked at a hospital that said all teenagers with gender dysphoria must be affirmed. I quit my job to blow the whistle.

By Tamara Pietzke
February 5, 2024

Perhaps you read the long investigation about detransitioners published in this weekend's New York Times. It is comprehensive and sober and we highly recommend it.

It's also a piece we are confident would never have made it into the paper were it not for independent publications like ours taking the journalistic

and reputational risk over the past few years to pursue the subject of "gender-affirming" care and the subsequent harms inflicted on vulnerable young people. In this, we are proud to stand alongside Hannah Barnes, Lisa Selin Davis, Hadley Freeman, Helen Joyce, Leor Sapir, Abigail Shrier, Jesse Singal, Kathleen Stock, Quillette and others, who took the arrows so that the mainstream press could finally start reporting on what's really happening,

What is immensely clear is that individual testimonies—whistleblower accounts like those we've published by Jamie Reed and Dr. Riittakerttu Kaltiala—have made the change we are now beginning to see.

And that change is now impossible to deny: witness the arrival of lawsuits from young people who say they have suffered the consequences of these life-altering treatments.

Today, therapist Tamara Pietzke adds her voice to those of our other whistleblowers, and tells how she could no longer go along with the pressure to transition her patients.

✚ ✚ ✚

I know from firsthand experience what hard times are. Though I had a happy childhood, raised as the middle child by working-class parents in Washington State, my mom died of ovarian cancer when I was 22.

After that, my family fell apart. I felt lost and alone.

I decided to become a therapist because I didn't want anyone to go through what I had, feeling like no one on this planet cares about them. At least they can say their therapist does.

I earned my master's in social work from the University of Washington in 2012, and I have worked as a therapist for over a decade in the Puget Sound area. Most recently, I was employed by MultiCare, one of the largest hospital systems in the state.

For the six years I was there, I worked with hundreds of clients. But in mid-January, I left my job because of what I will go on to describe.

The therapeutic relationship is a special one. We are the original "safe space," where people are able to explore their darker feelings and painful experiences. The job of the therapist is to guide a patient to self-understanding and sound mental health. This is a process that requires

careful assessment and time, not snap judgments and confirmation of a patient's worldview.

But in the past year I noticed a concerning new trend in my field. I was getting the message from my supervisors that when a young person I was seeing expressed discomfort with their gender—the diagnostic term is *gender dysphoria*—I should throw out all my training. No matter the patient's history or other mental health conditions that could be complicating the situation, I was simply to affirm that the patient was transgender, and even approve the start of a medical transition.

I believe this rise of "affirmative care" for young people with gender dysphoria challenges the very fundamentals of what therapy is supposed to provide.

I am a 36-year-old single mother of three young kids all under the age of six. I am terrified of speaking out, but that fear pales in comparison to my strong belief that we can no longer medicalize youth and cause them potentially irreversible harm. The three patients I describe below explain why I am taking the risk of coming forward.

✚ ✚ ✚

Last spring, I started seeing a new client, who at 13 years old had one of the most extreme and heartbreaking life stories I've ever heard. (For the sake of clarity, I am referring to all patients by their biological sex.)

My patient's mother has bipolar disorder and was so abusive to my patient that the mother was given a restraining order. My patient was sexually assaulted by an older cousin, by one of her mother's boyfriends, and also once at school by a classmate. Her diagnoses include depression, PTSD, anxiety, intermittent explosive disorder, and autism. She is being raised by her mother's ex-boyfriend (not the one who assaulted her).

The year before I started seeing her, when she was 11, she was hospitalized for talking about committing suicide. Later that year, a pediatrician diagnosed her with gender dysphoria after she started to question her gender. The pediatrician referred her to Mary Bridge Children's Gender Health Clinic, whose clinicians recommended she take medicine to suppress her periods and that she think about starting testosterone.

Mary Bridge, MultiCare's pediatric hospital, runs the gender clinic for minors and employs nurses, social workers, dietitians, and

endocrinologists, who provide gender-affirming care, which includes prescribing hormones to young patients who question their gender. In order to get that prescription, patients first need a recommendation letter from a therapist. Because Mary Bridge is a part of MultiCare, their patients were often referred to therapists like me who were in their system.

In an April 2022 blog post, a Mary Bridge social worker wrote that the gender clinic's referrals increased from less than five a month in 2019 to more than 35 a month in 2022. In May 2022, the clinic received a $100,000 donation from Patient-Centered Outcomes Research Institute "to study health care disparities" in transgender youth.

The clinic operates in Washington, one of the states with some of the most lenient legislation on gender transition for youth. In May 2023, the state legislature passed a law guaranteeing that youth seeking a medical gender transition can stay at Washington shelters—and the shelters are not required to notify their parents.

Because of my patient's autism, it was difficult for us to engage in introspective conversations. During our first visit, she came over to my desk to show me extremely sadistic and graphic pornographic videos on her phone. She stood next to me, hunched over, hyper-fixated on the videos as she rocked back and forth. She told me during one session that she watched horror and porn movies growing up because they were the only ones available in her house.

She showed up to our therapy sessions in disheveled, loose-fitting clothes, her hair greasy, her eyes staring down at the ground, her face covered by a Covid mask almost like a protective layer. She went by a boy's name, but she never raised gender dysphoria with me directly—though one time she told me she would get mad at the sound of her own voice because "it sounds too girly." When I asked her how she felt about an upcoming appointment at the gender clinic, she told me she didn't know she had one.

In between scrolling through videos on her phone, she told me how she cried every night in bed and felt "insane." She described a time when she was eight years old and her mother nearly killed her sister. She remembered her mother being taken away. At times, she would "age-regress," she told me, by watching *Teletubbies* and sucking on pacifiers.

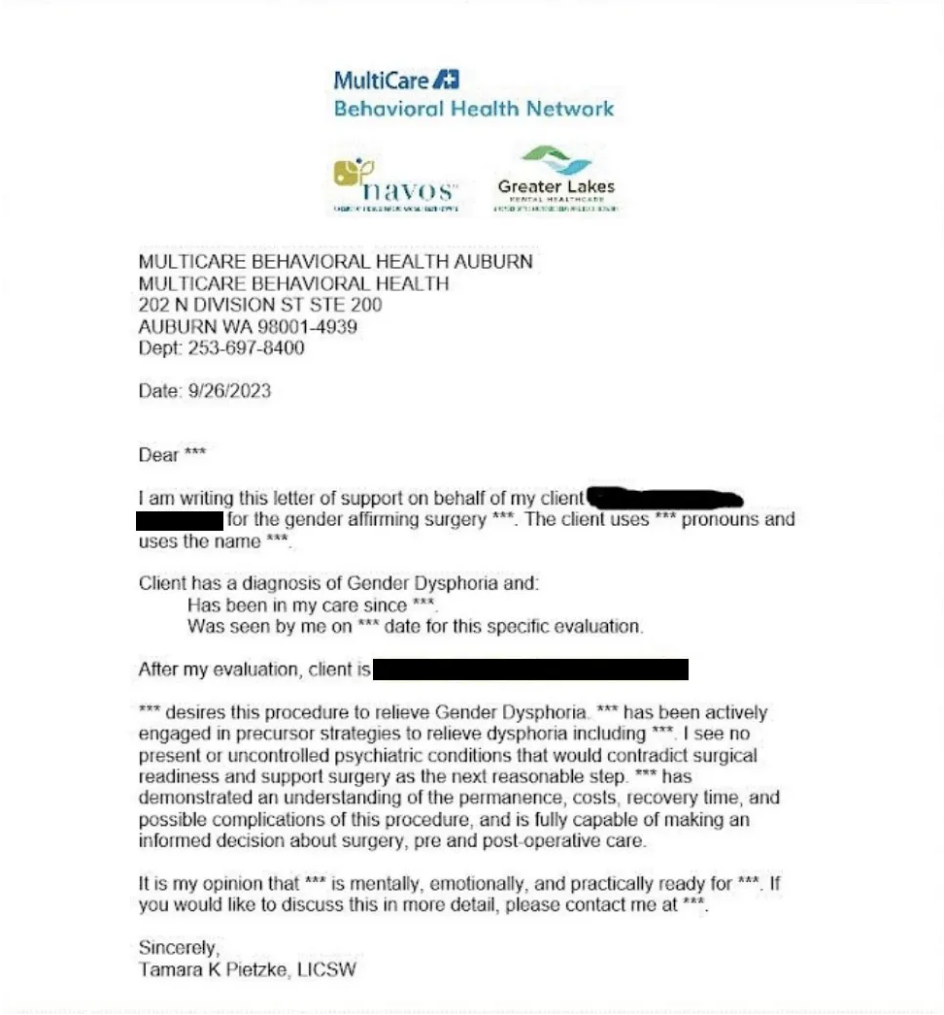
When she started seeing me, she had recently threatened to "blow up the school," which resulted in her expulsion.

