

Article

Censorship of Essential Debate in Gender Medicine Research

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Abstract: The integrity of the gender medicine research literature has been compromised, not only by censorship of correct articles, but also by censorship of critiques of articles with unsupported (for instance exaggerated), misleading or erroneous statements. Many such statements concern the evidence base, which can be evaluated rigorously using a key component of evidence-based medicine, systematic reviews of the evidence. These reviews currently find there is limited to very little confidence that estimates of benefit from (and sometimes harm from) medical gender intervention, that is, puberty blockers, hormones and/or surgeries, are likely to match true outcomes. Several medical societies and articles in medical journals have been claiming otherwise, misrepresenting the evidence base as a whole and/or relying upon unsupported or non-representative individual study findings or conclusions. For example, high likelihood of benefit and low risk of adverse outcomes from medical gender interventions are often claimed, while less invasive alternative treatment options are either omitted or mischaracterized. Other unsupported, erroneous or misleading statements occur when studies minimize or omit mention of significant limitations, or report findings or conclusions not supported by their own data; these are then sometimes quoted by others as well. In addition, correctly reported studies are sometimes misrepresented. Critiques which attempt to rectify such statements are frequently rejected. Some examples are presented here. Such rejections have stifled scientific debate, interfering with the continual scrutiny and cross checks needed to maintain accuracy in the research literature. Currently, erroneous and unsupported statements circulate and repeat between journals and medical society guidelines and statements, misinforming researchers, clinicians, patients and the general public.

Keywords: gender dysphoria; censorship; debate in medicine; gender-affirming; transgender; exploratory therapy

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1. Introduction

Gender medicine (puberty blockers, hormones, and surgeries) is one way to treat gender dysphoria, a kind of distress with one's sexed body (Drescher, 2025). These medical interventions are sometimes collectively referred to as "gender-affirming" medical care (Rafferty et al., 2018), and in the US, treatment for gender dysphoria includes puberty blockers for some eight-year-olds, double mastectomies for some twelve-year-olds, and genital surgeries on some minors (Olson-Kennedy et al., 2025; Tang et al., 2022; Terhune et al., 2022); in many states there is no minimum recommended age for medical gender interventions aside from phalloplasty (Coleman et al., 2022). Minors are sometimes offered puberty blockers or hormones on their first clinic visit (Terhune et al., 2022) or after a 2-hour appointment (Damiano, 2024), while for those above the age of consent, hormones are available online (without prior mental health assessment, a model of care called "informed consent" [Cavanaugh et al., 2016; Plume Clinic, 2024]). In 2021 alone, over 4000 US minors started hormones (intended to be taken lifelong), and at least hundreds undergo gender surgeries each year (Terhune et al., 2022). Including adults, over 50,000 gender-affirming surgeries were performed in the US from 2016 to 2020: 57% of the patients had breast/chest surgeries and over a third (35%) had genital surgeries (including hysterectomy 9%, orchiectomy 7%, vaginoplasty 7%) (Wright et al., 2023). A medical letter of support for surgery with one appointment and one-to-two week turnaround time is advertised online (Plume Clinic, n.d.).

These interventions are being provided in a setting of considerable expert disagreement regarding both the use of medical interventions for gender dysphoria (Block, 2023; Kozłowska et al., 2024; Vrouwenraets et al., 2015) and how to best treat gender dysphoria more generally. There is no consensus. In addition, although one of the key aims in treating gender dysphoria is to relieve its associated distress and improve psychological functioning (Baker et al., 2021; Gorin, 2024), evidence of benefit from the above gender medicine interventions is "remarkably weak" for minors (Cass, 2024) and numerous rigorous systematic reviews also find low and very low certainty evidence of benefit of these interventions for patients under 21 and under 26 (Brignardello-Petersen & Wiercioch, 2022; Department of Health and Human Services, 2025, Chapter 5; McDeavitt et al., 2025a, Table 3; Miroshnychenko et al., 2025a). There are similar findings of low quality or very low quality/insufficient evidence of benefit for all ages (Baker et al., 2021; Georgas et al., 2018). Well conducted systematic reviews of the evidence¹ follow specific steps (Brignardello-Petersen et al., 2025) to arrive at an assessment of the certainty of the evidence as a whole, and along with meta-analyses they comprise the most reliable form of evidence in evidence-based medicine, which is current best medical practice (Evidence-Based Medicine Working Group, 1992; McDeavitt et al., 2025a). Findings of low/very low certainty evidence of benefit for gender medicine means that there is

¹ Those conducting a systematic review to evaluate a body of evidence first determine the question(s) and eligibility (inclusion and exclusion) criteria, then search for and select studies using a predetermined (repeatable because explicitly stated) search strategy, abstract data of included studies and assess for bias, summarize the studies' data, and then assess the certainty of the evidence as a whole and draw conclusions. They are not always well-conducted – see, for instance, Clayton et al. (2022). There are specific reporting steps and assessment tools for systematic reviews (Page et al., 2021; Shea et al., 2017).

limited/very little (respectively) confidence that estimates of effects of these interventions will match true effects (Balschem et al., 2011).

