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American College of Pediatricians <admin@acpeds.org>

Fwd: Ashford / Children's email chain

1 message

Michelle Cretella <director@acpeds.org> Thu, Nov 12, 2020 at 2:35 PM
To: "Krystle L. Hunter, PhD" <admin@acpeds.org>

PLEASE FILE THIS ENTIRE STRING IN MY EXEC. DIR. FOLDER AS "HOW TO DEFUND TRANS PEDIATRICS"

Michelle Cretella, M.D.
Executive Director
American College of Pediatricians
The Best for Children
https://www.acpeds.org/

---------- Forwarded message ---------
From: **William Stigall** <william.stigall@gmail.com>
Date: Thu, Nov 5, 2020 at 8:38 AM
Subject: Fwd: Ashford / Children's email chain
To: Quentin Van Meter <kidendo@comcast.net>, Michelle Cretella <director@acpeds.org>

Begin forwarded message:

From: Rob Hays <rhays@ashfordinc.com>
Subject: Ashford / Children's email chain
Date: November 5, 2020 at 7:23:21 AM CST
To: William Stigall <william.stigall@gmail.com>

Begin forwarded message:

From: "Bennett, Monty" <mbennett@ashfordinc.com>
Date: January 26, 2020 at 9:51:55 PM PST
To: Dawn Kahle <Dawn.Kahle@childrens.com>, Bill Braem <bill.braem@childrens.com>
Cc: "Hays, Rob" <rhays@ashfordinc.com>
Subject: Children's Health "GeneCIS" program
Reply-To: mbennett@ashfordinc.com

Dawn & Bill,

Thanks for sending us that selection of empirical studies on the experiences of minors with gender dysphoria or gender identity disorder (GID). They share a variety of common conclusions, as well as significant limitations which give rise to concerns about the wisdom and ethics of arresting adolescents' sexual development and permanently sterilizing minors. I told you that both me and Rob remained open to the idea that such therapy could be fine - even helpful - for children. However, after reading the studies you presented and researching others, we can't come to any other conclusion than you are being reckless with the lives of the innocent.

There are four central themes in those studies.

First, while body image appears to improve following hormone treatment or surgery (e.g., Becker et al., 2018; DeVries et al., 2014; Ristori et al., 2020), psychological functioning—including anxiety and depressive symptoms—does not improve in a sustained manner nor nearly as much as one might expect given the radical nature of the treatments.

It is no surprise that participants' body image improves somewhat following surgery, given the nature of dysphoria and the longing to look different. But improved body image does not seem to bring greater emotional health—a more important concern—in its wake. The more recent of the two studies by deVries et al. (2014) highlighted this in particular: while participants may feel better about their bodies, depression, anger, and anxiety either rose or did not change after surgery (for either "natal" males or females). Internalizing and externalizing T scores either barely moved or increased after surgery (apart from natal females externalizing). Neither anger nor anxiety diminished notably in either (natal) sex of GID patients. (While Beck Depression Index estimates did decline over time, neither sex of GID patients were in clinical range at T0.) More recently, Şenol Turan and his co-authors (2018: 2358) "observed that in addition to Phobic Anxiety there were no significant differences after (hormone therapy) in Obsessive–Compulsive, Interpersonal Sensitivity, Depression, and Additional Symptoms in participants with FtM GD compared to female controls."

The systematic review of research you sent by Stefan Rowniak and his collaborators' (2019) is quite on target in claiming that "there have been few high-quality studies" here, and that "the certainty of the findings was low to very low due to issues with imprecision and indirectness." Because of that, they note, "recommendations for hormone use to improve quality of life, depression and anxiety could not be made." Did you catch that? The very study review you sent concluded that recommendations concerning the use of these nasty drugs could not be made. THIS is what you're relying on?

