Understanding and Responding to Our Transgender Moment

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ABSTRACT: At the heart of the transgender moment are radical ideas about the human person – in particular, that people are what they claim to be, regardless of contrary evidence. Transgender activists do not admit that this is a metaphysical claim. They do not want to have the debate on the level of philosophy, so they dress it up as a scientific and medical claim. But modern medicine cannot reassign sex physically, and attempting to do so does not produce good outcomes psychosocially. Transgender medicine is based on a transgender worldview. But the worldview promoted by transgender activists is inherently confused and filled with internal contradictions. Activists never acknowledge those contradictions. Instead, they opportunistically rely on whichever claim is useful at any given moment. But if you pull too hard on any one thread of transgender ideology, the whole tapestry comes unraveled.

PEOPLE SAY THAT WE LIVE in a postmodern age that has rejected metaphysics. That is not quite true. We live in a postmodern age that promotes an alternative metaphysics. As I explain in *When Harry Became Sally: Responding to the Transgender Moment*, at the heart of the transgender moment are radical ideas about the human person – in particular, that people *are* what they claim to be, regardless of contrary evidence. A transgender boy *is* a boy, not merely a girl who *identifies as* a boy. It is understandable why activists make these claims. An argument about transgender identities will be much more persuasive if it concerns who someone *is*, not merely how someone *identifies*. And so the rhetoric of the transgender moment drips with ontological assertions: people *are* the gender they prefer to be. That is the claim.

Transgender activists do not admit that this is a metaphysical claim. They do not want to have the debate on the level of philosophy, so they dress it up as a scientific and medical claim. And they have co-opted many professional associations for their cause. Thus the American Psychological Association, in a pamphlet titled "Answers to Your Questions about Transgender People, Gender Identity, and Gender Expression," tells us, "*Transgender* is an umbrella term for persons whose *gender identity*, *gender expression*, or behavior does not conform to that typically associated with the sex to which they were assigned at birth."[1]

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[1]American Psychological Association, "Answers to Your Questions About Trans-

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Notice the politicized language: a person's sex is "assigned at birth." Back in 2005, even the Human Rights Campaign referred instead to "birth sex" and "physical sex."[2]

The phrase "sex assigned at birth" is now favored because it makes room for "gender identity" as the real basis of a person's sex. In an expert declaration to a federal district court in North Carolina concerning H.B. 2 (a state law governing access to sex-specific restrooms), Dr. Deanna Adkins stated, "From a medical perspective, the appropriate determinant of sex is gender identity."[3] Dr. Adkins is a professor at Duke University School of Medicine and the director of the Duke Center for Child and Adolescent Gender Care (which opened in 2015). Adkins argues that gender identity is not only the preferred basis for determining sex, but "the only medically supported determinant of sex."[4] Every other method is bad science, she claims: "It is counter to medical science to use chromosomes, hormones, internal reproductive organs, external genitalia, or secondary sex characteristics to override gender identity for purposes of classifying someone as male or female."[5]

This is a remarkable claim, not least because the argument recently was that gender is only a social construct, while sex is a biological reality. Now, activists claim that gender identity is destiny, while biological sex is the social construct.

Adkins does not say whether she would apply this rule to all mammalian species. But why should sex be determined differently in humans than in other mammals? And if medical science holds that gender identity determines sex in humans, what does this mean for the use of medicinal agents that have different effects on males and females? Does the proper dosage of medicine depend on the patient's sex, or on his or her gender identity?

But what exactly is this "gender identity" that is supposed to be the true medical determinant of sex? Adkins defines it as "a person's inner sense of belonging to a particular gender, such as male or female."[6] Note that little phrase "such as," implying that the options are not necessarily limited to male or female. Other activists are more forthcoming in admitting that gender identity need not be restricted to the binary choice of male or female, but can include both or neither. The American Psychological Association, for example, defines "gender identity" as "a person's internal sense of being male, female, or something else."[7]

Adkins asserts that being transgender is not a mental disorder, but simply "a normal developmental variation." And she claims, further, that medical and mental

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gender People, Gender Identity, and Gender Expression," p. 1, http://www.apa.prg/topics/lgbt/transgender.pdf.

[2] Moulton and Seaton, *Transgender Americans: A Handbook for Understanding*, 5.

[3] Declaration of Deanna Adkins, M.D., U.S. District Court, Middle District of North Carolina, Case 1:16-cv-oo236-TDS-JEP, p. 5.