Medical interventions for gender dysphoria have thus not been shown likely to be beneficial long term (including to relieve gender dysphoria), nor, more specifically, have they been shown to lower suicide risk (Baker et al., 2021; Christensen et al., 2025; Miroshnychenko et al., 2025a, 2025b; Ruuska et al., 2024). Importantly, their benefits have also not been shown to be likely to outweigh risks of adverse outcomes such as regret (sometimes associated with detransition [Cohn, 2023; Feigerlova, 2025]) or associated but not yet sufficiently studied serious physical harms (Department of Health and Human Services, 2025, ch. 7; Miroshnychenko et al., 2025b; Schwartz et al., 2025), including infertility and other harms to reproductive organs, bone density, and the cardiovascular system (Cheng et al., 2019; De Roo et al., 2016; Ludvigsson et al., 2023; Nota et al., 2019). In fact, the group who pioneered gender interventions in minors recently called for “an explicit discussion on the objectives of [medical gender interventions] for adolescents,” saying: “The linear narrative of improvement in GAMT [gender-affirming medical treatment] for adolescents is limited and ...” [Oosthoek et al., 2024]).

Also unknown are gender dysphoria’s etiology (Levine et al., 2022), for whom gender dysphoria might endure (Byrne, 2024; Cass, 2024, p. 22), and likely outcomes with alternative treatments (e.g., “watchful waiting” [de Vries & Cohen-Kettenis, 2012] or other psychological support [Churcher Clarke & Spiliadis, 2019; Evans & Evans, 2021; Heathcote et al., 2024; Hutchinson, 2025; Withers, 2020]) or without interventions (natural history). The evidence underlying psychosocial support without medical intervention is also low certainty; however, it has many fewer risks than medical intervention (Heathcote et al., 2024). For youth: “Confirming [a] young person’s self-diagnosis of gender dysphoria or gender incongruence is easy. Clarifying the developmental forces that have influenced it and determining an appropriate intervention are not” (Levine et al., 2022). There is currently “no reliable way to accurately predict which young people might benefit from a medical transition and which might benefit from alternative pathway(s) or interventions(s)” (Cass, 2024, p. 134). Reasons that so little is known include (Cass, 2024, p. 34) the lack of systematic studies of long-term outcomes (at least a decade of follow-up appears to be required [Cass, 2024; Cohn, 2023]), inadequacies of available shorter-term studies (Abbruzzese et al., 2023; McDeavitt, 2024; McDeavitt et al., 2025a), and insufficient (mostly non-existent) randomized controlled trials comparing those who were and weren’t treated.

2. Unsupported, Misleading or Erroneous Statements

However, in addition to these many unknowns, the field of gender medicine is also suffering from erroneous information (Levine et al., 2022) and censorship. There is censorship of attempts to publish (Bailey, 2024; Baxendale, 2024; Block, 2024a; “Research into Trans Medicine Has Been Manipulated”, 2024; Selin Davis, 2024a) or otherwise disseminate correct information (e.g., within medical societies, Johnson, 2024; Nainggolan, 2021; Ryan, 2024; Selin Davis, 2024b). The focus here is instead on censorship of attempts to *correct* unsupported, misleading, or erroneous claims regarding medical gender interventions, i.e. censorship of debate.

Unsupported, misleading or erroneous statements regarding gender medicine have appeared in many authoritative US medical journals, including *JAMA* (found, for example,

in Barbee et al., 2024; Lepore et al., 2022; Tordoff et al., 2022), *New England Journal of Medicine (NEJM)* (McNamara et al., 2022) *Pediatrics* (Georges et al., 2024; Turban et al., 2020b), *Journal of Adolescent Health* (Budge et al., 2024; Hughes et al., 2021; Kidd & Sequeira, 2024), *Annual Review of Medicine* (Lee & Rosenthal, 2023), and *Nature Reviews Endocrinology* (Lopez & Kuper, 2023; Rosenthal, 2021); more examples are below. Such statements include exaggerations of how well the evidence is known, e.g., stating, in spite of the abovementioned low/very low certainty evidence, that these interventions are known to be likely beneficial or even “lifesaving” (this last statement risks creating a nocebo effect [Appleby, 2024; Clayton, 2023] by implying that not receiving the interventions would be life-threatening, and suicide is socially contagious). The inaccurate claim of established benefit is also often used to conclude that randomized controlled trials would be unethical. There is also the inaccurate (Balsheim et al., 2011) claim or implication that only randomized controlled trials can improve the evidence base. Another frequent incorrect claim is that the regret rate is known and that it is low or rare: the rate is not known (Cohn, 2023). Bustos et al. (2021) is a low-quality (Brignardello-Petersen & Wiercioch, 2022) systematic review often quoted for a low regret rate (<1%), but its authors acknowledge that “limitations ... and moderate-to-high risk of bias in some studies represent a big barrier for generalization of the results of this study,” where “some studies” is 23 of its 27 studies – 97% of the included participants (Expósito-Campos & D’Angelo, 2021), and all the included studies suffer from premature follow-up, significant loss to follow up, or both (Cohn, 2023, Appendix). Similarly unsupported (Cheung et al., 2025; Clayton et al., 2024; McDeavitt et al., 2025b, Table 3c) is the claim that treatments with similar low-quality evidence of benefit and comparable risks (infertility, etc.) are common in pediatric medicine, nor has it been shown (Byrne, 2024)² that gender dysphoria in adolescence is likely to be enduring or that (D’Angelo, 2025) any treatment to address gender distress besides gender affirming therapy and social and medical interventions to alter physical characteristics is harmful. A false choice is sometimes presented between only two options: “gender affirming therapy,” i.e., “a therapeutic stance that focuses on affirming a patient’s gender identity and does not try to ‘repair’ it” (Yarbrough et al., 2017) or conversion/other harmful “therapy.” Some who advocate for gender affirming care do not even mention alternatives to gender affirmation besides no treatment (Rosenthal, 2021). Another frequent claim is that there is expert consensus regarding best practice; as noted earlier, there is considerable expert disagreement.