In the study by Costa and her co-authors (2015), we recognize that children's psychosocial functioning (CGAS) improved over time with treatment. However, both adolescents who received hormone treatment and those who did not only shifted from "some noticeable problems" (a score of 51-60) to "some problems" (61-70), remaining below the threshold of "doing all right" (71-80). Their Table 2 results underwhelm, suggesting that "delayed eligible GD adolescents" trail "immediately eligible GD adolescents," but only by a modest degree and always within the identical grouping—meaning the two groups are not statistically different from each other, signaling that hormone therapy treatment did *not* demonstratively distinguish adolescent experience here. The "psychological support" available to each group is likely responsible for the rising psychosocial functioning *for both groups*. Counseling, of course, is light years less invasive than hormones or surgery. I remain extremely concerned that psychological problems of dysphoric youth are being treated physiologically, even as research into depression is moving away from a "chemical imbalance" (or bodily) narrative toward a more trauma-based assessment of depression. There is evidence (which you did not send us) that this is the case among dysphoric youth.

Invasive treatments that make minors modestly happier with their bodies but does not profoundly improve their psychological functioning and well-being is tantamount to opening a new frontier of plastic surgery on adolescents. It is a deep well of sustainable income for clinicians but doesn't ultimately do more for the patients than satisfy their longing to appear different from their natal sex, in exchange for **permanent infertility and a lifelong dependence upon sustaining treatments.**

Second, the conduct of medical research here is disturbingly irregular here. Unlike with the study of gay and lesbian Americans, a population that has remained fairly stable over time, the population that self-identifies as transgender has exploded of late—especially, but not exclusively, among adolescents—which brings to the fore prudential concerns about diagnostic (i.e., measurement) validity. This in turn poses significant challenges for the empirical validity of studies in this domain. The problem is compounded by the flexibility in research designs, definitions, outcomes, and analytical strategies that have characterized the study of the transgender population and their experiences.

Control groups are avoided in most of the studies you sent us, purportedly for "obvious ethical reasons" (Fisher et al., 2016: 8). It would seem absolutely critical to discern what happens to those adolescents who do not (or perhaps cannot) persist in seeking more extensive treatment approaches. Most adolescents presenting at clinics have historically been would-be desistors who would not likely mature into transgender adults. Pressure to conduct early invasive treatments *before puberty has*

begun (and before age of informed consent) are altering this longstanding common outcome. This is territory rife with ethical concern that even researchers acknowledge (deVries et al., 2014). Psychiatrist and longtime gender identity expert Stephen Levine highlights the quandary now facing professionals attempting to counsel transgender patients on the biological, social, and psychological risks posed by any treatment approach. Such risks are real and ought to be discussed. But an ethical discussion of risk—the very backbone of informed consent—could be construed by patients as "conversion therapy." Levine notes that while the World Professional Association for Transgender Health (WPATH) endorses informed consent, this principle is increasingly at odds with its own recommendation of offering hormone therapy on demand. Talking over the risks of radical treatments seems itself increasingly risky (to clinicians' careers).

Indeed, the study of transgender treatments is not approached like those in other medical subdisciplines—where the benefits of new treatments accrue to future patients while the risks are borne by study participants. Instead, practitioners have seemingly dismissed the notion of considerable and longstanding risks of treatment and adopted a standard of benefit that seems narrowly defined around the calming of dysphoria at any cost, based largely on published *p* values and simple tests of statistical significance, almost always ignoring effect size and the more prudent "number needed to treat" (NNT), a calculus *never* reported in published studies.
Low statistical power is endemic, admitted only in limitation sections (e.g., Gorin-Lazard et al., 2012). There is a reckoning ahead for such clinical and statistical recklessness and imprudence.

Third, although researchers commonly hold that gender identities and sexual orientation are distinctive phenomenon, very little attention is being paid *clinically* to the large and significant correlation between the two, as is evidenced in several studies you sent us (e.g., deVries et al., 2011; Gorin-Lazard et al., 2013; Turan et al., 2018; Wallien and Cohen-Kettenis 2008) This enigma raises unaddressed questions, including even whether adolescents are prone to experience GID as a coping mechanism or perhaps a "reparative therapy" of sorts for same-sex attraction (SSA). We are not promulgating a theory here, but rather observing that researchers are not attending to the messiness that is the overlap between gender dysphoria and SSA (as well as autism) in adolescents. All the more reason to tread lightly on the lives and bodies of our children.