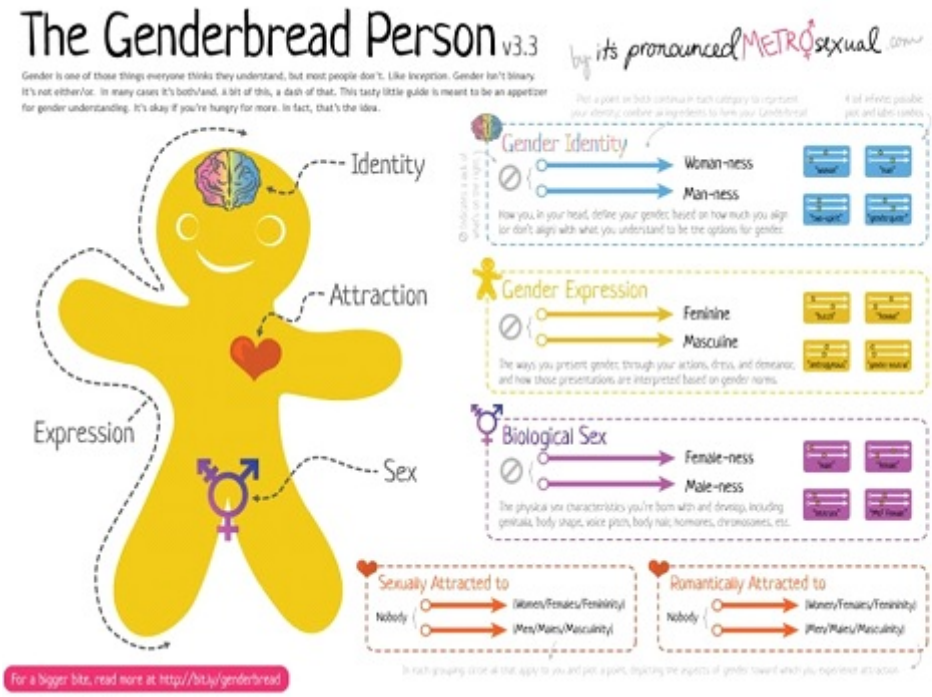
[4] Ibid., 6.

[5] Ibid., 7.

[6] Ibid., 4.

[7] American Psychological Association, "Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression."

Electronic copy available at: https://ssrn.com/abstract=3172277



health professionals who specialize in the treatment of gender dysphoria are in agreement with this view.[8]

Transgender Catechism

These notions about sex and gender are now being taught to young children. Activists have created child-friendly graphics for this purpose, such as the "Genderbread Person."[9] The Genderbread Person teaches that when it comes to sexuality and gender, people have five different characteristics, each of them falling along a spectrum.

There's "gender identity," which is "how you, in your head, define your gender, based on how much you align (or don't align) with what you understand to be the options for gender." The graphic lists "4 (of infinite)" possibilities for gender identity: "woman-ness," "man-ness," "two-spirit," or "genderqueer." The second characteristic is "gender expression," which is "the way you present gender, through your actions, dress, and demeanor." In addition to "feminine" or "masculine," the options are "butch," "femme," "androgynous," or "gender neutral." Third is "biological sex," defined as "the physical sex characteristics you're born with and develop, including genitalia, body shape, voice pitch, body hair; hormones, chromosomes, etc." The final two characteristics concern sexual orientation: "sexually attracted to" and "romantically attracted to." The options

[8] Declaration of Deanna Adkins, 6.

[9] Sam Killermann, "The Genderbread Person v3," *It's Pronounced Metrosexual* (March 16, 2015), http://itspronouncedmetrosexual.com/2015/03/the-genderbread-person-v3/.

include "Women/Females/ Femininity" and "Men/Males/Masculinity." Which seems rather binary.

The Genderbread Person tries to localize these five characteristics on the body: gender identity in the brain, sexual and romantic attraction in the heart, biological sex in the pelvis, and gender expression everywhere. The Genderbread Person presented here is the most recent, version 3.3, incorporating adjustments made in response to criticism of earlier versions. But even this one violates current dogma. Some activists have complained that the Genderbread Person looks overly male.

A more serious fault in the eyes of many activists is the use of the term "biological sex." *Time* magazine drew criticism for the same transgression in 2014 after publishing a profile of Laverne Cox, the "first out trans person" to be featured on the cover. At least the folks at *Time* got credit for trying to be "good allies, explaining what many see as a complicated issue," wrote Mey Rude in an article titled "It's Time for People to Stop Using the Social Construct of 'Biological Sex' to Defend Their Transmisogyny." (It is hard to keep up with the transgender moment.) But *Time* was judged guilty of using "a simplistic and outdated understanding of biology to perpetuate some very dangerous ideas about trans women," and failing to acknowledge that biological sex "isn't something we're actually born with, it's something that doctors or our parents assign us at birth."[10]

Today, transgender "allies" in good standing don't use the Genderbread Person in their classrooms, but opt for the "Gender Unicorn," which was created by Trans Students Educational Resources (TSER).[11] It has a body shape that doesn't appear either male or female, and instead of a "biological sex" it has a "sex assigned at birth." Those are the significant changes to the Genderbread Person, and they were made so that the new graphic would "more accurately portray the distinction between gender, sex assigned at birth, and sexuality."[12]

According to TSER, "Biological sex is an ambiguous word that has no scale and no meaning besides that it is related to some sex characteristics. It is also harmful to trans people. Instead, we prefer 'sex assigned at birth' which provides a more accurate description of what biological sex may be trying to communicate."[13] The Gender Unicorn is the graphic that children are likely to encounter in school. These are the dogmas they are likely to be catechized to profess.