Often results are quoted from studies which have continued to be frequently cited in spite of their errors (such as conclusions not supported by their data³) or (often unmentioned) serious limitations (see discussion of some examples in Abbruzzese et al., 2023; Clayton et al., 2022); another example is the regret review mentioned above.

The misstatements tend to be in one direction, that is, tending to assert stronger likelihood of benefit and lower risk of adverse gender medicine outcomes than the

² Gender dysphoria before puberty was seen in studies to resolve in the majority of cases absent social and medical transition (Singh et al., 2021).

³ For example, studies inferring a causal relationship from a cross-sectional study, studies only considering minority stress as a possible cause for poor treatment outcomes (not also, e.g., the possibility that the medical treatment might have itself caused the harm), studies neglecting confounders, and studies with insufficient follow up time, follow up percentage, inappropriate measurement instruments and/or study inclusion criteria, or other study design flaws.

evidence supports, while omitting or mischaracterizing less invasive alternative treatment options. The erroneous, misleading and unsupported claims have propagated through the research literature, and as described below, into medical society guidelines and policies (Wikipedia, based upon the research literature, thus has many erroneous, misleading, and unsupported statements on this topic as well).

3. Examples of Censored Rebuttals

Critiques pointing out errors or unsupported statements in medical articles often take the form of letters to the editor, which, if accepted (at the editor's discretion), may appear alongside the article, allowing readers to see what is being debated. Critiques can also be published on PubPeer, a post publication peer-review website, or in another journal; for these, people need to seek critiques of a paper outside of the original journal. Possible outcomes of a critique include correction or retraction of the original article. Although critiques of statements such as described above are sometimes accepted for publication, often they are rejected, leaving the claims unchallenged in the journal and, if the critique does not appear elsewhere, in the research literature more generally.

This section describes several examples of critiques rejected by the original journal. The next section considers broader trends in the published corpus and rejections by a third-party post-publication peer-review platform.

The first example is a paper whose conclusions were unsupported by its data and analysis: "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation," by Turban et al. (2020b), which appeared in *Pediatrics*, the journal of the American Academy of Pediatrics (AAP). From their analysis of an anonymous online survey, the authors reported an association between receiving puberty blockers and lower odds of lifetime suicidal ideation. They concluded, "This study strengthens recommendations by the Endocrine Society and WPATH for [puberty blockers] to be made available for transgender adolescents who want it" (Turban et al., 2020b, p. 7); WPATH, the World Professional Association for Transgender Health, is a gender specialist organization which includes clinicians, patients, and others. However, the findings were based on a question known to have "elicited unreliable answers about puberty blockers" (Biggs, 2020), the survey was nonrepresentative, and the authors' inference of possible cause and effect might have been reversed, i.e., it might have been that those with higher lifetime odds of suicidal ideation were less likely to be offered puberty blockers (the study was rated low quality in a rigorous systematic review [Taylor et al., 2024b]). *Pediatrics* rejected M. Biggs' comment noting these objections, giving no reason in their letter,⁴ but his critique was compelling enough to later be accepted and published by *Archives of Sexual Behavior* (Biggs, 2020).⁵ The Turban et al. (2020b) paper continues to be highly cited (416 citations according to Google Scholar at the end of February 2025), often for implying that medical gender interventions are likely to be beneficial (Endocrine Society, 2020) or that lack of them increases suicidal ideation⁶ or risk (Rapaport, 2020).

⁴ M. Biggs (private communication).

⁵ Surprisingly, the AAP subsequently then did publish M. Biggs' comment, without informing him (Biggs, private communication).

⁶ "Gender-affirming medical interventions improve social and mental health outcomes, such as decreased suicidal ideation and improved peer relations that last into adulthood" (Hughes et al., 2021); "Studies

Another article led by J. Turban in 2020, in *JAMA Psychiatry*, “Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults” (Turban et al., 2020a), used the same nonrepresentative online survey to assert that recalled lifetime exposure [“gender identity conversion efforts,” defined by one survey question⁷] was associated with severe psychological distress in the previous month, and higher odds of reported lifetime suicide attempts. The authors stated: “These results support policy statements from several professional organizations that have discouraged this practice” and two of the authors also wrote an op-ed: “It’s time for conversion efforts to be illegal in every state, before more people die” (Turban & Keuroghlian, 2019), emphasizing a tie between suicide risk and conversion therapy. However, as noted earlier, many who advocate for the US gender-affirming model consider any therapy besides affirmation as harmful: the lead author J. Turban stated in a later interview:

There’s no psychiatric intervention for gender dysphoria. There are medical interventions for gender dysphoria, if you will. And it’s not the rule like right, how the psychiatrist’s going to treat gender dysphoria, they’re not like they’re not going to make that go away. [...] The only way that it’s ever been proposed that psychiatry can do that was through conversion therapy, which obviously doesn’t work. (Webberly, 2021).

A longer version of one rejected response, later published in *Archives of Sexual Behavior* (“One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria”) noted:

To the best of our knowledge, all of the letters written to the Editor of *JAMA Psychiatry*, many by respected academics and clinicians who outlined the serious problems in the study, have been rejected (some of them were later submitted as non-indexed comments in the online publication) (D’Angelo et al., 2021).

Again, psychotherapy is not conversion therapy (D’Angelo, 2025), and again, it has not been shown that gender-affirming interventions reduce the risk of suicide or that not providing them increases it, either in systematic reviews (Baker et al., 2021; Christensen et al., 2025) or in a recent several-decade Finnish national record study (Ruuska et al., 2024). Nonetheless the article had 234 citations in late February 2025 in Google Scholar.

