Survey Response to Australian Society of Plastic Surgeons' Application 1754 for Medicare item numbers for consultations and surgical procedures for 'gender affirmation' in adults with gender incongruence.

This is the AF4WR completed survey submitted on 14 February 2025 to the Medical Services Advisory Committee of the federal Department of Health and Aged Care as part of the pre-MSAC public consultation process.

Note Addendum with explanation of and issues regarding gender surgeries as raised by a Fellow of the UK Royal College of Surgeons.

Following is a Word version of the MSAC Consultation Survey, in its entirety. The survey includes information and a sub-set of questions aimed at all respondents. In addition, it contains four sub-sets of questions directed at specific groups of respondents. A border has been added to pages that contain respondent specific questions to try and make it clear which questions are aimed at which type of respondent.

- Information and questions **FOR ALL RESPONDENTS TO COMPLETE** are on pages with no border.

- A sub-set of questions directed to consumers, carers, and other interested individuals is on pages with a yellow border.

- A sub-set of questions directed to health professionals and health academics is on pages with a blue border.

- A sub-set of questions directed to consumer organisations is on pages with a green border.

- A sub-set of questions directed to medical, health and other (non-consumer) organisations is on paper with a purple border.

Information prompts appear throughout the survey to assist respondents to consider what information they may want to give MSAC. These prompts are under the heading '**Examples of information MSAC may find helpful'.** The prompts are examples only and not intended to limit input in any way.

If you are unable to complete the survey in the OHTA Hub, you may download this document, complete the relevant questions, including all compulsory questions, and email it to commentsMSAC@health.gov.au. Input must be received before the closing date for consultation.

Overview

Consultation is open on applications for consideration by the **Medical Services Advisory Committee** (MSAC) and its subcommittees — the PICO Advisory Subcommittee (PASC) and Evaluation Subcommittee (ESC). Consultation input helps MSAC and its subcommittees to better understand how a proposed health service or technology fits in the Australian health care environment. It does this by providing MSAC with an insight into the potential effect of the proposed health service or technology on:

- the lives of people with the health condition, their carers, family, and friends
- clinical practice and
- the Australian health care system.

The MSAC considers applications for public funding of a wide range of health services and technologies, including:

- pathology tests, such as blood or urine tests
- diagnostic imaging procedures such as x-rays and CT scans
- prevention and early detection services, such as cancer screening or genetic testing
- medical and surgical procedures
- other services or technologies to support the diagnosis, prevention, treatment and monitoring of physical and mental health conditions.

The MSAC refers to these collectively as **health services or technologies.**

How to provide input

You can give input to MSAC by completing the online survey. To help your preparation, you can download a copy of the questions asked in the survey. To do this, click on the relevant Microsoft Word link below (under 'Related'). There are different questions for different types of respondents, but they all seek similar types of information. If you have trouble using the survey, you can complete the Microsoft Word version and email to commentsMSAC@health.gov.au.

To help people understand the proposed health service or technology, MSAC publishes a copy of the MSAC application form and related PICO set. You can find these documents by right clicking on the "MSAC application documents" link below (under 'Related') and selecting 'open link in new tab'. This will open the application webpage in a new tab. You will find a copy of the MSAC application form and latest PICO document on the webpage. If the MSAC PICO Advisory Subcommittee has already considered the application, the most recent version of the PICO will be called a **PICO confirmation.** The 'MSAC application documents' link will not be accessible from the survey itself, so it is recommended you click on the link before you commence the survey.

A PICO is a framework that is used when evaluating health services or technologies. It is important because it tells us about who the technology is for, how it would be used, what is the alternative in Australia, and what effect it is intended to have. PICO stands for **P**opulation, **I**ntervention, **C**omparator and **O**utcome and describes:

- who would be able to use the proposed health service or technology (**Population**). For example, it will specify the health condition(s) and other features, such as patient age, disease stage etc.
- the proposed health service or technology and how it would be delivered (**Intervention**).
- how the health condition is currently managed in Australia (**Comparator**). If there is no way to manage the health condition, then this may say 'no comparator' or 'best supportive care'.
- how the effect of the proposed health service or technology will be measured (**Outcome**). Outcomes can be immediate, such as reduced pain, or happen in the future, such as improved five-year survival rates. Outcomes can be felt by the person or the health system, or both. For example, reduced hospitalisations.

Reviewing the PICO for the application will mean you can answer more of the survey questions. You will still be able to answer some questions without reading the PICO document. If you are unsure what to say in your input, check out the drop-down menus under most questions. These give examples of information MSAC may find helpful. Not all examples will apply to all applications.