Fourth, the Costa (2015) study you passed along, which was noted earlier, is itself now caught up in the controversy surrounding the UK's Tavistock Centre, whose protocol lowered the age of delivering puberty blockers based on a study that is now under scrutiny. The Tavistock Centre itself is under investigation. University of Oxford sociologist Michael Biggs supports the investigation, maintaining that adolescents "were not given the information they needed in order to take this momentous life-changing step." Tavistock's own governor resigned in early 2019, observing that what is going on at Tavistock "is negligent," a situation made "10 times worse" because of the exponential rise in patients over the past several years. He continued:

> I fear that in 10 years' time, there will be a lot of people in their mid-20s whose lives have been wrecked by poor assessment and poor evidence based treatment, who will have been rushed down a path which they should never have been taken down so swiftly….I fear that some of these young transgender patients will have grounds to sue the NHS in years to come.

Indeed, such legal maneuvers have already commenced.

There are additional studies that you could have sent us but did not, which would have served as cautionary advice for gender clinics. For example, a 2019 study in the journal *Circulation* documents how natal males on transgender hormone therapy exhibit a doubled risk of stroke or deep vein thrombosis. This is most definitely not attributable to social stigma. Another study, one in appearing in 2019 in the *American Journal of Psychiatry* concluded that "gender-affirming" surgeries are associated with a reduction in demand for subsequent mental health treatment of patients with GID. This study featured a rare (but welcome) large sample, drawing upon a near-census of Sweden, and yet found no effect of "time since initiating hormone treatment" on the likelihood of subsequently receiving mental health services. Its authors did, however, detect a statistically significant effect of time since last "gender-affirming" surgery on reduced mental health treatment. However, the NNT—which was unreported but is calculable from what appears in its tables—is a staggering 49, meaning the beneficial effect of surgery is so modest that a clinic would have to perform 49 gender-affirming surgeries before they could expect to prevent one additional person from seeking subsequent

mental health treatment. If no other treatment was available, or the treatment was not invasive and the hazards were insignificant, clinics might consider this a low-risk but low-payoff approach. But neither of those applies here—by a long shot. Conducting 49 surgeries to secure one additional patient who benefits? It's unheard of.

Gender clinics are normalizing infertility-inducing and permanently disfiguring surgeries in children on the advice of medical research conducted without control groups, without concern for effect sizes, and without sensible understandings of risks versus benefits. This is in part because the threat of suicidal transgender teens is being weaponized against the better judgment of physicians and researchers. Clinicians are being bullied into writing a radical prescription based on fear and groupthink in clinical environments in which objections are socially difficult to raise. This is *not* how medical research and clinical operations are supposed to work. Indeed, they do not work this way in other domains of medicine.

Just because the American Academy of Pediatrics and the American Psychological Association have been quick to throw their weight behind actions that 20 years ago would not have passed a "human subjects review" committee for its lopsided risk, modest benefits, and violations of (truly) informed consent for minors, does not mean that Children's Medical Center of Dallas is prudent for having opened and maintained a clinic, interest in its offerings notwithstanding. Sometimes protocols are wrong, maintained more by fleeting political will than thoughtful, emergent empirical consensus. The matter of treating transgender youth early and aggressively is based far more on activist researchers' will than on the ethical treatment of minors or the conclusions of the scientific studies you sent us. The latter, frankly, are quite modest and underwhelming, while the risks of lifelong medicalization and irreversible surgeries are significant.

You guys may very well be involved in child abuse. The evidence points to that being more likely the case than not. Do you personally really want to be a part of this? What do you think your liability will be 10 or more years from now when Children's or you personally (because of your involvement) are sued? If not for the obvious moral reason, then I suggest you look at the financial implications to your employer and to yourselves. You all may very well become bankrupted, regardless of how much insurance your organization carries. Is it wrong that I will volunteer to testify that you guys knew (by way of this email) that there was very little proof that your sterilization program was either safe or effective?