A third example is from the *NEJM*. “Protecting Transgender Health and Challenging Science Denialism in Policy,” by McNamara et al. (2022), was a Perspective summarizing legal disagreements about the evidence regarding medical interventions associated with gender-affirming care. It claimed that there was “no way” for a randomized controlled trial to have clinical equipoise, i.e., uncertainty regarding likely benefit of treatment, “since evidence demonstrates mental health benefits, reduced suicidality ... associated with this care.”⁸ They also claimed “studies of those who have undergone medical

also find that transgender youth who receive transition-related care report less suicidal ideation than transgender youth who want transition care but do not receive it. Access to transition-related care is not just a boon to the health of transgender youth, but also a lifesaving resource” (Barbee et al., 2022).

⁷ “Did any professional (such as a psychologist, counselor, or religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?” quoted in D’Angelo et al. (2021).

⁸ Their claimed loss of equipoise implicitly extended “associated with this care” to imply causality.

transition have typically found rates of regret of less than 1%” without noting that these studies were unreliable, implied puberty blockers were safe (“Witnesses ... claimed that puberty blockers cause irreversible bone changes and infertility, despite their established safety for the treatment of precocious puberty”), and described “statements that gender dysphoria should be treated with psychotherapy alone” as “inflammatory.”

NEJM rejected my Letter to the Editor pointing out these and other misleading or unsupported statements (my submitted letter is in the Appendix A). In response to follow-up questions, the editor informed me that Perspectives articles, as opinion pieces, are given some license, and expressed very little confidence in the umbrella review I had cited, especially as it was not peer reviewed and in disagreement with medical society guidelines (discussion about guidelines is below). Ironically, the *NEJM* Perspective itself cited two unpublished white papers on a Yale website ([The Yale Integrity Project](#), n.d.) for many of its misleading or unsupported statements. This was prioritization of expert opinion over a systematic review, contrary to a basic principle of evidence-based medicine. I had cited this particular umbrella review ([Brignardello-Petersen & Wiercioch, 2022](#)) because it was comprehensive and letters to the editor are only allowed five references. In addition, I had reason to believe it was well conducted as it was led by a McMaster professor who develops methodology tools as well as using them; McMaster is a world leader in developing and applying evidence-based medicine methods. My further appeals did not succeed.

Since my exchange with *NEJM*, many more systematic reviews and investigations have come out ([McDeavitt et al., 2025a](#), Table 3; [Department of Health and Human Services, 2025](#), ch. 5); seven were commissioned for the Cass Review final report ([Cass, 2024](#); [Gender Identity Service Series, 2024](#)). Their findings align with the review I had quoted. The Cass Review was an extensive independent review of pediatric gender medicine commissioned by England’s National Health Services (NHS). In response to Dr. Cass’s final report, NHS England immediately committed to implementing its recommendations ([NHS England, 2024](#)) and the impact of the Review’s findings has extended well beyond the United Kingdom. In addition, soon after, ESCAP [European Society for Child & Adolescent Psychiatry], with member adolescent and child psychiatry societies from over 30 European countries, released a statement regarding “an urgent need for safeguarding clinical, scientific, and ethical standards” ([Drobnič Radobuljac et al., 2024](#)).

The lead author of the *NEJM* article also led a critique of the Cass Review final report ([McNamara et al., 2024](#)), released on the same abovementioned Yale Integrity Project website (several Yale Integrity Project articles [[The Yale Integrity Project, 2025](#)] make similar claims regarding gender medicine). This Yale critique had several arguments in common with the *NEJM* article I had critiqued; however, in this case, two peer-reviewed rebuttals were published ([Cheung et al., 2025](#); [McDeavitt et al., 2025b](#)). Thus some corrections or clarification of the points I had challenged finally did appear in peer-reviewed journals (but not in *NEJM*).

The fourth example is a *JAMA Surgery* article “Postoperative Regret Among Transgender and Gender-Diverse Recipients of Gender-Affirming Surgery,” by [Barbee et al. \(2024\)](#). The authors claimed that the regret rate of gender-affirming surgery is “profoundly low,” when in reality the regret rate is not credibly measured ([Cohn, 2023](#)), and there is no reason to expect it is “profoundly low.” Similarly, they made unsubstantiated claims that gender-affirming medical interventions are “safe and effective,” with “clear”

benefits. My Letter to the Editor, “Efficacy and regret rates are still unknown for gender-affirming surgery,” pointed out these statements were unsupported. It was accepted.

I had followed *JAMA*’s instructions exactly, one and only one affiliation for a Letter to the Editor,⁹ and for disclosures:

Authors are expected to provide detailed information about all relevant financial interests, activities, relationships, and affiliations (*other than those affiliations listed in the title page of the manuscript*) including ... [emphasis mine]

My relevant (and title page) affiliation was the Society for Evidence-Based Gender Medicine (SEGM) and I’d accurately said I had nothing to disclose. However, about a month after my letter’s acceptance, another editor wrote to me about my signed author agreement and I agreed to add a disclosure with detailed information about my affiliated institution, SEGM, its aims and my financial and other relationships to it. But then I asked for confidentiality before providing other information she wanted (entirely unrelated to gender medicine or my letter), asking for a means of contact. Instead of assuring me regarding editorial confidentiality, and to my surprise, the editor simply rejected my accepted Letter to the Editor. I asked for reasons; some weren’t clarified even when I asked, and the others did not seem accurate to me. My appeal failed.

More importantly, at no time was the accuracy of my letter called into question. It had been accepted and pointed out a serious issue to three editors, critically relevant for a patient consenting to undergo these surgeries: the claim of a “profoundly low” likelihood of regret for life-altering gender surgeries is unsupported and benefit has not been established, and yet the *JAMA* article to which I was responding incorrectly claims the opposite. The article remains unchallenged and, having been published in *JAMA*, continues to be taken very seriously.