I knew I couldn't solve all of her problems, or make her feel better in just a few therapy sessions. My initial goal was to make her feel comfortable opening up to me, to make the therapy room a place where she was heard and felt safe. I also wanted to try to protect her from falling prey to outside influences from social media, her peers, or even the adults in her life.

With a patient like this, with so many intersecting and overwhelming problems, and with such a tragic history of abuse, it took our first three sessions to get her feeling more comfortable to even talk to me, and to understand the dimensions of her problems. But when I called her guardian last fall to schedule a fourth appointment, he asked me to write her a letter of recommendation for cross-sex hormone treatment. That is, at age 13, she was to start taking testosterone. Such a letter from me begins the process of medical transition for a patient.

In Washington State, that's all it takes—a few visits with a therapist and a letter, often written using a template provided by one's superiors—for minors to undergo the irreversible treatments that patients must take for a lifetime.

I was scared for this patient. She had so many overlapping problems that needed addressing it seemed like malpractice to abruptly begin her on a medical gender transition that could quickly produce permanent changes.



MultiCare
Behavioral Health Network

navos Greater Lakes

MULTICARE BEHAVIORAL HEALTH AUBURN
MULTICARE BEHAVIORAL HEALTH
202 N DIVISION ST STE 200
AUBURN WA 98001-4939
Dept: 253-697-8400

Date: 9/26/2023

Dear ***

I am writing this letter of support on behalf of my client [redacted] for the gender affirming surgery ***. The client uses *** pronouns and uses the name ***.

Client has a diagnosis of Gender Dysphoria and:
Has been in my care since ***.
Was seen by me on *** date for this specific evaluation.

After my evaluation, client is [redacted]

*** desires this procedure to relieve Gender Dysphoria. *** has been actively engaged in precursor strategies to relieve dysphoria including ***. I see no present or uncontrolled psychiatric conditions that would contradict surgical readiness and support surgery as the next reasonable step. *** has demonstrated an understanding of the permanence, costs, recovery time, and possible complications of this procedure, and is fully capable of making an informed decision about surgery, pre and post-operative care.

It is my opinion that *** is mentally, emotionally, and practically ready for ***. If you would like to discuss this in more detail, please contact me at ***.

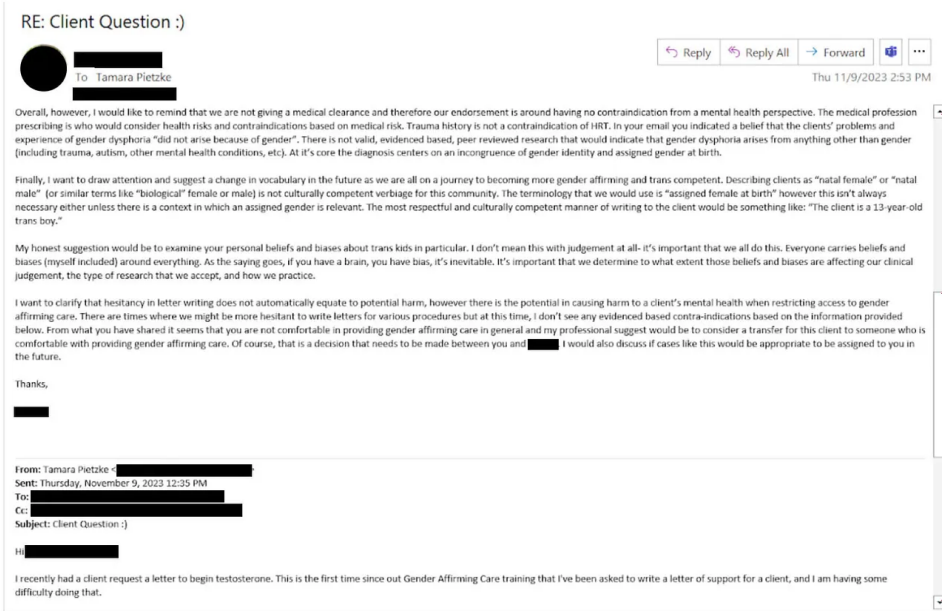
Sincerely,
Tamara K Pietzke, LICSW

The MultiCare recommendation letter Tamara was given for approving the medical treatment of minors with gender dysphoria.

I emailed a program manager in my department at MultiCare and outlined my concerns. She wrote back that my client's trauma history has no bearing on whether or not she should receive hormone treatment.

"There is not valid, evidenced-based, peer-reviewed research that would indicate that gender dysphoria arises from anything other than gender (including trauma, autism, other mental health conditions, etc.)," she wrote.

She also warned that "there is the potential in causing harm to a client's mental health when restricting access to gender-affirming care" and suggested I "examine [my] personal beliefs and biases about trans kids."



RE: Client Question :)

[redacted]
To Tamara Pietzke
[redacted]

Reply | Reply All | Forward

Thu 11/9/2023 2:53 PM

Overall, however, I would like to remind that we are not giving a medical clearance and therefore our endorsement is around having no contraindication from a mental health perspective. The medical profession prescribing is who would consider health risks and contraindications based on medical risk. Trauma history is not a contraindication of HRT. In your email you indicated a belief that the clients' problems and experience of gender dysphoria "did not arise because of gender". There is not valid, evidenced based, peer reviewed research that would indicate that gender dysphoria arises from anything other than gender (including trauma, autism, other mental health conditions, etc). At it's core the diagnosis centers on an incongruence of gender identity and assigned gender at birth.

Finally, I want to draw attention and suggest a change in vocabulary in the future as we are all on a journey to becoming more gender affirming and trans competent. Describing clients as "natal female" or "natal male" (or similar terms like "biological" female or male) is not culturally competent verbiage for this community. The terminology that we would use is "assigned female at birth" however this isn't always necessary either unless there is a context in which an assigned gender is relevant. The most respectful and culturally competent manner of writing to the client would be something like: "The client is a 13-year-old trans boy."

My honest suggestion would be to examine your personal beliefs and biases about trans kids in particular. I don't mean this with judgement at all- it's important that we all do this. Everyone carries beliefs and biases (myself included) around everything. As the saying goes, if you have a brain, you have bias, it's inevitable. It's important that we determine to what extent those beliefs and biases are affecting our clinical judgement, the type of research that we accept, and how we practice.

I want to clarify that hesitancy in letter writing does not automatically equate to potential harm, however there is the potential in causing harm to a client's mental health when restricting access to gender affirming care. There are times where we might be more hesitant to write letters for various procedures but at this time, I don't see any evidenced based contra-indications based on the information provided below. From what you have shared it seems that you are not comfortable in providing gender affirming care in general and my professional suggest would be to consider a transfer for this client to someone who is comfortable with providing gender affirming care. Of course, that is a decision that needs to be made between you and [redacted] I would also discuss if cases like this would be appropriate to be assigned to you in the future.

Thanks,

[redacted]

From: Tamara Pietzke <[redacted]>
Sent: Thursday, November 9, 2023 12:35 PM
To: [redacted]
Cc: [redacted]
Subject: Client Question :)

Hi [redacted]

I recently had a client request a letter to begin testosterone. This is the first time since out Gender Affirming Care training that I've been asked to write a letter of support for a client, and I am having some difficulty doing that.

When Tamara outlined her concerns about giving a patient testosterone to her manager at MultiCare, she was told to "examine your personal beliefs and biases about trans kids."

She then reported me to MultiCare's risk management team, who removed my client from my care and placed her with a new therapist.

A risk manager's job is to minimize the hospital's liability, but in my case, they deemed that my concerns posed a greater risk to my client than giving her a life-altering procedure with no proven long-term benefit.

✚ ✚ ✚

I shouldn't have been surprised by this. Just a few months earlier, in September of last year, I was one of over 100 therapists and behavioral specialists at the MultiCare hospital system required to attend mandatory training on "gender-affirming care."

As hard as it is to believe given my work, I hadn't heard about gender-affirming care before that moment. I needed to know more. So each night in the week leading up to the training, I searched online for information about gender-affirming care. After putting my kids to bed, I sat glued to my computer screen, losing sleep, horrified at what I found.

I discovered that neither puberty blockers nor cross-sex hormones (testosterone or estrogen) were approved by the Food and Drug Administration as a treatment for gender dysphoria. In fact, prescribing these treatments to kids can have drastic side effects, including infertility, loss of sexual function, increased risk of heart attack, stroke, cardiovascular disease, cancer, bone density problems, blood clots, liver toxicity, cataracts, brain swelling, and even death.

While gender clinicians claim hormonal treatment improved their patients' psychological health, the studies on this are few and highly disputed.