Please stop damaging our children. Before it's too late. And please send back immediately all the monies Ashford has ever donated to you guys. I cannot have my firm be associated with your experimentation on children.

Sincerely,

Monty Bennett

> On Thu, Jan 9, 2020 at 6:44 PM Dawn Kahle <Dawn.Kahle@childrens.com> wrote:
>
> Monty and Rob,
>
> Some of the research we supplied yesterday is a synopsis of the larger studies completed. We were able to obtain access to the full research reports for an even more in-depth look and review. We hope you find this helpful. Please let me know if this email size is too large with all of these attachments, and I will find another way to share them.

Thanks,

Dawn

From: Dawn Kahle
Sent: Wednesday, January 8, 2020 6:41 PM
To: 'mbennett@ashfordinc.com' <mbennett@ashfordinc.com>; Hays, Rob <rhays@ashfordinc.com>
Cc: Bill Braem <Bill.Braem@childrens.com>; Smith, Kristy <ksmith@ashfordinc.com>
Subject: RE: [EXTERNAL] RE: [EXTERNAL] RE: [EXTERNAL] RE: Update

Monty and Rob,

Thank you for your patience as we worked to gather this information and ensure we had links to the research in the *types* of publications you requested, which of course does not include *all* research studies available. Also, our clinical team has research on this topic publishing in the next few months in the journal, *Pediatrics*. It is under embargo until it publishes.

Here are additional studies from journals our clinical team references for gender-affirming care as treatment for youth experiencing gender dysphoria show an improvement in their quality of life, anxiety and depression.

- The effect of cross-sex hormones on the quality of life, depression and anxiety of transgender individuals: a quantitative systematic review. *JBI database of systematic reviews and implementation reports.* 2019.
- A cross-sectional multicenter study of multidimensional body image in adolescents and adults with gender dysphoria before and after transition-related medical interventions. *Archives of sexual behavior.* 2018.
- Alterations in body uneasiness, eating attitudes, and psychopathology before and after cross-sex hormonal treatment in patients with female-to-male gender dysphoria. *Archives of sexual behavior.* 2018.
- Cross-sex hormone treatment and psychobiological changes in transsexual persons: two-year follow-up data. *The Journal of Clinical Endocrinology & Metabolism.* 2016.
- Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The journal of sexual medicine.* 2015.
- Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics.* 2014.
- Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med.* 2011.

Thank you,

Dawn

Dawn Kahle
Senior Director of Communications
Marketing & Communications

children'shealth

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From: Bennett, Monty <mbennett@ashfordinc.com>
Sent: Thursday, December 26, 2019 11:41 PM
To: Dawn Kahle <Dawn.Kahle@childrens.com>
Cc: Hays, Rob <rhays@ashfordinc.com>; Bill Braem <Bill.Braem@childrens.com>
Subject: Re: [EXTERNAL] RE: [EXTERNAL] RE: [EXTERNAL] RE: Update

Thanks Dawn,

None of the links you included had any information (that I saw) regarding the efficacy or the safety of a program that includes drugs or otherwise of trying to match a child's self-perceived "gender" with what they were born with by trying to change the latter. Could u point this out in case I missed it? Surely you would not be taking children through any program unless it has been shown to be safe and effective, right?

On Fri, Dec 20, 2019 at 10:16 AM Dawn Kahle <Dawn.Kahle@childrens.com> wrote:

> Our clinic follows established care guidelines from the Endocrine Society, the World Professional Association of Transgender Health (WPATH) and the American Academy of Pediatrics.
>
> Physicians who provide this care are endocrinologists, so the Endocrine Society has done much of the research about this condition. There are a number of studies that are available. I am working to gather studies to share with you, and I will include some

studies outside of endocrinology, if possible. I will be back in touch – hopefully within the next week – with the additional research you have requested.