When I submitted a modified version of my letter to another journal, it told me the content was more appropriate for *JAMA*. The original letter is in this paper’s appendix.

4. Body of Literature

Incorrect papers are not new, and one possibility is that *NEJM* was just not keeping up with every possible correction in spite of claims, or perhaps aims, of high accuracy,¹⁰ and similarly for *JAMA*. It was possible that the errors I had tried to rebut (e.g., inaccurate claims of known benefit and inaccurate claims of known and known to be low regret rate) were uncommon.

On February 20, 2025, *NEJM*’s search function returned 32 articles to me with the words “gender-affirming” in them. Focusing on those appearing since the article I critiqued, I did find a set of letters to the editor (Biggs et al., 2023) pointing out serious concerns regarding a single study (Chen et al., 2023), an accompanying article (de Vries & Hannema, 2023), and the evidence base. De Vries and Hannema (2023) claimed: “current information shows that mental health improves with GAH

⁹ Letter to the Editor. Instructions for Authors. (2025, February 10) *JAMA* website. [link to the article](#)

¹⁰ “The *Journal*’s careful editing process often requires extensive revisions and involves detailed checking for accuracy.” [link to the article](#).

[gender-affirming hormones], whereas withholding treatment may lead to increased gender dysphoria and adversely affect psychological functioning.” Several other *NEJM* articles also had erroneous statements similar to the ones my rejected letter had critiqued: “Gender-affirming care is a cornerstone of multidisciplinary health support for transgender and nonbinary people; it is widely recognized as essential, evidence based, and often lifesaving” (Coelho et al., 2025); “These bills often take aim at gender-affirming care, ignoring research demonstrating that such care improves mental health outcomes” (Guerra et al., 2025); “Surgical affirmation has been shown to significantly improve the health and well-being of trans people” (Murphy et al., 2025); and “It is not hyperbole to say that lives are at risk in states pursuing these bans on needed care” (Ulrich, 2024).

Also, although several *NEJM* articles have covered current issues in gender medicine (e.g., regarding various American laws), the only article *NEJM* seemed to have published by February 2025 regarding the Cass Review, 10 months old at that point, was a recent Perspective article which was critical of it (Aaron & Konnoth, 2025). The Perspective has many unsupported statements in common with the already rebutted Yale critique by McNamara et al. (2024); thus many of its inaccurate or unsupported claims had already been rebutted by Cheung et al. (2025) three months before it appeared.

Similarly, my search on PubMed for “JAMA gender-affirming surgery,” also on 20 February 2025, retrieved 49 articles. I found one instance where uncertainties and growing international caution were pointed out, but again in a Letter to the Editor (Hunter, 2022) not an article itself, in response to a paper inaccurately claiming “access to GAC clearly improves health outcomes” (Park et al., 2021). Another article described inadequate implementation of patient-reported outcome measures (Kamran et al., 2023), and a third made a plea for collecting outcomes to get high quality information (but stated without support “clinical trials would not be ethically or technically feasible for gender-affirming interventions” [Agochukwu-Mmonu et al., 2022]). Several papers claimed established benefit or low regret rates: “There is a growing body of literature supporting the positive outcomes of gender-affirming surgery (GAS) on transgender and gender diverse individuals” (Marano et al., 2021); “Given the benefits of GAS” (Wright et al., 2023); “regret for transition is exceedingly rare [...] Given the established benefits of GAS and the rarity of regret” (Wu & Keuroghlian, 2023); “Despite the fact that discontinuation of gender-affirming medical or surgical interventions is rare” (Turban et al., 2022); “Despite the demonstrated health and well-being benefits associated with genital gender-affirming surgery (GAS)” (Stranix & Bluebond-Langner, 2022), “Genital gender-affirming surgery (GAS) is safe and offers substantial benefits to patients” (Downing et al., 2022); and “Given the profound benefits and the medical necessity of gender-affirming care...” (Peters, 2024).

Thus, *JAMA* and *NEJM* have published many articles with unsupported statements of likely benefit and expected low regret rate for gender-affirming surgery in particular and gender-affirming medical intervention more generally. The issues in the articles I tried to correct in these very influential journals were not anomalous. The journals’ interest in accuracy was not consistently resulting in corrections and discussion of disagreements in the literature. Thus it was a significant step when *JAMA* published a Viewpoint by Gorin et al. (2025a) the day after the January 2025 USC Censorship in the Sciences Conference:

Interdisciplinary Perspectives¹¹ reporting on many of the concerns and developments in the understanding of pediatric gender medicine, including the Cass Review.

It should be noted that, all along, a few journals have been publishing research (and discussion, e.g., [Levine et al. \(2022\)](#); [Drescher \(2023\)](#), [Levine et al. \(2023\)](#)) on this topic, such as the *Archives of Sexual Behavior*, which published the originally rejected rebuttals to the two Turban et al. papers described above. However, this journal was itself subject to what appeared to be attempted censorship. There was a public effort ([Adams et al., 2023](#)) by numerous clinicians, including WPATH's then president M. Bowers and WPATH's current president A. Radix, to get the journal's editor removed, which failed. (It was combined with a successful effort [[Bailey, 2024](#)] to make the journal retract a paper [[Diaz & Bailey, 2023](#)].) That is, clinicians and researchers in the field attempted to remove an editor whose journal was publishing critiques that had been rejected elsewhere.

PubPeer, a post-publication peer review site which links critiques to published articles, is another platform where one can try to make corrections. It is designed for open discussion of research and received a 2024 award for its work from the Einstein Foundation. The citation read:

"PubPeer is a widely used online platform for post publication review and legitimate discussion of published scientific data.