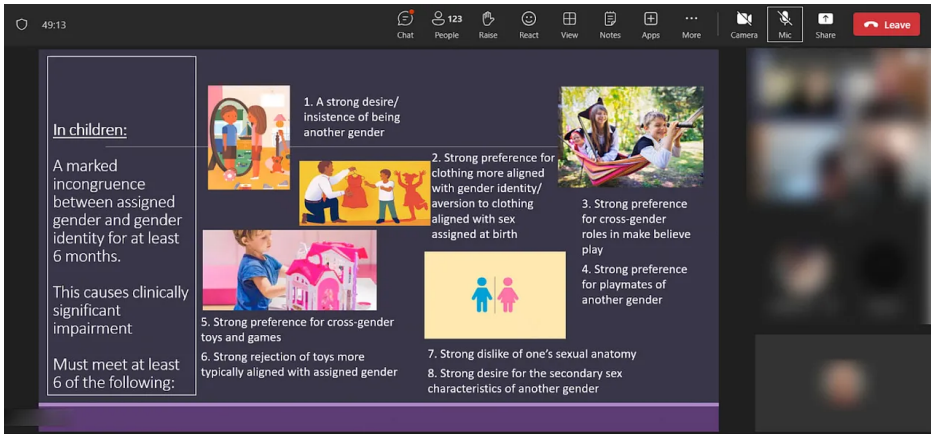
I found that those experiencing gender dysphoria are up to six times more likely to also be autistic, and they are also more likely to suffer from schizophrenia, trauma, and abuse.

The research also implies that the dramatic rise in these diagnoses across the West likely have a strong element of social contagion. In children ages 6 to 17, there was a 70 percent increase in diagnoses of gender dysphoria in the U.S. from 2020 to 2021. In Sweden there was a 1,500 percent increase in these diagnoses among girls 13–17 from 2008 to 2018.

Yet, countries that were once the pioneers of gender transition medicine are now starting to backtrack. In 2022, England announced it will close its only gender clinic after an investigation uncovered subpar medical care, including findings that some patients were rushed toward gender transitions. Sweden and Finland undertook comprehensive analyses of the state of gender medicine and recommended restrictions on transition of minors.

I decided—though it was potentially dangerous to my career and to me—to ask questions about the findings I discovered.

The training I attended laid out an affirming model of gender care—from pronouns and "social transition" to hormone treatments and surgical intervention. In order for children to be diagnosed with gender dysphoria, the training stated, patients must meet six of eight characteristics, ranging from "a strong desire/insistence of being another gender" to "strong preference for cross-gender toys and games."

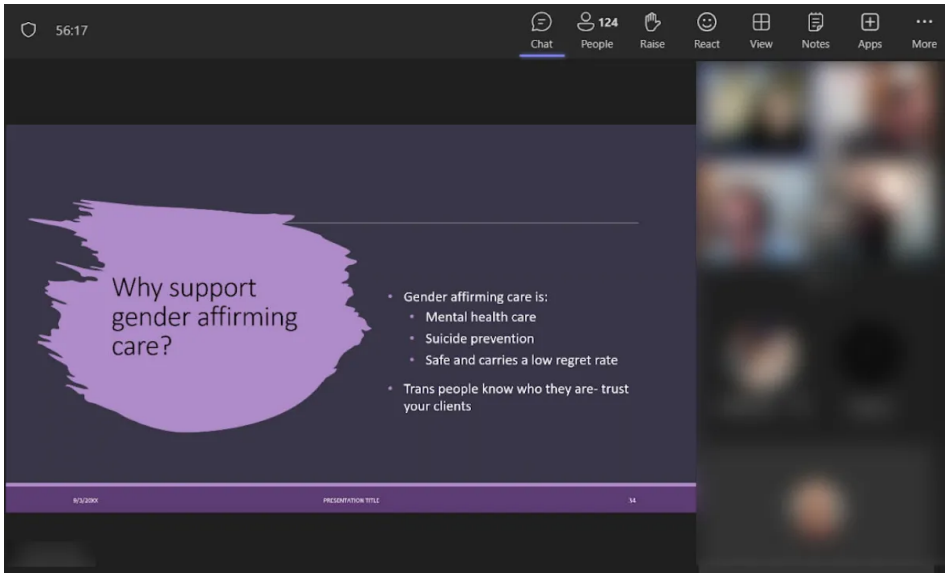


Tamara and her MultiCare colleagues were trained to diagnose gender dysphoria among their young patients when they met six of the eight above characteristics.

It was made abundantly clear to all in attendance that these recommendations were "best practice" at MultiCare, and that the hospital would not tolerate anything less.

When the leader of the training brought up hormone treatments, I shakily tapped the unmute button on Zoom and asked why 70 to 80 percent of female adolescents diagnosed with gender dysphoria have prior mental health diagnoses.

She flashed a look of disgust as she warned me against spreading "misinformation on trans kids." Soon the chat box started blowing up with comments directed at me. One colleague stated it was not "appropriate to bring politics into this" and another wrote that I was "demonstrating a hostility toward trans folks which is [a] direct violation of the Hippocratic Oath," and recommended I "seek additional support and information so as not to harm trans clients."



In the training, gender-affirming treatment is presented as "suicide prevention."

As soon as I closed my laptop, I burst into tears. I care so deeply about my clients that even thinking about this now makes me cry. I couldn't understand how my colleagues, who are supposed to be my teammates, could be so quick to villainize me. I also wondered if maybe my colleagues were right, and if I had gone insane.

Later, my boss reached out to me and told me it was "inappropriate" of me to raise these questions, telling me that a training session was not the proper forum. When I tried to present the evidence that caused me

concern—the lack of long-term studies, the devastating side effects—she told me she didn't have time to read it.

"I am speaking out because nothing will change unless people like me blow the whistle," Tamara writes. "I am desperate to help my patients."

In retrospect, this ideology had been growing in power for a long time.

I remember in 2019 seeing signs of how gender dysphoria arose among many of my most vulnerable female clients, all of whom struggled with previous psychological problems.

In 2019, I started seeing a 16-year-old client after her pediatrician referred her to me for anxiety, depression, and ADHD. When I first met her, she had

long blonde hair covering her eyes, to the point you could barely see her face. It was like she was going through the world trying to be invisible.

In 2020, during the pandemic, she told me she had started reading online a lot about gender, and said she started feeling like she wasn't a girl anymore.

Around this time, her anxiety became so debilitating she couldn't leave her house—not even to go to school. After taking a year off school during the pandemic, she enrolled in an alternative school for kids struggling with mental health. I was relieved that she was making friends for the first time, and seemed to be feeling a lot better.

Then she started using they/he pronouns, identified as pansexual, and replaced the skirts and fishnet stockings she often wore with disheveled and baggy clothes. Her long hair became shorter and shorter. She started wearing a binder to flatten her breasts. She tried out a few different names before settling on one that's gender neutral.

The official diagnosis I gave her was "adjustment disorder"—an umbrella term often applied to young people who are having a hard time coping with difficult and stressful circumstances. It's the type of diagnosis that doesn't follow a child forever—it implies that mental distress among kids is often transient.

She came out as transgender to her family in 2021. Her mother was supportive, but her dad wasn't. Regardless, she went to her pediatrician seeking a referral to a gender clinic.

In 2022, she went to Mary Bridge Children's Gender Health Clinic for the first time, where the clinicians informed her and her parents that if she didn't receive hormone replacement therapy, she could be "at increased risk for anxiety, depression, and worsening of mental health/psychological trauma," according to her patient records. Her dad refused to start his daughter on testosterone, and so all the clinic could do was prescribe birth control to stop her period due to her "menstrual dysphoria," or distress over getting her period. Which is something I thought all teenage girls experienced.

Five months later, she swallowed a bottle of pills and her mother had to rush her to the emergency room.

By early 2023, my client logged on to our weekly session, which we started doing by Zoom, and she told me she identified as a "wounded male dog." She explained to me that this was her "xenogender," a concept she had discovered online, which references gender identities that go "beyond the human understanding of gender." She said she felt she didn't have all of the right appendages, and that she wanted to start wearing ears and a tail to truly feel like herself.

I was stunned. All I could do was silently nod along.

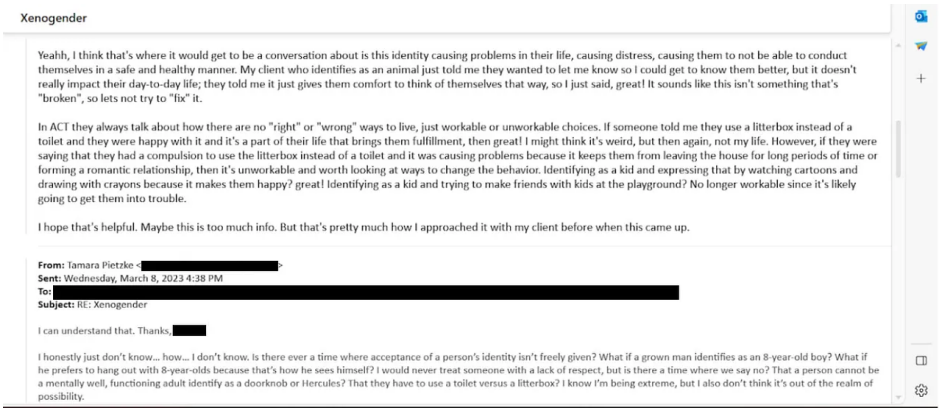
After the session, I emailed my colleagues looking for advice. "I want to be accepting and inclusive and all of that," I wrote, but "I guess I just don't understand at what point, if ever, a person's gender identity is indicative of a bigger issue."