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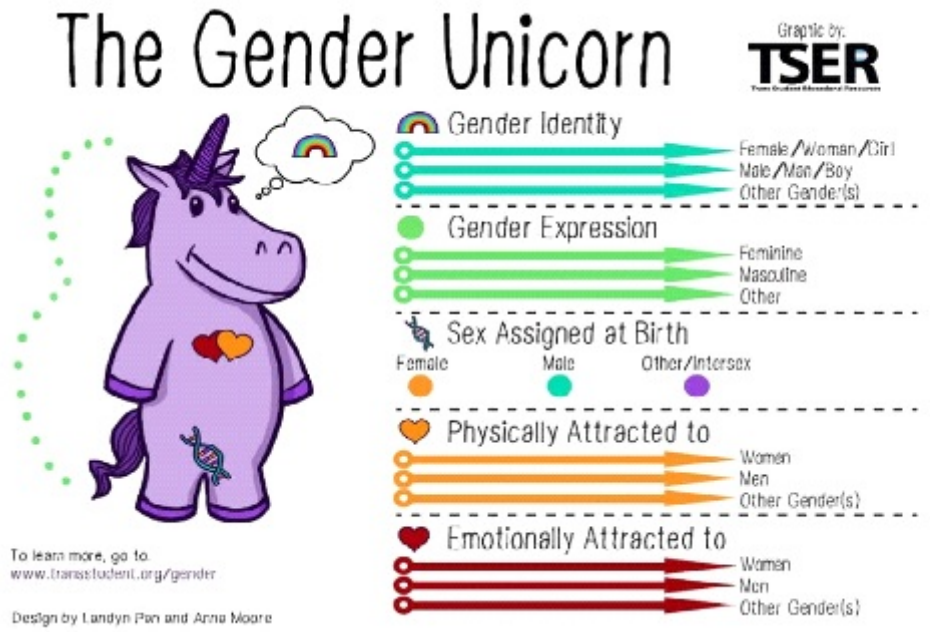
[10] Mey Rude, "It's Time for People to Stop Using the Social Construct of 'Biological Sex' to Defend Their Transmisogyny," *Autostraddle* (June 5, 2014), https://www.autostraddle.com/its-time-for-people-to-stop-using-the-social-construct-of-biological-sex-to-defend-their-transmisogyny-240284/.

[11] Trans Student Educational Resources, "The Gender Unicorn," https://www.trans-student.org/gender.

[12] Ibid.

[13] Ibid.



While activists claim that the possibilities for gender identity are rather expansive – man, woman, both, neither – they also insist that gender identity is innate, or established at a very young age, and thereafter immutable. Dr. George Brown, a professor of psychiatry and a three-time board member of the World Professional Association for Transgender Health (WPATH), stated in his declaration to the federal court in North Carolina that gender identity "is usually established early in life, by the age of two to three years old."[14] Addressing the same court, Dr. Adkins asserted that "evidence strongly suggests that gender identity is innate or fixed at a young age and that gender identity has a strong biological basis."[15] (At no point in her expert declaration did she cite any sources for any of her claims.)

Transgender Contradictions

If the claims presented in this article strike you as confusing, you're not alone. The thinking of transgender activists is inherently confused and filled with internal contradictions. Activists never acknowledge those contradictions. Instead, they opportunistically rely on whichever claim is useful at any given moment.

Here I am talking about transgender *activists*. Most people who suffer from gender dysphoria are not activists, and many of them reject the activists' claims. Many of them may be regarded as victims of the activists, as I show in my book. Many of those who feel distress over their bodily sex know that they aren't really the opposite sex, and do not wish to "transition." They wish to receive help in

[14] Declaration of George R. Brown, M.D., DFAPA, U.S. District Court, Middle District of North Carolina, Case 1:16-cv-oo425, p. 7.

[15] Declaration of Deanna Adkins, 4.

coming to identify with and accept their bodily self. They do not think their feelings of gender dysphoria define reality. But transgender activists do. Regardless of whether they identify as "cisgender" or "transgender," the activists promote a highly subjective and incoherent worldview.