[...]

PubPeer allows everyone to post anonymous or signed comments about research that has been published in the scientific literature, open a discussion on its content and integrity, and point out shortcomings or commend good methodology."¹²

I learned of PubPeer after my *NEJM* critique was rejected. I submitted my *NEJM* critique to their site with some minor modifications and it was accepted and published two days later. In the next month I submitted critiques of three other articles (another rejected *NEJM* critique, and two critiques I wrote especially for PubPeer), which were all also accepted and published within a few days of submission. The three other critiqued articles were:

- Moving Beyond Psychiatric Gatekeeping for Gender-Affirming Surgery ([Wu & Keuroghlian, 2023](#))
- Psychosocial Functioning in Transgender Youth after 2 Years of Hormones ([Chen et al., 2023](#))
- Regret after Gender Affirming Surgery – A Multidisciplinary Approach to a Multifaceted Patient Experience ([Jedrzejewski et al., 2023](#))

However, a month after my first critique was accepted and published on the site, all four critiques were removed within a five-minute period and then listed on the site as rejected. I wrote to PubPeer, asking why they had been removed – they had already been accepted and published, and as far as I know I met all their requirements ([PubPeer FAQ, n.d.](#)). I received no reply. I subsequently asked what I needed to change in order to get them

¹¹ See [link to the article](#).

¹² PubPeer-Einstein Foundation Institutional Award 2024 (2024). [link to the article](#).

published, and received no answer. I sent several emails, and also used their online contact form. In addition, I emailed one of the people who had started PubPeer. I have not received any reply to any of these queries.

Thus, in my experience, all three medical information sources have blocked corrections to (frequent) important errors and unsupported statements in (their, for *JAMA* and *NEJM*) articles about gender medicine.

5. Closed Loop between Journals and Medical Societies

In the censorship of journal articles, medical societies appear to play a key role. Medical societies run several of the relevant journals, and also produce guidelines and recommendations which are both quoted by research articles and relied upon by many clinicians, patients and their families, and policy makers. Articles making incorrect or unsupported claims about gender dysphoria or its treatment often rely upon other such articles or upon medical society recommendations or statements, rather than systematic reviews (that is, they prioritize expert opinion – “eminence” based medicine – rather than “evidence” based medicine). As described above, it appears the *NEJM* editor did this with my rejected letter.

Normally, medical society guidelines would not be in conflict with an expert systematic review, because trustworthy medical society guidelines are based upon systematic reviews of the evidence (Lima et al., 2023; Steinberg et al., 2011) and link the strength of the recommendations to the strength of the evidence (Block, 2023; Brignardello-Petersen et al., 2021). However, guideline reviews and investigations have found significant shortcomings in key gender medicine guidelines and policies (Block, 2023; Dahlen et al., 2021, 2022; Taylor et al., 2024a). For instance, the AAP policy statement (Rafferty et al., 2018) recommending US “gender affirming care” is not based on systematic reviews; rather, its cited references “repeatedly said the very opposite of what AAP attributed to them” (Cantor, 2020), among other issues (McDeavitt, 2025). The Endocrine Society guidelines (Hembree et al., 2017) make strong recommendations based upon evidence they themselves report to be low or very low certainty (i.e., with limited to very little confidence for accurately estimating outcomes), without providing justification (Block, 2023). Instead of being based upon systematic reviews, WPATH interfered with the systematic reviews it had commissioned, inaccurately claimed a systematic review for their adolescent recommendations was not possible (Coleman et al., 2022; several already existed [Brignardello-Petersen & Wiercioch, 2022]), and then, after publication, dropped all but one minimum age recommendation (for phalloplasty) for medical interventions, under pressure from the US Biden Administration and the AAP (Block, 2024a; Department of Health and Human Services, 2025, ch. 10; Ghorayshi, 2024a; “Research into Trans Medicine Has Been Manipulated”, 2024).

In fact, a recent rigorous pediatric gender medicine guideline review traced how most societies’ recommendations rely upon earlier Endocrine Society and WPATH recommendations, which were themselves interdependent, rather than following standards for international guideline development. They note this “may explain why there has until recently been an apparent consensus on key areas of practice for which evidence remains lacking” (Taylor et al., 2024a, p. S71). It concludes “Healthcare services and professionals should take into account the poor quality and interrelated nature of published guidance” (Taylor et al., 2024a, p. S65).

In the US, the Biden administration's Health and Human Services (HHS) statement advocating for gender affirming care for young people (U.S. Health and Human Services, 2022) directed readers to the abovementioned AAP, Endocrine Society, and WPATH recommendations. HHS claimed medical interventions "improve[s] ... mental health and overall well-being" and that gender-affirming care is "demonstrated to yield lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life" (one reference cited in support did not "demonstrate" rather saying "emerging research suggests [benefits]" [Wagner et al., 2019] the other two cannot establish causality [Green et al., 2022; Hughto et al., 2020]). The Editor-in-Chief of the *British Medical Journal* summarized the situation in 2023: "Much of this clinical practice [in the United States] is supported by guidance from medical societies and associations, but closer inspection of that guidance finds that the strength of clinical recommendations is not in line with the strength of the evidence" (Abbasi, 2023).

Statements from medical societies outside of guidelines also carry weight, and include unsupported claims such as there being a "comprehensive body of ... research supporting the positive impact" of gender interventions (American Psychological Association, 2024), that "Youth who are able to access gender-affirming care [...] experience significantly improved mental health outcomes" (Endocrine Society, 2020), and that "Gender-affirming care is medically-necessary, evidence-based care that improves ... physical and mental health" (American Medical Association, 2021).