I asked them: "Is there ever a time where acceptance of a person's identity isn't freely given?"

The consensus from my colleagues was that it wasn't a big deal.

"It sounds like this isn't something that's 'broken,' " one colleague wrote me back, "so let's not try to 'fix' it."

"If someone told me they use a litterbox instead of a toilet and they were happy with it and it's part of their life that brings them fulfillment, then great!" she continued. "I might think it's weird, but then again, not my life."



Xenogender

Yeahh, I think that's where it would get to be a conversation about is this identity causing problems in their life, causing distress, causing them to not be able to conduct themselves in a safe and healthy manner. My client who identifies as an animal just told me they wanted to let me know so I could get to know them better, but it doesn't really impact their day-to-day life; they told me it just gives them comfort to think of themselves that way, so I just said, great! It sounds like this isn't something that's "broken", so lets not try to "fix" it.

In ACT they always talk about how there are no "right" or "wrong" ways to live, just workable or unworkable choices. If someone told me they use a litterbox instead of a toilet and they were happy with it and it's a part of their life that brings them fulfillment, then great! I might think it's weird, but then again, not my life. However, if they were saying that they had a compulsion to use the litterbox instead of a toilet and it was causing problems because it keeps them from leaving the house for long periods of time or forming a romantic relationship, then it's unworkable and worth looking at ways to change the behavior. Identifying as a kid and expressing that by watching cartoons and drawing with crayons because it makes them happy? great! Identifying as a kid and trying to make friends with kids at the playground? No longer workable since it's likely going to get them into trouble.

I hope that's helpful. Maybe this is too much info. But that's pretty much how I approached it with my client before when this came up.

From: Tamara Pietzke <[redacted]>
Sent: Wednesday, March 8, 2023 4:38 PM
To: [redacted]
Subject: RE: Xenogender

I can understand that. Thanks, [redacted]

I honestly just don't know... how... I don't know. Is there ever a time where acceptance of a person's identity isn't freely given? What if a grown man identifies as an 8-year-old boy? What if he prefers to hang out with 8-year-olds because that's how he sees himself? I would never treat someone with a lack of respect, but is there a time where we say no? That a person cannot be a mentally well, functioning adult identify as a doorknob or Hercules? That they have to use a toilet versus a litterbox? I know I'm being extreme, but I also don't think it's out of the realm of possibility.

After learning that one of Tamara's patients identified as "a wounded male dog," a colleague replied: "If someone told me they use a litterbox instead of a toilet and they were happy with it and it's part of their life that brings them fulfillment, then great!"

I was baffled and alarmed by her unquestioning affirmation. At what point does a change in identity represent a mental health concern, and not something to be celebrated and affirmed? Fortunately, my client never

brought up her "xenogender" again. She also isn't on testosterone due to her father's disapproval. So I kept these thoughts to myself, and ultimately, in order to keep my job, I let it go.

✚ ✚ ✚

Another female patient, who transitioned as a teen, serves as a warning of what happens when we passively accept the idea that gender transition will entirely resolve a patient's mental health issues.

This client, who I started seeing in 2022, is now 23 and rarely leaves the house, spends most of the day in bed playing video games, and envisions no path to working or functioning in the outside world due to a variety of mental health problems. In 2016, this patient was diagnosed with autism, anxiety, and gender dysphoria. Later the diagnoses grew to include depression, Tourette syndrome, and a conversion disorder. In 2018, at age 17, the Mary Bridge Gender Health Clinic prescribed testosterone, despite the fact that this patient is diabetic and one of the hormone's side effects is that it might increase insulin resistance. The patient's mother, who has another transgender child, strongly encouraged it.

This patient now has a wispy mustache and a deepened voice, but does not pass as male. It turns out that testosterone, which will be prescribed for life, did not relieve the patient's other mental illnesses.

My biggest fear about the gender-affirming practices my industry has blindly adopted is that they are causing irreversible damage to our clients. Especially as they are vulnerable people who come to us at their lowest moments in life, and who entrust us with their health and safety. And yet, instead of treating them as we would patients with any other mental health condition, we have been instructed—and even bullied—to abandon our professional judgment and training in favor of unquestioning affirmation.

I am speaking out because nothing will change unless people like me—who know the risks of medicalizing troubled young people—blow the whistle. I am desperate to help my patients.

And I believe, if I don't speak out, I will have betrayed them.

✚ ✚ ✚

Tamara Pietzke is a therapist based in Washington.

Read Jamie Reed's account of malpractice at The Washington University Transgender Center at St. Louis Children's Hospital, "I Thought I Was Saving Trans Kids. Now I'm Blowing the Whistle." And for those concerned about the state of gender medicine for young people today, visit The LGBT Courage Coalition.

Become a Free Press subscriber today:

Monday, February 5, 2024

Comments 364

Write a comment...

Carole 4 hrs ago

Tamara - I found your account agonizing. I applaud your courage. I am a retired child psychotherapist and have experienced fear that the entire field has been corrupted and co-opted by a strange agenda with no grounding in research. It is important for people to realize that many (likely most) experienced and traditionally trained therapists are not in favor of this but fear extreme repercussion. Truly, the therapist that I saw conforming to the bizarre notion of gender affirming care for children were the most poorly trained with little to no understanding of research methodology and analyses. I appreciate your knowledge that children are all about change and nothing there is permanent unless you surgically or chemically alter it.

LIKE (166) REPLY SHARE

42 replies

Kevin Durant? The $79.99/mo Newsletter 4 hrs ago

Approve all transitions. Admit all immigrants. Believe all women. Zero COVID.

Jeez it's almost like these people are utopian psychopaths.

LIKE (111) REPLY SHARE

44 replies

See all comments

Latest

EXHIBIT 132

Los Angeles Times

WORLD & NATION

This abortion doctor is not ready to leave Alabama. 'You don't want me here? That's why I'm gonna stay'

Dr. Leah Torres administers an ultrasound on a woman seeking prenatal care at West Alabama Women's Center in Tuscaloosa. (Gina Ferazzi / Los Angeles Times)

BY JENNY JARVIE | NATIONAL CORRESPONDENT

APRIL 28, 2023 3 AM PT

TUSCALOOSA, Ala. — People often ask Dr. Leah Torres why she stays in Alabama.

The 43-year-old OB-GYN — who strides into her clinic most mornings wearing a clitoris pendant and T-shirts with a slogan declaring "ABORT THE PATRIARCHY" — does not consider this conservative Deep South state her home.

A few weeks after she arrived, the state Board of Medical Examiners revoked her temporary medical license to practice, accusing her of ethical violations.

It took her seven months to get it back, a legal battle that cost her $115,360.93, according to the price tag she affixed to the framed license hanging in her office at the West Alabama Women's Center.

The center was one of the busiest abortion clinics in the state, until the Supreme Court struck down Roe vs. Wade last year. Abortion became illegal in Alabama, one of over a dozen states with full bans. Now that doctors who perform the procedure in Alabama risk up to 99 years in prison, Torres finds herself, once again, unable to offer the full spectrum of reproductive medical care she was trained for.

But Torres has no intention of backing down.

"You don't want me here? That's why I'm gonna stay," she said, sitting at a desk strewn with laboratory invoices and a tiny fetus replica handed out by antiabortion campaigners. "I'm not leaving, just out of spite!"

Torres believes her work is not done in Alabama, a state with the third-highest maternal mortality rate in the nation and the sixth-highest infant death rate. The Republican-dominated Legislature joined nine other conservative states in refusing to expand Medicaid, which would allow more than 200,000 uninsured non-elderly adults in the state to become eligible for coverage.

A 27-year-old woman holds images of her 10-week-old fetus at West Alabama Women's Center in Tuscaloosa. The clinic, which shut down briefly after Alabama banned abortion, now focuses on prenatal care, birth control, miscarriage treatment and transgender care. (Gina Ferazzi / Los Angeles Times)

After shutting down for a week in July after the U.S. Supreme Court ruling, her clinic reopened its doors as a "pay what you can" nonprofit offering low-income and uninsured women basic reproductive health services that can be hard to access in Alabama.

Torres and the clinic are offering hormone therapy for transgender people, including teenagers — wading into another culture-wars fray at a time when Alabama and other conservative states are moving to ban such treatment for minors.

"There's so much work here," Torres said. "Alabama's really dead set on compromising people's lives, especially LGBTQ+ youth, especially pregnant people. These are expendable people in the eyes of the state of Alabama."

‘We have to push back’

When Tina Collins, the front office manager, picks up the phone — “West Alabama Women’s Center!” — she frequently has to inform callers the clinic no longer provides abortions.

“No ma’am, we do not,” she says gently in her south Georgia drawl. “They are illegal in Alabama. You can go to our website, the West Alabama’s Women’s Center, or you can go to the website redstateaccess.org.”

In July, when the tiny brick clinic reopened with abortions no longer on its list of services, staff members were nervous. Robin Marty, the clinic’s director of operations, gave everyone firm instructions not to provide callers with information on obtaining abortions out of state or by mail.

