Subject: RE: Invoice for Information Request
Date: Wednesday, October 25, 2023 at 5:31:24 PM Eastern Daylight Time
From: Miszkowski, Stephanie
To: AO Records
Attachments: image001.png, [EXTERNAL] Manhattan Institute_ Yes, Europe is Restricting _Gender-Affirming Care_.pdf

EXTERNAL SENDER

Good afternoon –

I received notification that you paid the invoice for this information request. I have completed the review of the responsive items and attached is the only correspondence that meets the criteria in your request. Please confirm receipt of this email, and I will close out your request.

Thank you.

Stephanie Miszkowski | Agency Paralegal
Office of Public Information Requests
Department of Administration
DESK 406.444.2686

From: Miszkowski, Stephanie
Sent: Thursday, October 5, 2023 10:03 AM
To: records@americanoversight.org
Subject: Invoice for Information Request

Good morning –

We have conducted a preliminary search of the requested information in your letter of September 29, 2023. Your request included a search for emails between a provided list of government officials (six listed names) and a provided list of external entities beginning with Eagle Forum (six provided names). Please note that payment is required prior to the release of the requested documents. Additionally, as stated on the invoice, the request will be closed if payment is not received within 30 days.

Please let me know if you have any questions. Thank you.

Stephanie Miszkowski | Agency Paralegal
Office of Public Information Requests
Department of Administration
DESK 406.444.2686

From: Patrick Pullis
To: Heggem, Chris; Oppel, Glenn
Cc: Matteo Moran
Subject: [EXTERNAL] Manhattan Institute: Yes, Europe is Restricting "Gender-Affirming Care"
Date: Friday, February 17, 2023 10:06:57 AM
Attachments: C2_signature_mismall_18158f4b-846e-4d5c-9ecf-c4d6a9249c18.png

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Hi Christine and Glenn,

My name is Patrick Pullis, and I work on the external affairs team at the Manhattan Institute. I wanted to pass along an op-ed recently published in *City Journal* by our Fellow Leor Sapir [city-journal.org] – Yes, Europe Is Restricting "Gender-Affirming Care" [city-journal.org].

The article addresses several common arguments used by activists and opponents of state legislation regulating the use and prescription of "gender affirming care", including what constitutes the Dutch protocol and how claims that European countries have not banned "gender affirming care" are highly misleading.

I've copied the text of the article below. Please let me know if you would like to discuss this issue further, and we would be happy to set up a meeting for you with the author and/or our external affairs team.

A common claim by Americans who oppose state restrictions on "gender-affirming care" is that Sweden, Finland, and the U.K. have not done away with hormonal interventions—and therefore that Republican lawmakers who seek such restrictions are going beyond Europe, and presumably against what European health authorities recommend. Jack Turban, a prominent voice in the affirmative-medicine movement and a notorious source of misinformation on this issue, has said [twitter.com] that "not a single country" in Europe "has banned gender-affirming care for trans youth." The claim is true in a narrow and technical sense, but highly misleading.

In the past few years, European health authorities conducted systematic reviews of evidence for the benefits and risks of puberty blockers and cross-sex hormones. The findings from these reviews—that the certainty of benefits is very low—guided the hand of policymakers there to restrict access to hormones. Currently, minors in these countries can access puberty blockers and cross-sex hormones only if they meet strict eligibility requirements as set out in the Dutch protocol and only in the context of a tightly controlled research setting.

As I've explained in past [city-journal.org] writings [city-journal.org], the research from the Dutch clinics is championed even by American proponents of "affirmative" medicine as the gold standard in pediatric gender medicine. These advocates either don't know or are deliberately misleading the public about the discrepancy between the Dutch protocol and what is actually happening in American clinics. The American approach effectively puts distressed teenagers in the driver's seat of making risky and irreversible medical decisions. It assumes that "gender identity" is innate and immutable, that some kids are just born "trans" and can know this from as young as toddlerhood. It also uses the "minority stress" model to explain away co-occurring mental-health problems, which appear in roughly three-quarters of patients presenting at pediatric gender clinics.

In effect, once a child declares that he is trans, the role of doctors is to "affirm" that declaration medically. Parents are to consent to treatments or get out of the way. Mental-health professionals

are there only to help the child cope with the stress that comes from being in a minority, since, as Turban puts it [t.co], "most of society is awful."

One source of confusion, therefore, concerns what, exactly, white-gowned activists like Turban mean when they say "gender-affirming care." As Hilary Cass noted in her report to the U.K.'s National Health Service, the American affirmative model removes the main guardrails put in place by the Dutch protocol, resulting in a lack of medical "safeguarding." At least in its official policy, Europe is decidedly not practicing what Turban considers "gender-affirming care."

To be sure, the problems with the American affirmative model should not conceal the fact that the Dutch study itself rests on a very shaky empirical foundation. The study's flaws were discussed at length [tandfonline.com] in a recent peer-reviewed article, but two in particular should be mentioned before considering the European systematic reviews.