Privacy and Consent

Privacy information

Your personal information is protected by law, including the *Privacy Act 1988* and the Australian Privacy Principles (APPs). Personal information is information or an opinion about an identified, or reasonably identifiable, individual. The Department of Health and Aged Care (the department) is collecting personal information from you via Citizen Space. We will collect this information at the time that you submit your survey. This survey is for the purpose of consulting on an MSAC application submitted to the Office of Health Technology Assessment. To protect privacy, **please do not include** personal information about another individual (third party) in your input. If you need to include information about another individual in your survey response, you will need to inform that individual of the contents of this notice and obtain their consent to the department collecting their personal information.

Some questions, such as your name and email address, are required. If you do not provide your personal information, you will not be able to submit the survey.

How we will use your input

The department routinely shares consultation input with MSAC and its subcommittees and with the applicant.

The department generally shares **input from groups/organisations** in full. If personal information of a third-party is included in the input, the department will redact this information before sharing. In respect of organisational input, we are unlikely to disclose your personal information to any overseas recipients but note that some applicants will have overseas affiliates.

The department shares **input from individuals** with MSAC and its subcommittees but will redact information that may enable the respondent or a third party to be identified. Input from individuals is only shared with the applicant in summary form. We will not disclose your personal information to any overseas recipients.

The department prepares a summary of consultation input and shares it with MSAC and its subcommittees and the applicant. This summary does not include personal information about individuals who provide input or third parties.

From time to time, the department may also share consultation input with:

- **Other Health Technology Assessment Committees**. For example, if an application is also being considered by the Pharmaceutical Benefits Advisory Committee or the Medical Devices and Human Tissue Advisory Committee, we may share MSAC consultation input with these committees or their sub-committees.
- **Health Technology Assessment (HTA) Groups**, to inform their reports to MSAC. The department contracts HTA Groups to prepare documents that help MSAC with its appraisal. If HTA Groups receive copies of consultation input, it is in the same form as that provided to MSAC.
- **Representatives from state and territory governments**, where the application is for a service to be delivered through public hospitals. If the department shares input with state and territory representatives, it is in the same form as that provided to the applicant.

The department may publish a summary of consultation input on the MSAC website as part of the PICO Confirmation and/or Public Summary Document for the application. The summaries in these documents contain no personal information about individuals or third parties. The summaries may include the names of organisations who give input and may attribute views/comments to these organisations. Organisations should not include information or opinions in their input that they would not wish to see in the public domain.

The department's privacy policy contains information about:

- how you can contact the department if you want to access or correct personal information that the department holds about you.
- how you can complain about a breach of the APPs or of a registered APP code that binds the department.
- how the department will deal with your complaint.

You can get a copy of the department's privacy policy by:

- contacting the department on telephone (02) 6289 1555 or free call 1800 020 103.
- sending an email to **enquiries@health.gov.au**
- downloading it from department's website.

If you wish to contact the department about a privacy-related matter, including questions about this notice, please contact the department's Privacy Officer by one of the following methods:

Post: Privacy Officer
Department of Health and Aged Care
23 Furzer Street
WODEN ACT 2606

Email: privacy@health.gov.au

Consent

☒ I have read the above text on how the department will handle personal information included in my response to this MSAC consultation survey. I consent to the department collecting, using, and disclosing my personal information, including any sensitive information, as described above. *(Required)*

By submitting a response to this survey, I acknowledge that:

- I understand that copyright in the content of my survey response will vest in the Commonwealth of Australia.
- Where relevant, I have obtained the consent of any individuals whose personal information is included in my survey response, to the department collecting this information for the purposes outlined in this notice.
- I understand that the Department has complete discretion as to whether my response to this survey is included, in full or in part, in any published summaries (with personal information removed).

Contact Details

The Department requires this information so we can contact you if we need to clarify the information you give us. It also helps us to avoid collecting duplicate input from the same person.

REDACTED

1. Providing Input

Please check the box below that best represents the main reason you have decided to give input to MSAC. We know that more than one of the descriptions may apply to some people. The survey has one set of questions for consumers, carers, and other individuals. There is a separate, but similar, set of questions for health professionals. Individuals will have the option to answer both sets of questions if they choose, regardless of which box they check.

There are also questions specific to those providing input on behalf of an organisation. Please select one of these options if you are:

- giving the views of a group or organisation (not just your own views) **and**
- the group or organisation has authorised you to submit its views.