Now they’ve adopted a slightly bolder approach, plastering the reception window with stickers offering website links for abortion information. “Need to be unpregnant?” asks a sticker at eye level of the front desk. “RED STATE ACCESS CAN HELP.”

“Safe. Private. Informed,” another says. “Learn about self-managed abortion.”

“We have to push back,” Marty said. “If we don’t test these things, then they won already … and we’re going to be trapped forever.”

As abortion clinics have shuttered across Alabama, Mississippi and Louisiana, national organizations have devoted resources to setting up new centers and mobile clinics in blue states. But women who travel for abortions still need care when they come home.

Earlier this month, a 20-year-old nursing student came to the clinic with her mother for a follow-up appointment a month after driving to Georgia for a medication abortion.

A TV news report about the court battle over the abortion pill mifepristone plays in the waiting room of West Alabama Women's Center, once one of the busiest abortion clinics in Alabama. (Gina Ferazzi / Los Angeles Times)

After passing a sign that said "Still Open for Non-Abortion Services," they slipped through a glass door into an empty waiting room that used to teem with patients. On the day before Roe was overturned, 67 people came to the clinic for medication abortions. Now the clinic sees about 15 patients a week.

The medication had worked and there were no complications, but the woman's mother was indignant that politicians had forced them to take a day off work and school to make the six-hour round trip to Atlanta.

"I feel like your body is yours, not the government's," said Renetha Abernathy, a 57-year-old nurse. "We should have full healthcare right here in our own area, so we can make that choice."

WORLD & NATION

Abortion pill ruling: Texas judge revokes FDA approval, but another judge contradicts him

April 7, 2023

POLITICS

Supreme Court sides with FDA on abortion pills, blocks Texas rulings for now

April 21, 2023

Earlier that week, Torres met a pregnant patient who told her that the local OB-GYN clinic that gave her prenatal care and delivered her baby 15 months ago made her wait nearly three hours for an appointment and rebuked her when she complained. The woman suspected — as did Torres — that the stark discrepancy in care was because she had switched from Blue Cross Blue Shield to Medicaid.

Even patients with insurance have trouble accessing care. Tyeshia Smith, 31, a mental health worker who has done sex work, came to the clinic because she wanted another child but worried about her fertility. Her menstrual cycle had become irregular in recent months, and she feared sexually transmitted diseases had taken a toll on her body.

Tyeshia Smith, 31, a mental health worker who lives with her mother in Tuscaloosa, went to the West Alabama Women's Center after having trouble getting appointments at other area facilities. (Gina Ferazzi / Los Angeles Times)

The first clinic she called couldn't see her until July. Another didn't answer, so she left a voicemail.

"Every aspect of healthcare here in Alabama to me is 20 years back," Smith, who is from Ohio, said as she waited in an exam room for a Pap smear.

Over the last year, Torres has treated women who have miscarried or learned their pregnancies are nonviable and have trouble finding care, as physicians across the state become more fearful of ending up in jail.

WORLD & NATION

The woman who brought down Roe vs. Wade wants to take abortion battle to California

June 24, 2022

In February, Alison, a 36-year-old in Montgomery who spoke on condition that her full name not be used, started bleeding about seven weeks after getting pregnant via artificial insemination. When she went to her OB-GYN for an emergency ultrasound, she was told the pregnancy wasn't viable — there was a sac, but no fetal tissue or heartbeat. The doctor, seeming uncomfortable, told her to go home and wait for her body to pass the tissue.

Over the next few days, Alison bled and cramped so badly she could not get out of bed. Her grief and anxiety swelled as she read online about sepsis and fretted that if the sac did not pass it could harm her fertility.

After the bleeding subsided the fifth day, she decided to drive 100 miles to Tuscaloosa to see Torres. The ultrasound showed she was out of danger. Torres spent 20 minutes reassuring her she had not done anything wrong.

"This is our body's way of preventing us from heartache," Torres told her, noting that sometimes bodies reject cells that are unhealthy. "Miscarriage is terrible; this was a blessing."

For the first time during the ordeal, Alison said, she felt seen and taken care of.

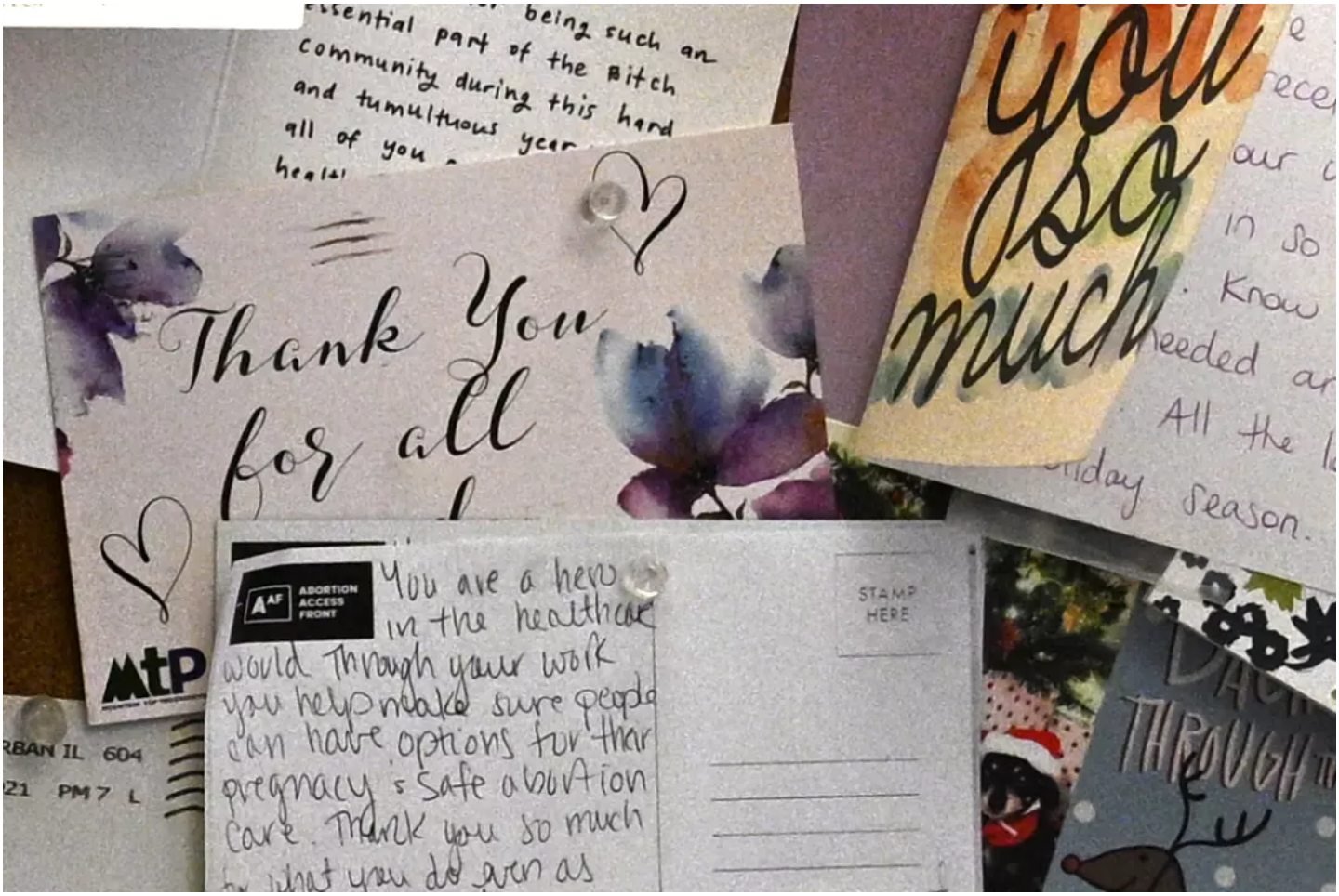
Escaping 'corporate medical hell'

The door to Torres' office is usually open, adorned with buttons that say "TRUST WOMEN" and "I'M ON YOUR SIDE" and a flag that proclaims "ROUND THESE PARTS, WE RESPECT PRONOUNS."

Dr. Leah Torres, left, consults with Robin Marty, director of operations at West Alabama Women's Center in Tuscaloosa. (Gina Ferazzi / Los Angeles Times)

As an activist who promotes herself in her Twitter bio as a "sex+, gender-affirming repro health specialist"— tagline "GTFO of my uterus" — Torres has always chafed at the idea of the paternalistic physician.

"I am not going to be the 'Do as I say' doctor," she said before meeting a transgender patient last week for a telehealth appointment. "I want them to understand that this is a team effort and that I'm not a magic wizard with all of the answers. I am a human being too."



Thank-you notes to the staff hang on a bulletin board inside West Alabama Women's Center. (Gina Ferazzi / Los Angeles Times)

Throughout her medical career, Torres has often felt thwarted.