On the one hand, they claim that the real self is something other than the physical body, in a new form of Gnostic dualism, yet at the same time they embrace a materialist philosophy in which only the material world exists. They say that gender is purely a social construct, while asserting that a person can be "trapped" in the wrong gender. They say that there are no meaningful differences between man and woman, yet they rely on rigid sex stereotypes to argue that "gender identity" is real, while human embodiment is not. They claim that truth is whatever a person says it is, yet they believe there's a *real* self to be discovered inside that person. They promote a radical expressive individualism in which people are free to do whatever they want and define the truth however they wish, yet they try ruthlessly to enforce acceptance of transgender ideology.

It is hard to see how these contradictory positions can be combined. If you pull too hard on any one thread of transgender ideology, the whole tapestry comes unraveled. But here are some questions we can pose:

If gender is a social construct, how can gender identity be innate and immutable? How can one's identity with respect to a social construct be determined by biology in the womb? How can one's identity be unchangeable (immutable) with respect to an ever-changing social construct? And if gender identity is innate, how can it be "fluid"? The challenge for activists is to offer a plausible definition of gender and gender identity that is independent of bodily sex.

Is there a gender binary or not? Somehow, it both does and does not exist, according to transgender activists. If the categories of "man" and "woman" are objective enough that people can identify as, and *be,* men and women, how can gender also be a spectrum, where people can identify as, and *be*, both, or neither, or somewhere in between?

What does it even mean to have an internal sense of gender? What does gender feel like? What meaning can we give to the concept of sex or gender – and thus what internal "sense" can we have of gender – apart from having a body of a particular sex? Apart from having a male body, what does it "feel like" to be a man? Apart from having a female body, what does it "feel like" to be a woman? What does it feel like to be *both* a man and a woman, or to be *neither*? The challenge for the transgender activist is to explain what these feelings are like, and how someone could know if he or she "feels like" the opposite sex, or neither, or both.

Even if trans activists could answer these questions about feelings, that still wouldn't address the matter of reality. Why should feeling like a man – whatever that means – *make* someone a man? Why do our feelings determine reality on the question of sex, but on little else? Our feelings don't determine our age or our height. And few people buy into Rachel Dolezal's claim to identify as a black

woman, since she is clearly not. If those who identify as transgender *are* the sex with which they identify, why does that not apply to other attributes or categories of being? What about people who identify as animals, or able-bodied people who identify as disabled? Do all of these self-professed identities determine reality? If not, why not? And should these people receive medical treatment to transform their bodies to accord with their minds? Why accept transgender "reality," but not trans-racial, trans-species, and trans-abled reality? The challenge for activists is to explain why a person's "real" sex is determined by an inner "gender identity," but age and height and race and species are not determined by an inner sense of identity.

Of course, a transgender activist could reply that an "identity" is, by definition, just an inner sense of self. But if that's the case, gender identity is merely a disclosure of how one feels. Saying that someone is transgender, then, says only that the person has feelings that he or she is the opposite sex. Gender identity, so understood, has no bearing at all on the meaning of "sex" or anything else. But transgender activists claim that a person's self-professed "gender identity" *is* that person's "sex." The challenge for activists is to explain why the mere feeling of being male or female (or both or neither) *makes* someone male or female (or both or neither).

Gender identity can sound a lot like religious identity, which is determined by beliefs. But those beliefs don't determine reality. Someone who identifies as a Christian believes that Jesus is the Christ. Someone who identifies as a Muslim believes that Muhammad is the Final Prophet. But Jesus either is or is not the Christ, and Muhammad either is or is not the Final Prophet, regardless of what anyone happens to believe. So, too, a person either is or is not a man, regardless of what anyone – including that person – happens to believe. The challenge for transgender activists is to present an argument for why transgender beliefs determine reality.

Determining reality is the heart of the matter, and here too we find contradictions. On the one hand, transgender activists want the authority of science as they make metaphysical claims, saying that science reveals gender identity to be innate and unchanging. On the other hand, they deny that biology is destiny, insisting that people are free to be who they want to be. Which is it? Is our gender identity biologically determined and immutable, or self-created and changeable? If the former, how do we account for people whose gender identity changes over time? Do these people have the wrong sense of gender at some time or other? And if gender identity is self-created, why must other people accept it as reality? If we should be free to choose our own gender reality, why can some people impose their idea of reality on others just because they identify as transgender? The challenge for the transgender activist is to articulate some conception of truth as the basis for how we understand the common good and how society should be ordered.

As I document in depth in *When Harry Became Sally*, the claims of transgender activists are confusing because they are philosophically incoherent.