Thanks,

Dawn

From: Bennett, Monty <mbennett@ashfordinc.com>
Sent: Friday, December 20, 2019 12:57 AM
To: Hays, Rob <rhays@ashfordinc.com>
Cc: Dawn Kahle <Dawn.Kahle@childrens.com>; Bill Braem <Bill.Braem@childrens.com>
Subject: Re: [EXTERNAL] RE: [EXTERNAL] RE: Update

Yes. Indeed. Is what you sent all that is relied upon by your GeneCIS program to determine the efficacy and safety of their gender reassignment/reorientation program?

> On Thu, Dec 19, 2019 at 11:36 AM Hays, Rob <rhays@ashfordinc.com> wrote:
>
> Dawn & Bill,
>
> Thank you for this information. We will definitely spend time reading through these links and studies as we are very much trying to learn and understand the medical science behind the program.
>
> In our desire to be open-minded and to learn, it would be helpful to know whether or not the information you provided is the full extent of data/studies available. Are there other important studies that the doctors of the Genecis program rely upon on a regular basis that aren't included in what you sent over? Are there studies outside of endocrinology, for example, that provide data & evidence to the efficacy of the recommended treatments that come from the Genecis program? I would imagine the doctors in the program can easily name the 10 or 20 most important papers in their respective fields. To the extent they are aware of additional studies outside of what you've sent us thus far, it would be very helpful for us to see those in order to get a fulsome and understanding of the topic.
>
> The long-term health and wellness of children is really, really important to us (which is why we have historically donated to Children's), so we want to make sure that we are getting the full picture and not missing crucial studies that could meaningfully impact our understanding of the medicine.
>
> Thank you so much for your help in this.

All the best,

Rob

ASHFORD

Rob Hays
Co-President & Chief Strategy Officer
Ashford
14185 Dallas Parkway, Suite 1100
Dallas, TX 75254
Direct Line: 972-778-9434
Fax Line: 972-490-9605
Email Address: rhays@ashfordinc.com

On Thu, Dec 19, 2019 at 9:58 AM Dawn Kahle <Dawn.Kahle@childrens.com> wrote:

> Monty,
>
> Here is the information you requested, which includes two position papers as well as other papers and research:
>
> - The attached position paper is by the Pediatric Endocrine Society. If you click on this link, you will find a section on Transgender Care that provides additional information
> - Here is a position paper from the American Academy of Pediatrics. This organization has published a number of studies and has other information about gender dysphoria.
>
> Thanks,
>
> Dawn
>
> children's health
>
> **Dawn Kahle**
> *Public Information Officer*
> *Senior Director of Communications*
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From: Bennett, Monty <mbennett@ashfordinc.com>
Sent: Wednesday, December 18, 2019 4:41 PM
To: Bill Braem <Bill.Braem@childrens.com>
Cc: Dawn Kahle <Dawn.Kahle@childrens.com>; Rob Hays <rhays@ashfordinc.com>
Subject: Re: [EXTERNAL] RE: Update

So when can I expect the information?

On Wed, Dec 18, 2019 at 4:31 PM Bill Braem <Bill.Braem@childrens.com> wrote:

> Thanks Monty. I've shared your request with the appropriate individuals and Dawn Kahle, Public Information Officer at Children's Health, is the best person to help you directly. By copy of this message, I am connecting her with you directly. She also is available at 214-456-5379.

From: Bennett, Monty <mbennett@ashfordinc.com>
Sent: Wednesday, December 18, 2019 3:57 PM
To: Bill Braem <Bill.Braem@childrens.com>
Cc: Rob Hays <rhays@ashfordinc.com>
Subject: Update

using the Phish-Alert button in Outlook, if available, or forward to spam@childrens.com.

Bill,

Thanks for coming last week to visit with us. You asked me many times what you could do for me. I answered that you could show me the studies/evidence supporting the benefits/outcomes of gender realignment in general and Children's GeneCIS program specifically. You agreed.

When can I expect to see this information? I know you want the best for our community's children as much as I do. And I know you want to be sure that children are being helped, not harmed, by your GeneCIS program. So please share the data asap.

Regards,

Monty

Please consider the environment before printing this e-mail

ASHFORD HOSPITALITY TRUST

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