When the comprehensive Cass Review final report of pediatric gender medicine, based upon numerous rigorous systematic reviews finding otherwise, was released, there was minimal response from many prominent US medical societies (Block, 2024b). A comparison was voiced by Dr. Cass, who said she "respectfully [disagreed] with [the AAP] on holding on to a position that is now demonstrated to be out of date by multiple systematic reviews" (Ghorayshi, 2024b). The subsequent HHS report (Department of Health and Human Services, 2025) got a more explicit response. Although the HHS report was based upon rigorous evidence review, the AAP nonetheless characterized it as "[prioritizing] opinions over dispassionate reviews of evidence" (Kressley, 2025), while WPATH inaccurately responded that "studies consistently show its [gender-affirming care's] positive impact, including improved mental health and overall quality of life" (WPATH & USPATH, 2025), and the Endocrine Society inaccurately said "Medical studies show that access to this care improves the well-being of transgender and nonbinary people" (Christensen, 2025).

It appears a closed loop has formed. The journals seem to be relying upon society guidelines and recommendations to evaluate submitted articles rather than objectively examining the merit of the articles themselves. In turn, the society guidelines and societies appear to mostly be relying upon each other's statements (Taylor et al., 2024a) and upon (sometimes unreliable) select articles from the journals, rather than systematic reviews of the evidence (or, in the case of the Endocrine Society, are making strong recommendations based on low and very low certainty evidence). In the absence of evidence-based criticism (such as letters to the editor) and ensuing debate to ensure accuracy, many errors or unsupported or misleading statements in the literature remain uncorrected and continue to be repeated. Published articles in this field are undependable and the credibility and basis for authority of the journals and the body of literature more generally has been undermined.

6. Medical Impacts

It is not only an academic problem that this body of research literature has become permeated by erroneous articles. It is also medically dangerous. In medicine, ethical informed consent means a person understands the benefits, risks, and alternatives (including “doing nothing”) before consenting to undergo treatment (Levine et al., 2022). However, in the examples here, the incorrect statements regarding medical gender interventions frequently minimize the (unknown) likelihood of serious risk and overstate the (unknown) likelihood of benefit, as well as omitting mention of less risky and often viable alternatives (or disparaging them, e.g., the claims or implication that psychotherapy is harmful or never useful). Harm can extend well beyond the unreliability of the research literature, for instance, when an authoritative research article incorrectly tells patients and doctors that the regret rate for a serious irreversible procedure is known and less than 1% (or rare).

As mentioned in the introduction, the US affirmative model emphasizes puberty blockers, hormones and surgeries. Given the uncertainty as to whether these physical modifications of healthy bodies (including removal of healthy organs) are even beneficial for the condition they aim to treat, it would best serve these vulnerable patients for there to be intense scrutiny of the evidence, and rigorous debate to better understand the best way to support each individual. In particular, it would benefit patients and clinicians and others to have accurate information about what is and isn't known about risks, benefits and alternatives.

In response to the improved understanding of the limitations of the evidence, repeatedly reported by systematic reviews and synthesized for the case of pediatric medicine in the Cass Review 2024 final report (and more recently the HHS 2025 report [Department of Health and Human Services, 2025]), many governing and professional bodies internationally are turning away from the US affirmative model and towards offering psychotherapy as the first intervention (Block, 2023; Drobnič Radobuljac et al., 2024; French National Academy of Medicine, 2022; Ghorayshi, 2024c; Hansen et al., 2023).

It has also been observed (Baxendale, 2025) that those who advocate for gender-affirming care for minors (such as the US affirmative model) are tending to rely upon expert opinion (the least reliable form of evidence) while those calling for caution and prioritizing psychotherapy are relying upon systematic reviews of the evidence (the most reliable). Again, many current guidelines are consensus, i.e., expert opinion, based. As Baxendale discusses, expert opinion is much more susceptible to cognitive biases and group dynamics, and prioritizing it has lain behind many harmful past practices. In “The Gender Affirmative Treatment Model for Youth with Gender Dysphoria: A Medical Advance or Dangerous Medicine?” Clayton (2022) makes comparisons between gender medicine and past medical treatments which have eventually turned out to be harmful. She notes that, for instance, “many of the criticisms made about the inadequate evidence base of discredited historical treatments can be leveled against chest surgery for GD youth.” As Dr. Cass noted to young patients in her final report: “Firstly, you must have the same standards of care as everyone else in the NHS, and that means basing treatments on good evidence” (Cass, 2024, p. 14).

7. Conclusions

To summarize and conclude, misinformation currently plagues the gender medicine literature, in spite of attempts such as those described here to correct inaccuracies, misrepresentations, unsupported statements, and/or analysis errors. Several influential US medical societies and journals appear to be in lockstep, insufficiently implementing best practices designed to ensure accuracy and trustworthiness (examples described herein included societies not basing recommendations upon systematic reviews of the evidence and/or not tying the strength of recommendations to strength of the evidence, and journals blocking debate).

The standards to which journals are believed to adhere is the foundation of their impact, their authority and their value. Corrections of errors in the research literature are expected, rather, assumed, by readers of professional journals. The accompanying debate is widely recognized as essential. To quote a recent article co-authored by many of *JAMA*'s editors:

The free exchange of ideas is essential to scientific progress, just as it is integral to the founding ideals of the US. The integrity of the scientific process does not depend on blind trust in science or on an assumption that a scientific finding is always right. Rather, this integrity hinges on the confidence that the free exchange of scientific ideas grounded in rigorously conducted scientific inquiry, including the discussion, debate, and disagreement that results in further inquiry, ultimately leads to insights that are likely to be true. (Bibbins-Domingo et al., 2025).