First, the Dutch study's lead author, Annelou de Vries, has admitted that "resolution of gender dysphoria" was its "main finding." But this finding was based on a highly questionable use of the Utrecht Gender Dysphoria Scale—a measure originally developed for diagnostic purposes, not to assess treatment outcomes. The scale is sex-specific, which means that biological males and biological females are given different versions of it. Among other differences, the female version includes questions on menstruation while the male version includes questions about erections. In their follow-up assessments, the Dutch team gave boys who had undergone hormonal treatments the girls' scale and girls who had undergone hormonal treatments the boys' scale. Thus, biological males were asked whether experiencing menstruation caused them distress. Since even boys who "transition" do not get periods, those who answered the questionnaire reported a low level of distress. In other words, the plummeting scores in gender dysphoria that the Dutch team reported as their "main finding" was not necessarily due to actually resolved dysphoria, but more likely to switching the scales.

Second, replication is a bedrock of scientific analysis, yet the only attempt to date to replicate the Dutch study, conducted in the U.K., failed. Preliminary results from the study, which began in 2010, were reported as very unimpressive, with adolescents after one year of puberty suppression showing an "increase in internalising problems and body dissatisfaction, especially natal girls." Moreover, the cohort that received puberty blockers showed no statistically significant difference from the cohort that received only psychotherapy. As Michael Biggs has pointed out [tandfonline.com], the full picture of the study's findings became public only after a prolonged campaign to force the researchers to publish their findings.

Contrary to what American activists imply, the systematic reviews of evidence in Sweden, Finland, and the U.K. did not find that the Dutch study, on which the Dutch protocol is based, constitutes high-quality evidence. One of the core questions in the systematic review by the U.K.'s National Institute for Health and Care Excellence (NICE) was this: "In children and adolescents with gender dysphoria, what is the clinical effectiveness of treatment with GnRH analogues [puberty blockers] compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention?" Using the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) system, NICE assessed the Dutch study for seven reported metrics of mental health impact: gender dysphoria, depression, anger, anxiety, body image, global functioning, and psychosocial functioning.

It found that evidence for benefits across all seven measures was of "very low" certainty. NICE's conclusion about all the studies on puberty blockers, including the Dutch, was unequivocal: "Studies that found differences in outcomes could represent changes that are either of questionable clinical

value, or the studies themselves are not reliable and changes could be due to confounding, bias or chance." NICE conducted a separate systematic review for cross-sex hormones (which the Dutch study did not independently cover) and found that "[a]ll the studies . . . are uncontrolled observational studies, which are subject to bias and confounding and were of very low certainty using modified GRADE. A fundamental limitation of all the uncontrolled studies included in this review is that any changes in scores from baseline to follow-up could be attributed to a regression-to-the mean" (because patients tend to report for care at the peak of their distress).

The systematic reviews by Sweden's Committee for Medical and Social Evaluation (SBU), meantime, likewise found that the evidence for the mental-health benefits of hormones, including from the Dutch study, was very uncertain, because of the "moderate to high risk of bias" in these studies. The studies exhibit numerous methodological shortcomings, including confounding factors, lack of control groups, and high rates of attrition. "The identified scientific basis regarding hormone treatment of children and adolescents with gender dysphoria," SBU concludes, "is limited and it is not possible to draw any conclusions with moderate or high reliability. For most outcomes examined in this report, the evidence is insufficient and conclusions cannot be drawn." SBU also reported "low confidence" in the assessed health risks of hormonal interventions in minors. In essence, Sweden recognizes this as a medical experiment with no high-quality, reliable data on long-term benefits or risks.

The results from the evidence review in Finland are harder to interpret because most of the studies evaluated involved adults, and the review did not rate the quality and reliability of the studies. In other words, the review did not try to assess the degree to which even the positive findings in the Dutch study were causally related to the hormonal treatments. Nevertheless, on the basis of this review, and a study published by Finnish gender clinicians shortly thereafter finding that "medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities," the country's Council for Choices in Health Care (COHERE) issued new recommendations in 2020. Even for patients whose gender issues appeared first in childhood and intensified in adolescence (a pathway that is required for hormonal eligibility under the Dutch protocol but optional under the American-affirmative one), COHERE recommends that "the first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders." In the same document, COHERE emphasizes that "gender reassignment of minors is an experimental practice." This includes minors transitioned under the Dutch protocol.

Yes, Sweden, Finland, and the U.K. still allow a tiny subset of minors with gender issues access to puberty blockers and cross-sex hormones. But they are doing so under tight restrictions and against the findings of their own systematic reviews—or, as in the case of Finland, in full recognition that this constitutes medical experimentation on minors.

A good case can be made that Republicans who seek to ban these interventions entirely are being more faithful to the findings of the European evidence reviews. The real debate between red states in the U.S. and European health authorities is not about whether there is good evidence for pediatric gender transition. There isn't. Rather, the debate is about whether children as young as eight [ncbi.nlm.nih.gov] with a strong desire for "gender affirming" drugs have the ability to understand fully and give informed consent to the long-term consequences of these interventions—and even if they can, whether this justifies enlisting them in an uncontrolled medical experiment.

Have a great day,
Patrick Pullis

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