Activists rely on contradictory claims as needed to advance their position, but their ideology keeps evolving, so that even allies and LGBT organizations can get left behind as "progress" marches on. At the core of the ideology is the radical claim that feelings determine reality. From this idea come extreme demands for society to play along with subjective reality claims. Trans ideologues ignore contrary evidence and competing interests; they disparage alternative practices; and they aim to muffle skeptical voices and shut down any disagreement. The movement has to keep patching and shoring up its beliefs, policing the faithful, coercing the heretics, and punishing apostates, because as soon as its furious efforts flag for a moment or someone successfully stands up to it, the whole charade is exposed. That's what happens when your dogmas are so contrary to obvious, basic, everyday truths. A transgender future is not the "right side of history," yet activists have convinced the most powerful sectors of our society to acquiesce to their demands. While the claims they make are manifestly false, it will take real work to prevent the spread of these harmful ideas.

The Science of Sex Change

And these ideas can be harmful. There are human costs to getting human nature wrong. Contrary to the claims of activists, sex isn't "assigned" at birth – and that's why it can't be "reassigned." Sex is a bodily reality that can be recognized well before birth with ultrasound imaging. The sex of an organism is defined and identified by the way in which it (he or she) is organized for sexual reproduction.

This is just one manifestation of the fact that natural organization is "the defining feature of an organism," as neuroscientist Maureen Condic and her philosopher brother Samuel Condic explain. In organisms, "the various parts … are organized to cooperatively interact for the welfare of the entity as a whole. Organisms can exist at various levels, from microscopic single cells to sperm whales weighing many tons, yet they are all characterized by the integrated function of parts for the sake of the whole."[16]

Male and female organisms have different parts that are functionally integrated for the sake of their whole, and for the sake of a larger whole – their sexual union and reproduction. So an organism's sex – as male or female – is identified by its organization for sexually reproductive acts. Sex as a status – male or female – is a recognition of the organization of a body that can engage in sex as an act.

That organization is not just the best way to figure out which sex you are; it is the only way to make sense of the *concepts* of male and female at all. What else could "maleness" or "femaleness" even refer to, if not your basic physical capacity for one of two functions in sexual reproduction?

The conceptual distinction between male and female based on reproductive

[16] Maureen L. Condic and Samuel B. Condic, "Defining Organisms by Organization," *National Catholic Bioethics Quarterly* 5, no. 2 (Summer 2005): 336.

organization provides the only coherent way to classify the two sexes. Apart from that, all we have are stereotypes.

This shouldn't be controversial. Sex is understood this way across sexually reproducing species. No one finds it particularly difficult – let alone controversial – to identify male and female members of the bovine species or the canine species. Farmers and breeders rely on this easy distinction for their livelihoods. It's only recently, and only with respect to the human species, that the very concept of sex has become controversial.

And yet, as we saw earlier, medical experts such as Dr. Adkins profess that "[f]rom a medical perspective, the appropriate determinant of sex is gender identity."[17] In her sworn declaration to the federal court, Dr. Adkins called the standard account of sex – an organism's sexual organization – "an extremely outdated view of biological sex." Dr. Lawrence Mayer responded in his rebuttal declaration: "This statement is stunning. I have searched dozens of references in biology, medicine and genetics – even Wiki! – and can find no alternative scientific definition. In fact the only references to a more fluid definition of biological sex are in the social policy literature."[18] Just so. Dr. Mayer is a scholar in residence in the Department of Psychiatry at the Johns Hopkins University School of Medicine and a professor of statistics and biostatistics at Arizona State University.

Modern science shows that our sexual organization begins with our DNA and development in the womb, and that sex differences manifest themselves in many bodily systems and organs, all the way down to the molecular level. In other words, our physical organization for one of two functions in reproduction shapes us organically, from the beginning of life, at every level of our being.

Cosmetic surgery and cross-sex hormones cannot change us into the opposite sex. They can affect appearances. They can stunt or damage some outward expressions of our reproductive organization. But they can't transform it. They can't turn us from one sex into the other.

"Scientifically speaking, transgender men are not biological men and transgender women are not biological women. The claims to the contrary are not supported by a scintilla of scientific evidence," explains Dr. Mayer.[19] Or, as Princeton philosopher Robert P. George put it, "Changing sexes is a metaphysical impossibility because it is a biological impossibility."[20]

The Psychosocial Outcomes of Sex Change

Sadly, just as "sex reassignment" fails to reassign sex biologically, it also fails to bring wholeness socially and psychologically. As I demonstrate in *When Harry*

[17] Declaration of Deanna Adkins, 5.

[18] Expert Rebuttal Declaration of Lawrence S. Mayer, M.D., M.S., Ph.D, U.S. District Court, Middle District of North Carolina, Case 1:16-cv-00425-TDS-JEP.