Efforts by myself and others in support of these aims have been stymied for several years.¹³ It is critically important that *JAMA* and other journals uphold these principles in their editorial processes and decisions in the field of gender medicine. Improvement of the body of literature in this field is urgently needed. The January 2025 *JAMA* article (Gorin et al., 2025a) mentioning the Cass Review was a notable step in the right direction, as was the more recent publication of debate between the article's authors and critics (Gorin et al., 2025b; Streed & Baker, 2025). The research literature (and medical care) in this field would benefit greatly if more "free exchange of scientific ideas grounded in rigorously conducted scientific inquiry" regarding the ("remarkably weak" [Cass, 2024, p. 13] for pediatric, low/very low certainty more generally) gender medicine evidence base appeared in the pages of US medical society journals and elsewhere.

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¹³ I only gave two examples, where an editor stated reasons for rejection of a critique directly to me; I have also attempted to correct several other articles where I only received a form letter rejection, and am aware of several others' unsuccessful attempts as well.

Appendix A. Submitted Letters to the Editors of NEJM and JAMA

NEJM Letter to the Editor (rejected)

McNamara, Lepore and Alstott¹ (MLA) incorrectly assert critics of puberty blockers, hormones (often taken for life), and surgeries: “claim that gender-affirming care is “experimental” because the field is actively growing.” However:

The evidence does not currently “demonstrate” benefit. The low/very low certainty evidence of benefit, found by an expert evidence review synthesis² (incorrectly described by MLA, included reviews certainly evaluate studies before 2020), seems likely to remain until there are, e.g., well-conducted comparative observational studies or very large representative case series.² (MLA’s focus on RCTs is a straw man.)

These uncertain benefits are accompanied by significant risk. MLA say infertility risk concern is unsupported, because fertility isn’t *always* destroyed, then counsel offering fertility preservation!

Cardiovascular and bone harm are also documented.³

MLA inaccurately claim small regret, quoting studies with large loss to follow-up, premature outcomes, inappropriate regret proxies or non-representative samples.⁴ Regret rates are unknown.

Although it is now prioritized in progressive Sweden, Finland and the UK,⁵ MLA denounce psychotherapy as inflammatory, and insinuate an erroneous analogy with the pathologization of homosexuality.

MLA needs correction.

¹ (McNamara et al., 2022).

² (Brignardello-Petersen & Wiercioch, 2022).

³ (Levine et al., 2022).

⁴ (Expósito-Campos & D’Angelo, 2021).

⁵ (Block, 2022).

JAMA Letter to the Editor (accepted and then rejected, see main body)

Efficacy and regret rates are still unknown for gender-affirming surgery

Dear Editor,

The recent JAMA Surgery Viewpoint, “Postoperative Regret Among Transgender and Gender-Diverse Recipients of Gender-Affirming Surgery”¹ appears to need modification in order to be accurate.

For example, current evidence does not support the authors’ description of gender-affirming care (GAC) as “a safe and effective form of health care that allows TGD individuals to align their bodies with their own internal sense of self.”

Their cited reference 2 does not appear to have commissioned the requisite systematic reviews to rigorously evaluate the effectiveness of surgery. However, a thorough 2016 US government review found “there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria,”² and a recent long term record search, once corrected, found no benefit to having had surgery in any of its outcome measures.³ Another study reported “In our study, the level of life satisfaction in transgender people was not increased in transgender who had undergone gender-affirming surgery as compared to those who were unoperated.”⁴ Systematic reviews of the evidence are needed to make reliable statements, for each type of surgery.

For regret, the authors note how “technically similar” procedures are “vastly different regarding patients’ motive for seeking the procedure.”¹ Their point is crucial when looking at regret rates, or identifying which/how many patients would have undergone the procedure knowing what they do now.

The regret rate is currently unknown.⁵ Even though the authors state “evidence suggests that less than 1% of TGD individuals who receive GAS report surgical regret,” their source (their reference 3) has not held up under scrutiny; see [Cohn \(2023\)](#)⁵ and references therein. Limitations of the included studies include premature and/or insufficiently complete follow-up, inadequate measurement instruments and/or non-representative sample selection. (Observed regret times are poorly measured and range from 3–10 years on average, depending upon study population, intervention, etc.⁵) These shortcomings appear to undermine the reliability of regret studies more generally; for instance, their reference 10 appears to have only included as regretters those who volunteered this information, rather than following up their patients. The quoted 1% regret rate is thus wholly unreliable.

As quoted “low” or “profoundly low” surgical regret rates are not reliable, and surgical benefit has not been established, telling patients otherwise may compromise informed consent and the decision making process, undermining both and leading to harm.

[Note added for these proceedings: The evidence of benefit for gender surgeries has now been found to be very low (for most outcomes) or low certainty in at least 3 systematic reviews ([Dopp et al., 2025](#); [Georgas et al., 2018](#); [Miroshnychenko et al., 2025a](#)), and a recent register study found a higher incidence of depression, anxiety, suicidal ideation, and substance abuse amongst those with a previous gender dysphoria diagnosis who receive these surgeries, compared to those with no surgery ([Kulatunga-Moruzi et al., 2025](#)).]

¹ ([Barbee et al., 2024](#)).

² ([Gender Dysphoria and Gender Reassignment Surgery, 2016](#)).

³ ([Correction to Bränström and Pachankis, 2020](#)).

⁴ ([Grupp et al., 2023](#)).

⁵ ([Cohn, 2023](#)).

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