A Michigan native who also grew up in Florida, she studied medicine at the University of Illinois. After completing her OB-GYN and specialized family planning training in Philadelphia and Salt Lake City, she got a job in 2014 at a community clinic in northern Utah. The clinic would not let her incorporate abortion care into her general practice.

Her frustration built as she got embroiled in campaigns against Utah lawmakers' attempts to restrict abortion.

In 2018, Torres found herself at the center of an online firestorm after someone on Twitter accused her of infanticide and asked: "Do you hear their heartbeats when you

lay down at night?"

Torres replied: "You know fetuses can't scream, right? I transect the cord 1st so there's really no opportunity, if they're even far enough along to have a larynx."

CALIFORNIA

Horrifying stories of women chased down by the LAPD abortion squad before Roe vs. Wade

March 31, 2023

She refers to this incident now as the "tweet that broke my entire life."

Conservative pundit Ben Shapiro shared her tweet, commenting, "This is like a James Bond villain explaining his plan to 007, but a lot less self-aware." Torres deleted the post and clarified that she meant umbilical cord, not vocal cord. But the Daily Caller and a string of right-wing outlets posted articles naming Torres. Eventually, she was asked to sign a mutual separation agreement due to the death threats being received at the clinic.

Unable to find another job in Utah, she sued the Daily Caller for defamation, reaching a settlement in which she got $40,000. After a year without work, she moved to New Mexico to work at a hospital that did not perform abortions.

She earned enough to pay off her student loans but felt disenchanted. The system, as she saw it, did not just prevent doctors from performing a necessary procedure; it encouraged them to perform unnecessary ones, such as caesarean sections. "If a vaginal delivery pays half of what a C-section is, why would you do a vaginal delivery ever?" she said.

"Pregnant women — and I'll just be cis-normative for a second — are walking dollar signs," she railed. "They're not people. They are a commodity that makes money for

the hospital, for the healthcare network, for the insurance company and for the doctor."

When Marty called Torres in March 2020 to ask if she would be interested in leaving New Mexico to take on the role of medical director of an abortion clinic in a different state, Torres jumped at the offer.

"Sign me up," she said.

"Do you want to know where it is?" Marty asked.

"I don't care," Torres said. "I'm in corporate medical hell."

Alabama is not a haven for Torres. The state faces a critical shortage of OB/GYNs. In 1980, 45 of the state's 54 rural counties provided obstetric services; by 2019, the number was 16. A family of four qualifies for Medicaid benefits there only if the household income is under $450 dollars a month.

But the Tuscaloosa clinic offers Torres a place to serve the needy in a state that, as she sees it, is the "quintessential example of what corporate medicine really is."

For Torres, it is nothing short of a miracle that the clinic is still open.

Dr. Leah Torres, left, consults with Raven Williams, 17, with her boyfriend, Ethan Williams, 22, on prenatal care after confirming that she is pregnant. (Gina Ferazzi / Los Angeles Times)

Before Roe was overturned, when 95% of patients came to the clinic for abortions, the clinic brought in $200,000 a month. In the last 10 months, revenue from patients has totaled $20,000. Marty laid off five of the clinic's 11 staff members in August. But revenue has totaled $998,000, mostly through grants and fundraising, ensuring that the clinic can stay open at least through September.

A key prong of its new work is bringing in LGBTQ+ patients from across Alabama via telehealth appointments. The clinic is now offering HIV testing and medication to prevent HIV transmission.

It also provides hormone therapy to transgender patients, including minors — a move that is almost certain to bring the clinic into conflict with Alabama officials.

Transgender care, a new battleground

A year ago, Alabama became the first state to pass a law making it a felony for a doctor to prescribe or administer puberty blockers or hormone treatment to anyone younger than 19 "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex" — with prison sentences of up to 10 years.

But the law is partially blocked by a federal court until a September hearing. After consulting with attorneys, the Tuscaloosa clinic is, for now, quietly offering minors hormone treatment. The clinic's website states that it can "provide hormone therapy and other care to those over the age of 19," but Torres said that a "whisper network" promoted services for minors.

Over the last year, Torres said, she has prescribed hormone treatment to about 50 transgender patients. Two were younger than 19.

"This is the healthcare people need to keep them safe," Torres said. "I will fight for that."

Across the U.S. and Europe, debate is raging among health professionals about how to treat a rising number of adolescents who identify as transgender. There are no long-term clinical studies looking at how hormone treatments may affect fertility and sexual function. Countries such as Sweden, France and the U.K. have in recent years reversed course and adopted a more cautious approach, citing potential side effects and a growing number of people who regret transitioning.

Last year, the World Professional Assn. for Transgender Health, the leading medical group for transgender care, published new standards of care for gender-diverse adolescents seeking medical treatment, recommending that healthcare professionals

carry out "comprehensive biopsychosocial assessment" before providing them with puberty blockers, sex-changing hormones or mastectomies.

Torres does not believe adolescents seeking hormones require mental health evaluations.

"No, I don't need a psychologist or psychiatrist to evaluate someone who's telling me, 'This is how I felt for years,'" she said. "I know that how they felt for years is not pathological."

When meeting trans patients, Torres is upfront that she has been practicing such care for only a year.

"Full disclosure," she tells them, "this area of medicine is pretty new to me." She also points out that this is a relatively experimental area of medicine without a lot of data.

One transgender patient Torres recently started seeing through telehealth was referred to her because the teen's pediatrician and staff at a psychiatric hospital did not respect his gender identity and used his old name. The teen, who had a history of depression and anxiety, told Torres he had known he was a boy for years and wanted to take sex-changing hormones.

"There's so much work here," Dr. Leah Torres said of the women's clinic. "Alabama's really dead set on compromising people's lives, especially LGBTQ+ youth, especially pregnant people. These are expendable people in the eyes of the state of Alabama." (Gina Ferazzi / Los Angeles Times)

Torres told him straight up that she would prescribe a low dose of testosterone. She let the boy know she was glad he was seeing a therapist, even though she didn't require it. She believes trans people need to deal with the trauma of trans bigotry in Alabama, she said.

When she told him she was prescribing testosterone, his face lit up, she said. He asked her, "You mean right today?"

And that, she said, was why she did her job. The teen had tried for so long to get healthcare and been unsuccessful. She believes she is offering lifesaving care.

“I will do whatever I can within legal parameters,” Torres said later. “But at the end of the day, if it’s somebody’s life versus a bad law, I’m choosing that person’s life.”

Hopefully, she said, there would never be a conflict.

Jenny Jarvie

Jenny Jarvie is a national correspondent for the Los Angeles Times based in Atlanta.

EXHIBIT 133

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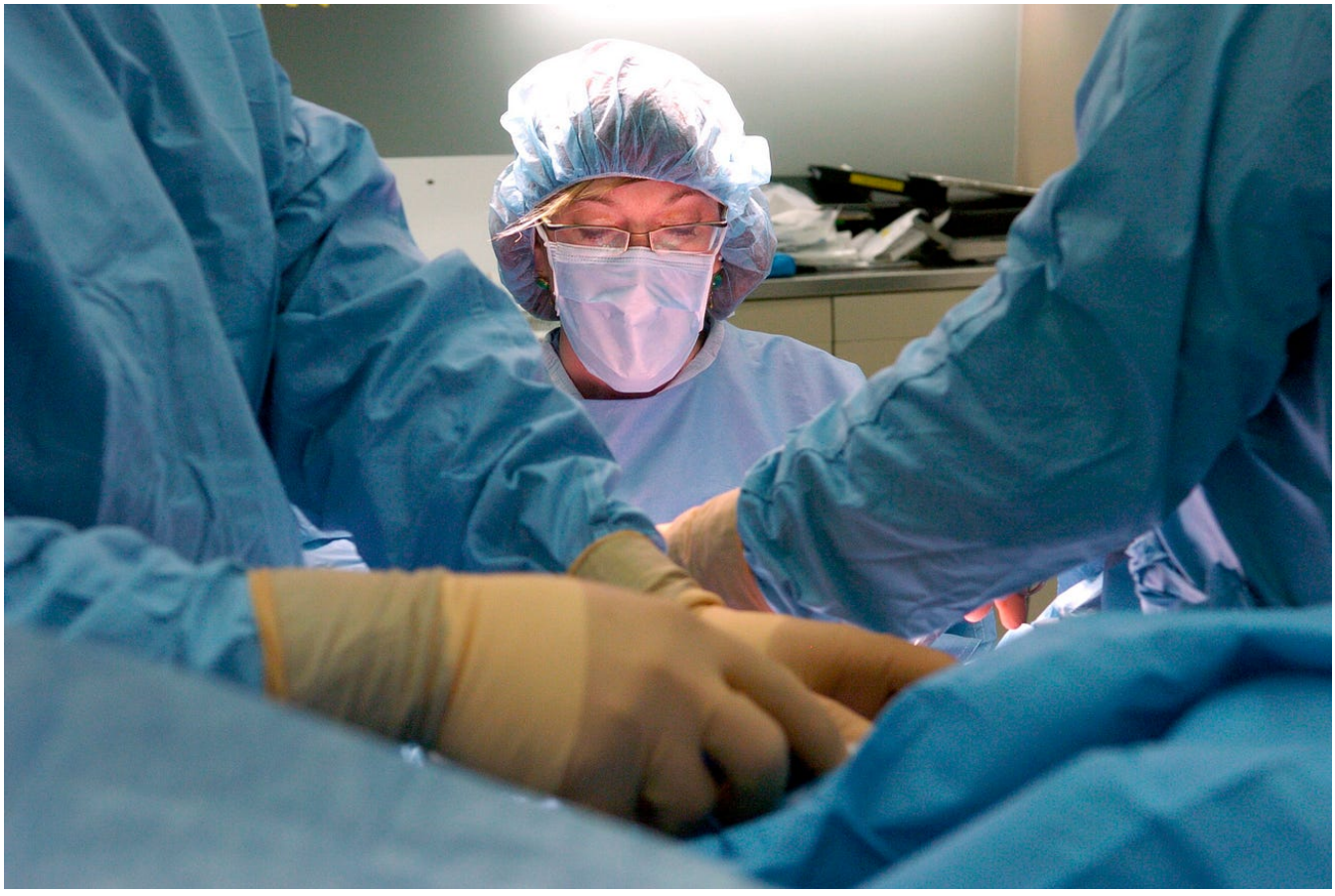