[19] Declaration of Lawrence S. Mayer, M.D., M.S., Ph.D, U.S. District Court, Middle District of North Carolina, Case 1:16-cv-00425-TDS-JEP, Exhibit K.

[20] Robert P. George, "Gnostic Liberalism," *First Things* (December 2016).

Became Sally, the medical evidence suggests that it does not adequately address the psychosocial difficulties faced by people who identify as transgender.

Even when the procedures are successful technically and cosmetically, and even in cultures that are relatively "trans-friendly," transitioners still face poor outcomes. Dr. Paul McHugh, the University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine, explains:

> Transgendered men do not become women, nor do transgendered women become men. All (including Bruce Jenner) become feminized men or masculinized women, counterfeits or impersonators of the sex with which they "identify." In that lies their problematic future.
>
> When "the tumult and shouting dies," it proves not easy nor wise to live in a counterfeit sexual garb. The most thorough follow-up of sex-reassigned people – extending over thirty years and conducted in Sweden, where the culture is strongly supportive of the transgendered – documents their lifelong mental unrest. Ten to fifteen years after surgical reassignment, the suicide rate of those who had undergone sex-reassignment surgery rose to twenty times that of comparable peers.[21]

Dr. McHugh points to the reality that because sex change is physically impossible, it frequently does not provide the long-term wholeness and happiness that people seek. Indeed, the best scientific research supports McHugh's caution and concern.

Here's how the *Guardian* summarized the results of a review of "more than 100 follow-up studies of post-operative transsexuals" by Birmingham University's Aggressive Research Intelligence Facility (Arif):

> Arif, which conducts reviews of healthcare treatments for the NHS, concludes that none of the studies provides conclusive evidence that gender reassignment is beneficial for patients. It found that most research was poorly designed, which skewed the results in favour of physically changing sex. There was no evaluation of whether other treatments, such as long-term counselling, might help transsexuals, or whether their gender confusion might lessen over time.[22]

"There is huge uncertainty over whether changing someone's sex is a good or a bad thing," said Chris Hyde, the director of Arif. Even if doctors are careful to perform these procedures only on "appropriate patients," Hyde continued, "there's still a large number of people who have the surgery but remain traumatized – often to the point of committing suicide."[23]

Of particular concern are the people these studies "lost track of." As the *Guardian* noted, "the results of many gender reassignment studies are unsound because researchers lost track of more than half of the participants." Indeed, "Dr. Hyde said the high drop out rate could reflect high levels of dissatisfaction or even suicide among post-operative transsexuals." Dr. Hyde concluded: "The bottom line is that although it's clear that some people do well with gender reassignment

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[21] Paul McHugh, "Transgenderism: A Pathogenic Meme," *Public Discourse* (June 10, 2015), http://www.thepublicdiscourse.com/2015/06/15145/.

[22] David Batty, "Mistaken identity," *Guardian* (July 30, 2004), https://www.theguardian.com/society/2004/jul/31/health.socialcare.

[23] https://www.theguardian.com/society/2004/jul/30/health.mentalhealth.

surgery, the available research does little to reassure about how many patients do badly and, if so, how badly."[24]

Arif conducted its review back in 2004, so perhaps things have changed in the past decade? Not so. In 2014, a new review of the scientific literature was done by Hayes, Inc., a research and consulting firm that evaluates the safety and health outcomes of medical technologies. Hayes found that the evidence on long-term results of sex reassignment was too sparse to support meaningful conclusions and gave these studies its lowest rating for quality:

> Statistically significant improvements have not been consistently demonstrated by multiple studies for most outcomes. . . . Evidence regarding quality of life and function in male-to-female (MtF) adults was very sparse. Evidence for less comprehensive measures of well-being in adult recipients of cross-sex hormone therapy was directly applicable to GD patients but was sparse and/or conflicting. The study designs do not permit conclusions of causality and studies generally had weaknesses associated with study execution as well. There are potentially long-term safety risks associated with hormone therapy but none have been proven or conclusively ruled out.[25]

The Obama administration came to similar conclusions. In 2016, the Centers for Medicare and Medicaid revisited the question whether sex reassignment surgery would have to be covered by Medicare plans. Despite receiving a request that its coverage be mandated, they refused, on the ground that we lack evidence that it benefits patients. Here's how the June 2016 "Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery" put it:

> Based on a thorough review of the clinical evidence available at this time, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria. There were conflicting (inconsistent) study results – of the best designed studies, some reported benefits while others reported harms. The quality and strength of evidence were low due to the mostly observational study designs with no comparison groups, potential confounding and small sample sizes. Many studies that reported positive outcomes were exploratory type studies (case-series and case-control) with no confirmatory follow-up.[26]

The final August 2016 "Decision Memo for Gender Dysphoria and Gender Reassignment Surgery" was even more blunt. It pointed out that "[o]verall, the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding

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[24] Ibid.