Dr. Marci Bowers performs gender reassignment surgery in Trinada'ss Mount San Rafael Hospital. (Glenn Asakawa/The Denver Post via Getty Images)

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.

By Abigail Shrier
October 4, 2021

For nearly a decade, the vanguard of the transgender-rights movement — doctors, activists, celebrities and transgender influencers — has defined the boundaries of the new orthodoxy surrounding transgender medical care: What's true, what's false, which questions can and cannot be asked.

They said it was perfectly safe to give children as young as nine puberty blockers and insisted that the effects of those blockers were "fully reversible." They said that it was the job of medical professionals to help minors to transition. They said it was not their job to question the wisdom of transitioning, and that anyone who did — including parents — was probably transphobic. They said that any worries about a social contagion among teen girls was nonsense. And they never said anything about the distinct possibility that blocking puberty, coupled with cross-sex hormones, could inhibit a normal sex life.

Their allies in the media and Hollywood reported stories and created content that reaffirmed this orthodoxy. Anyone who dared disagree or depart from any of its core tenets, including young women who publicly detransitioned, were inevitably smeared as hateful and accused of harming children.

But that new orthodoxy has gone too far, according to two of the most prominent providers in the field of transgender medicine: Dr. Marci Bowers, a world-renowned vaginoplasty specialist who operated on reality-television star Jazz Jennings; and Erica Anderson, a clinical psychologist at the University of California San Francisco's Child and Adolescent Gender Clinic.

In the course of their careers, both have seen thousands of patients. Both are board members of the World Professional Association for Transgender Health (WPATH), the organization that sets the standards worldwide for transgender medical care. And both are transgender women.

Earlier this month, Anderson told me she submitted a co-authored op-ed to The New York Times warning that many transgender healthcare providers were treating kids recklessly. The Times passed, explaining it was "outside our coverage priorities right now."

Over the past few weeks, I have spoken at length to both women about the current direction of their field and where they feel it has gone wrong. On some issues, including their stance on puberty blockers, they raised concerns that appear to question the current health guidelines set by WPATH — which Bowers is slated to lead starting in 2022.

WPATH, for instance, recommends that for many gender dysphoric and gender non-conforming kids, hormonal puberty suppression begin at the early stages of puberty. WPATH has also insisted since 2012 that puberty blockers are "fully reversible interventions."

When I asked Anderson if she believes that psychological effects of puberty blockers are reversible, she said: "I'm not sure." When asked

whether children in the early stages of puberty should be put on blockers, Bowers said: “I’m not a fan.”

When I asked Bowers if she still thought puberty blockers were a good idea, from a surgical perspective, she said: “This is typical of medicine. We zig and then we zag, and I think maybe we zigged a little too far to the left in some cases.” She added “I think there was naivete on the part of pediatric endocrinologists who were proponents of early [puberty] blockade thinking that just this magic can happen, that surgeons can do anything.”

I asked Bowers whether she believed WPATH had been welcoming to a wide variety of doctors’ viewpoints — including those concerned about risks, skeptical of puberty blockers, and maybe even critical of some of the surgical procedures?

“There are definitely people who are trying to keep out anyone who doesn’t absolutely buy the party line that everything should be affirming, and that there’s no room for dissent,” Bowers said. “I think that’s a mistake.”

Bowers is not only among the most respected gender surgeons in the world but easily one of the most prolific: she has built or repaired more than 2,000 vaginas, the procedure known as vaginoplasty. She rose to celebrity status appearing on the hit reality-television show “I Am Jazz,” which catalogues and choreographs the life of Jazz Jennings, arguably the country’s most famous transgender teen.

In January 2019, Jeanette Jennings threw her famous daughter a "Farewell to Penis" party. Over a million viewers looked in on guests feasting on meatballs and miniature wieners in the Jennings' Mediterranean-style Florida home. Family and friends cheered as Jazz sliced into a penis-shaped cake. The rather complicated upcoming procedure came to seem as little more than a Sweet Sixteen.

By that point, Jazz was already Time magazine's top 25 most influential teen, the co-author of a bestselling children's book and the inspiration for a plastic doll. She had served as youth ambassador to the Human Rights Campaign, and she had about one million Instagram followers. Hers was no longer just a personal story but an advertisement for a lifestyle and an industry.

On the day of the procedure — dutifully recorded for Instagram — Jazz's sister, Ari, teasingly wiggled a sausage in front of the camera. As Jazz was about to be wheeled into the operating room, she snapped her fingers and said, "Let's do this!"

The vaginoplasty she underwent is what surgeons call a "penile inversion," in which surgeons use the tissue from the penis and testicles to create a vaginal cavity and clitoris. With grown men, a penile inversion was eminently doable. With Jazz, it was much more difficult.

Like thousands of adolescents in America treated for gender dysphoria (severe discomfort in one's biological sex), Jazz had been put on puberty blockers. In Jazz's case, they began at age 11. So at age 17, Jazz's penis was the size and sexual maturity of an 11-year-old's. As Bowers explained to Jazz and her family ahead of the surgery, Jazz didn't have enough penile

and scrotal skin to work with. So Bowers took a swatch of Jazz's stomach lining to complement the available tissue.

At first, Jazz's surgery seemed to have gone fine, but soon after she said experienced "crazy pain." She was rushed back to the hospital, where Dr. Jess Ting was waiting. "As I was getting her on the bed, I heard something go pop," Ting said in an episode of "I Am Jazz." Jazz's new vagina — or neovagina, as surgeons say — had split apart.

Gender dysphoria, which Jazz had suffered from since age two, is very real, and by all accounts, excruciating. For the nearly 100-year diagnostic history of gender dysphoria, it overwhelmingly afflicted boys and men, and it began in early childhood (ages two to four). According to the DSM-V, the latest edition of the historical rate of incidence was .01 percent of males (roughly one in 10,000).

For decades, psychologists treated it with "watchful waiting" — that is, a method of psychotherapy that seeks to understand the source of a child's gender dysphoria, lessen its intensity, and ultimately help a child grow more comfortable in her own body.

Since nearly seven in 10 children initially diagnosed with gender dysphoria eventually outgrew it — many go on to be lesbian or gay adults — the conventional wisdom held that, with a little patience, most kids would come to accept their bodies. The underlying assumption was children didn't always know best.

But in the last decade, watchful waiting has been supplanted by "affirmative care," which assumes children *do* know what's best. Affirmative care proponents urge doctors to corroborate their patients' belief that they are trapped in the wrong body. The family is pressured to help the child transition to a new gender identity — sometimes having been told by doctors or activists that, if they don't, their child may eventually commit suicide. From there, pressures build on parents to begin concrete medical steps to help children on their path to transitioning to the "right" body. That includes puberty blockers as a preliminary step. Typically, cross-sex hormones follow and then, if desired, gender surgery.

The widespread use of puberty blockers can be traced to the Netherlands. In the mid-1990s, Peggy Cohen-Kettenis, a psychologist in Amsterdam who had studied young people with gender dysphoria, helped raise awareness about the potential benefits of blockers — formerly used in the chemical castration of violent rapists. Pharmaceutical companies were happy to fund studies on the application of blockers in children, and, gradually, what's called the Dutch Protocol was born. The thinking behind the protocol was: Why make a child who has suffered with gender dysphoria since preschool endure puberty, with all its discomforts and embarrassments, if that child were likely to transition as a young adult? Researchers believed blockers' effects were reversible — just in case the child did not ultimately transition.

Cohen-Kettenis later grew doubtful about that initial assessment. "It is not clear yet how pubertal suppression will influence brain development," she wrote in the European Journal of Endocrinology in 2006. Puberty is not merely a biochemical development; it is also "a psycho-social event that occurs in concert with one's peers," Doctor William Malone, an endocrinologist and member of the Society for Evidence Based Gender

Medicine, told me. Hormones do not merely stimulate sex organs during puberty; they also shower the brain.