[25] Hayes, Inc., "Hormone therapy for the treatment of gender dysphoria," *Hayes Medical Technology Directory* (Lansdale, PA: Winifred Hayes, 2014), quoted in Cretella, "Gender Dysphoria in Children and Suppression of Debate," *Journal of American Physicians and Surgeons* 21 (Summer 2016): 52. See also "Sex reassignment surgery or the treatment of gender dysphoria," *Hayes Medical Technology Directory* (2014).

[26] Tamara Syrek Jensen et al., "Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery," U.S. Centers for Medicare and Medicaid Services, File No. CAG-00446N (June 2, 2016), https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=282.

(a situation where the association between the intervention and outcome is influenced by another factor such as a co-intervention), small sample sizes, lack of validated assessment tools, and considerable lost to follow-up." That "lost to follow-up," remember, could be pointing to people who committed suicide.

And when it comes to the best studies, there is no evidence of "clinically significant changes" after sex reassignment:

> The majority of studies were non-longitudinal, exploratory type studies (i.e., in a preliminary state of investigation or hypothesis generating), or did not include concurrent controls or testing prior to and after surgery. Several reported positive results but the potential issues noted above reduced strength and confidence. After careful assessment, we identified six studies that could provide useful information. Of these, the four best designed and conducted studies that assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies did not demonstrate clinically significant changes or differences in psychometric test results after GRS [gender reassignment surgery].[27]

In a discussion of the largest and most robust study – the study from Sweden that Dr. McHugh mentioned in the quote above – the Obama Centers for Medicare and Medicaid pointed out the nineteen-times-greater likelihood for death by suicide, and a host of other poor outcomes:

> The study identified increased mortality and psychiatric hospitalization compared to the matched controls. The mortality was primarily due to completed suicides (19.1-fold greater than in control Swedes), but death due to neoplasm and cardiovascular disease was increased 2 to 2.5 times as well. We note, mortality from this patient population did not become apparent until after 10 years. The risk for psychiatric hospitalization was 2.8 times greater than in controls even after adjustment for prior psychiatric disease (18%). The risk for attempted suicide was greater in male-to-female patients regardless of the gender of the control. Further, we cannot exclude therapeutic interventions as a cause of the observed excess morbidity and mortality. The study, however, was not constructed to assess the impact of gender reassignment surgery *per* se.[28]

These results are tragic. And they directly contradict the most popular media narratives, as well as many of the snapshot studies that do not track people over time. As the Obama Centers for Medicare and Medicaid pointed out, "mortality from this patient population did not become apparent until after 10 years." So when the media tout studies that only track outcomes for a few years, and claim that reassignment is a stunning success, there are good grounds for skepticism.

As I explain in my book, these outcomes should be enough to stop the headlong rush into sex-reassignment procedures. They should prompt us to

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[27] Tamara Syrek Jensen et al., "Decision Memo for Gender Dysphoria and Gender Reassignment Surgery," U.S. Centers for Medicare and Medicaid Services, File No. CAG-00446N (August 30, 2016), https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282&bc.

[28] Ibid., discussing Cecilia Dhejne et al., "Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden," PLOS ONE 6 (February 2011): e16885.

develop better therapies for helping people who struggle with their gender identity. And none of this even begins to address the radical, entirely experimental therapies that are being directed at the bodies of children to transition them.[29]

The Purpose of Medicine, Emotions, and the Mind

Behind the debates over therapies for people with gender dysphoria are two related questions: How do we define mental health and human flourishing? And what is the purpose of medicine, particularly psychiatry?

Those general questions encompass more specific ones: If a man has an internal sense that he is a woman, is that just a variety of normal human functioning, or is it a psychopathology? Should we be concerned about the disconnection between feeling and reality, or only about the emotional distress or functional difficulties it may cause? What is the best way to help people with gender dysphoria manage their symptoms: by accepting their insistence that they are the opposite sex and supporting a surgical transition, or by encouraging them to recognize that their feelings are out of line with reality and learn how to identify with their bodies? All of these questions require philosophical analysis and worldview judgments about what "normal human functioning" looks like and what the purpose of medicine is.

Settling the debates over the proper response to gender dysphoria requires more than scientific and medical evidence. Medical science alone cannot tell us what the *purpose* of medicine is. Science cannot answer questions about meaning or purpose in a moral sense. It can tell us about the function of this or that bodily system, but it can't tell us what to do with that knowledge. It cannot tell us how human beings ought to act. Those are philosophical questions.

While medical science does not answer philosophical questions, every medical practitioner has a philosophical worldview, explicit or not. Some doctors may regard feelings and beliefs that are disconnected from reality as a part of normal human functioning and not a source of concern unless they cause distress. Other doctors will regard those feelings and beliefs as dysfunctional in themselves, even if the patient does not find them distressing, because they indicate a defect in mental processes. But the assumptions made by this or that psychiatrist for purposes of diagnosis and treatment cannot settle the *philosophical* questions: Is it good or bad or neutral to harbor feelings and beliefs that are at odds with reality? Should we accept them as the last word, or try to understand their causes and correct them, or at least mitigate their effects?

While the current findings of medical science, as shown above, reveal poor psychosocial outcomes for people who have had sex-reassignment therapies, that conclusion should not be where we stop. We must also look deeper for philosophical wisdom, starting with some basic truths about human well-being and healthy functioning. We should begin by recognizing that sex reassignment is physically impossible. Our minds and senses function properly when they reveal

[29] See *When Harry Became Sally*, chap. 6 in particular.

reality to us and lead us to knowledge of truth. And we flourish as human beings when we embrace the truth and live in accordance with it. A person might find some emotional relief in embracing a falsehood, but doing so would not make him or her objectively better off. Living by a falsehood keeps us from flourishing fully, whether or not it also causes distress.

This philosophical view of human well-being is the foundation of a sound medical practice. Dr. Michelle Cretella, the president of the American College of Pediatricians – a group of doctors who formed their own professional guild in response to the politicization of the American Academy of Pediatrics – emphasizes that mental health care should be guided by norms grounded in reality, including the reality of the bodily self. "The norm for human development is for one's thoughts to align with physical reality, and for one's gender identity to align with one's biologic sex," she says.[30] For human beings to flourish, they need to feel comfortable in their own bodies, readily identify with their sex, and believe that they are who they actually are. For children especially, normal development and functioning require accepting their physical being and understanding their embodied selves as male or female.

Unfortunately, many professionals now view health care – including mental health care – primarily as a means of fulfilling patients' desires, whatever those are. In the words of Leon Kass, a professor emeritus at the University of Chicago, today a doctor is often seen as nothing more than "a highly competent hired syringe":

> The implicit (and sometimes explicit) model of the doctor-patient relationship is one of contract: the physician – a highly competent hired syringe, as it were – sells his services on demand, restrained only by the law (though he is free to refuse his services if the patient is unwilling or unable to meet his fee). Here's the deal: for the patient, autonomy and service; for the doctor, money, graced by the pleasure of giving the patient what he wants. If a patient wants to fix her nose or change his gender, determine the sex of unborn children, or take euphoriant drugs just for kicks, the physician can and will go to work – provided that the price is right and that the contract is explicit about what happens if the customer isn't satisfied.[31]

This modern vision of medicine and medical professionals gets it wrong, says Dr. Kass. Professionals ought to profess their devotion to the purposes and ideals they serve. Teachers should be devoted to learning, lawyers to justice, clergy to things divine, and physicians to "healing the sick, looking up to health and wholeness." Healing is "the central core of medicine," Kass writes; "to heal, to make whole, is the doctor's primary business."

To provide the best possible care, serving the patient's medical interests, requires an understanding of human wholeness and well-being. Mental health care must be guided by a sound concept of human flourishing. The minimal standard of care should begin with a standard of *normality*. Dr. Cretella explains how this

[30] Michelle Cretella, "Gender Dysphoria in Children and Suppression of Debate," 51.

[31] Leon R. Kass, "Neither for Love nor Money: Why Doctors Must Not Kill," *Public Interest* 94 (Winter 1989): 28.

standard applies to mental health:

> One of the chief functions of the brain is to perceive physical reality. Thoughts that are in accordance with physical reality are normal. Thoughts that deviate from physical reality are abnormal – as well as potentially harmful to the individual or to others. This is true whether or not the individual who possesses the abnormal thoughts feels distress.[32]

Our brains and senses are designed to bring us into contact with reality, connecting us with the outside world and with the reality of ourselves. Thoughts that disguise or distort reality are misguided – and can cause harm. In *When Harry Became Sally*, I argue that we need to do a better job of helping people who face these struggles.

[32] Cretella, "Gender Dysphoria in Children and Suppression of Debate," 51. I would slightly tweak Dr. Cretella's phrasing here. The philosopher in me bristles a little at her definition of normality as applied to the brain. After all, plenty of people have false beliefs about reality, including physical reality: think about our debates over global warming and climate change. Both sides of the debate can't be right. Disagreement about contested issues is the norm for human rationality: frequently we don't immediately see the correct answer. We have to discover it discursively, usually in a communal process of give and take, point and counterpoint. I am sure Cretella agrees and would readily acknowledge all of this.