But at the very moment when Dutch researchers were beginning to raise concerns about puberty blockers, American health providers discovered it. In 2007, the Dutch Protocol arrived at Boston Children's Hospital, one of the preeminent children's hospitals in the nation. It would soon become the leading course of treatment for all transgender-identified children and adolescents in the United States. One of them was Jazz Jennings.

In 2012, a surgeon implanted a puberty blocker called Supprelin in Jazz's upper arm to delay the onset of facial hair and the deepening of her voice, among other things. Without these conventional masculine features, it would be easier, down the road, for doctors to make her look more feminine — more like the budding young woman she felt she was deep inside.

At the time, doctors knew less than they do now about the effects of puberty blockers. "When you enter a field like this where there's not a lot of published data, not a lot of studies, the field is in its infancy, you see people sometimes selling protocols like puberty blockers in a dogmatic fashion, like, 'This is just what we do,'" Bowers told me.

Once an adolescent has halted normal puberty and adopted an opposite-sex name, Bowers said: "You're going to go socially to school as a girl, and you've made this commitment. How do you back out of that?"

Another problem created by puberty blockade — experts prefer "blockade" to "blockage" — was lack of tissue, which Dutch researchers noted back in 2008. At that time, Cohen-Kettenis and other researchers noted that, in natal males, early blockade might lead to "non-normal pubertal phallic growth," meaning that "the genital tissue available for vaginoplasty might be less than optimal."

But that hair-raising warning seems to have been lost in the trip across the Atlantic.

Many American gender surgeons augment the tissue for constructing neovaginas with borrowed stomach lining and even a swatch of bowel. Bowers draws the line at the colon. "I never use the colon," she said. "It's the last resort. You can get colon cancer. If it's used sexually, you can get this chronic colitis that has to be treated over time. And it's just in the discharge and the nasty appearance and it doesn't smell like vagina."

The problem for kids whose puberty has been blocked early isn't just a lack of tissue but of sexual development. Puberty not only stimulates growth of sex organs. It also endows them with erotic potential. "If you've never had an orgasm pre-surgery, and then your puberty's blocked, it's very difficult to achieve that afterwards," Bowers said. "I consider that a big problem, actually. It's kind of an overlooked problem that in our 'informed consent' of children undergoing puberty blockers, we've in some respects overlooked that a little bit."

Nor is this a problem that can be corrected surgically. Bowers can build a labia, a vaginal canal and a clitoris, and the results look impressive. But, she said, if the kids are "orgasmically naive" because of puberty blockade, "the clitoris down there might as well be a fingertip and brings them no

particular joy and, therefore, they're not able to be responsive as a lover. And so how does that affect their long-term happiness?"

Few, if any, other doctors acknowledge as much. The Mayo Clinic, for instance, does not note that permanent sexual dysfunction may be among puberty blockers' risks. St. Louis Children's Hospital doesn't mention it, either. Oregon Health & Science University Children's Hospital and University of California at San Francisco don't. Nor was there any mention of sexual dysfunction in a recent New York Times story, "What Are Puberty Blockers?"

Jack Turban, the chief fellow in child and adolescent psychiatry at Stanford University School of Medicine, wrote, in 2018: "The only significant side effect is that the adolescent may fall behind on bone density."

But lack of bone density is often just the start of the problem. Patients who take puberty blockers almost invariably wind up taking cross-sex hormones — and this combination tends to leave patients infertile and, as Bowers made clear, sexually dysfunctional.

On an episode of "I Am Jazz," Jazz revealed that she had never experienced an orgasm and may never be able to. But she remains optimistic. "I know that once I fall in love and I really admire another individual that I'm going to want to have sex with them," Jazz said at 16, in an episode that aired in July of 2017.

In the year after her operation, Jazz would require three more surgeries, and then defer Harvard College for a year to deal with her depression. In 2021, she opened up about a binge-eating disorder that caused her to gain nearly 100 pounds in under two years.

Jazz has insisted she has "no regrets" about her transition. (I reached out to Jazz for an interview and never heard back). But subjecting patients to a course of serious interventions that cannot be scrutinized — even by experts — without one risking being tarred as anti-trans seems unlikely to be in anyone's best interest.

Bowers told me she now finds early puberty blockade inadvisable. "I'm not a fan of blockade at Tanner Two anymore, I really am not," she told me, using the clinical name of the moment when the first visible signs of puberty manifest. "The idea all sounded good in the very beginning," she said. "Believe me, we're doing some magnificent surgeries on these kids, and they're so determined, and I'm so proud of so many of them and their parents. They've been great. But honestly, I can't sit here and tell you that they have better — or even as good — results. They're not as functional. I worry about their reproductive rights later. I worry about their sexual health later and ability to find intimacy."

Bowers knows what the loss of fertility and sexual intimacy might entail: She has three children, all born before she transitioned, and she spent a decade tending to victims of female genital mutilation. "Those women, a lot of them experience broken relationships because they cannot respond sexually," she said. "And my fear about these young children who never experience orgasm prior to undergoing surgery are going to reach adulthood and try to find intimacy and realize they don't know how to respond sexually."

✚ ✚ ✚

In 2007, the year the U.S. began implementing the Dutch Protocol, the U.S. had one pediatric gender clinic, and it overwhelmingly served patients like

Jazz: natal males who expressed discomfort in their bodies in the earliest stages of childhood. (At age 2, Jazz reportedly asked Jeanette when the good fairy would turn him into a girl. Jazz's own social transition did not appear to proceed from peer influence and predated social media.)

Today, the U.S. has hundreds of gender clinics. Most patients are not natal males, like Jazz, but teenage girls. I wrote a book about these girls, "Irreversible Damage," which was based on interviews with them and their families. Peer influence and exposure to trans influencers on social media play an outsized role in their desire to escape womanhood. Unlike the patients of the Dutch Protocol, who were screened for other mental health comorbidities, these young women almost always suffer from severe anxiety and depression or other significant mental health problems — and those problems are often overlooked or ignored.

When public health researcher and former Brown University Professor Lisa Littman dubbed this phenomenon "rapid onset gender dysphoria" in 2018, the university apologized for her paper and ultimately pushed her out. Activists called the hypothesis of a social contagion among teen girls a "poisonous lie used to discredit trans people."

But Littman's research about the sudden spike in teen girl trans-identification has become increasingly difficult to deny: A recent survey by the American College Health Association showed that, in 2008, one in 2,000 female undergraduates identified as transgender. By 2021, that figure had jumped to one in 20.

While both Anderson and Bowers pointed out that "ROGD" has yet to be accepted as a diagnosis, Anderson said: "At our clinic at UCSF, for two years

now running, we're running two to one natal females to natal males." Two to one.

"As for this ROGD thing," Bowers said, "I think there probably are people who are influenced. There is a little bit of 'Yeah, that's so cool. Yeah, I kind of want to do that too.'"

Anderson agreed that we're likely to see more regret among this teenage-girl population. "It is my considered opinion that due to some of the — let's see, how to say it? what word to choose? — due to some of the, I'll call it just 'sloppy,' sloppy healthcare work, that we're going to have more young adults who will regret having gone through this process. And that is going to earn me a lot of criticism from some colleagues, but given what I see — and I'm sorry, but it's my actual experience as a psychologist treating gender variant youth — I'm worried that decisions will be made that will later be regretted by those making them."

What, exactly, was sloppy about the healthcare work? "Rushing people through the medicalization, as you and others have cautioned, and failure — *abject* failure — to evaluate the mental health of someone historically in current time, and to prepare them for making such a life-changing decision," Anderson said.

I asked Bowers about the rise of detransitioners, young women who have come to regret transitioning. Many said they were given a course of testosterone on their first visit to a clinic like Planned Parenthood. "When you have a female-assigned person and she's feeling dysphoric, or somebody decides that she's dysphoric and says your eating disorders are not really eating disorders, this is actually gender dysphoria, and then they

see you for one visit, and then they recommend testosterone — red flag!" Bowers said. "Wake up here."

Abigail Shrier is the author of "Irreversible Damage," which the Economist named one of the best books of 2020. Read more of her work at her newsletter, The Truth Fairy.

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Comments 232

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Steven N. Oct 4, 2021

At 2 years old, Jazz did not experience gender dysphoria, Jazz's parents did.

♡ 228 Reply Collapse

14 replies

ThinkPieceOfPie Oct 4, 2021

They're not creating a vagina by inverting a penis, anymore than a surgeon is creating a younger person by performing a facelift. At best it's a facsimile, at worst it's a disaster--the necessity for follow up surgeries is very high, from 40-60%, with as noted, limited function. Of course, a child doesn't understand what is at risk when they are 2, or 4 or 11. As Abigail has written elsewhere, some of these adolescent girls having breast amputated & taking testosterone haven't had a first kiss.

♡ 195 Reply Collapse

4 replies

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