Please select only one item *(Required)*

☐ I have the health condition that this health service or technology is for.

☐ I have the health condition that this health service or technology is for and have experience with the proposed health service or technology.

☐ I am a parent, partner or another person caring for someone from the above two groups.

☐ I am providing input on behalf of a consumer group or organisation. Consumer organisations are not-for-profit organisations representing the interests of healthcare consumers, their families, and carers.

☐ I am a health professional or health academic working in the area.

☒ I am providing input on behalf of a medical, health, or other (non-consumer) organisation. For example, input on behalf of a group of clinicians, research organisation, or professional college, or from an organisation that produces a similar service or technology.

☐ I am an interested individual who does not fall into any of the above categories.

2. If you are providing input on behalf of a group or organisation, what is the name of the group or organisation and what is your role with the organisation?

Australian Feminists for Women's Rights

Questions for Medical, Health and Other Organisations (non-consumer)

Please answer the survey questions in as much detail as you can. You do not need to complete the survey all at once. You can save it and come back later. But you must submit the survey before the consultation closing date.

Reviewing the Application Form and PICO set for the proposed health service or technology will help you to answer the questions. A link to these documents is provided under 'Related' at the bottom of the Overview page. You can access this link by using the back arrow on your browser until you reach the Overview page. Using the 'back' option at the bottom of the survey page will **not** take you to the required page. If the MSAC PICO Advisory Subcommittee has considered the application, the most recent version of the PICO will be called a **PICO confirmation.**

Towards the end of the survey, you can upload a file (up to 25 MB in size). You can use this to give MSAC other information that you think it may find helpful. If the information is available on a website, you do not need to upload it, just link to the information in your answers.

1. What is the organisation's experience with the proposed health service or technology, or with the related health condition?

Australian Feminists for Women's Rights is a women's rights organisation which has done extensive research and advocacy into numerous aspects of gender ideology, which is what is behind this application. Our work, as well as the individual work of some of our members spans many years and is evidence based. The information we provide in this review is authoritative and independent of the influences impacting the clarity and impartiality of many groups advocating in this area, including that of medical colleges, the AMA and health services.

We say that the application under consideration is fundamentally flawed due to failing any of the expected and required evidentiary standards for health care. The application is premised on an acceptance that the ideology of 'gender identity' and the practice of a "gender affirmation" model of treatment are legitimate, evidence-based areas of medicine. This is not so. On the contrary, the practice of "gender affirmation" treatments is pre-experimental, its assumptions and imperatives are ideological and entirely inconsistent with both Australian and international standards of health care.

When fully examined without dogma and ideological rhetoric, evidence shows gender ideology and the "affirmation model" of treatment are grounded in and reliant upon sexist stereotypes that have been clearly identified as harmful to women and girls.

This is evidenced in the Sex Discrimination Act where the definition of "gender identity" contained in the Act is a circular one which is based on sex stereotypes.

The introduction of gender ideology into our health and social systems has greatly undermined extensive whole-of-government investments to overcome demeaning sex stereotyping of women and girls that are accepted and expected directions of health policy in Australia.

An unhealthy promotion of sexist stereotypes is one of the harms this ideology has been allowed to foster. It relies entirely on hollow, emotive, unscientific and circular logic and has undermined evidence-based medicine in the treatment of vulnerable young Australians for too long now.

The majority of western countries across the world are now ceasing and winding back the very practices proposed to be introduced via this Application from the Australian Society of Plastic Surgeons (the Society). Should the Application be approved, it will further highlight that Australia as an antipodean outlier in the world, cast adrift from ethical, evidence-based and accountable medical governance.

2. Is the proposed population(s) for the health service or technology appropriate?

Examples of information MSAC may find helpful.

- Are the proposed eligibility criteria appropriate?
- Are there groups who could benefit from the proposed health service or technology, but who are not included in the eligible population?
- Is the proposed population too broad? That is, does it include groups who would not benefit from the proposed health service or technology?
- Are there key differences between the proposed eligible Australian population and the participants in studies or other evidence relied on in the application?
- Will the proposed eligibility criteria impact (positively or negatively) people who are known to face health inequalities. For example, First Nations people or people with a disability?

The proposed population(s) / eligibility criteria are described in the 'population' section of the PICO.

The proposed consultations and surgical procedures are not fit for purpose for any population and the Application should be rejected outright.

Although the proposed surgical procedures are equally harmful for males and females, children and adults, our focus for this submission is on females 18+, who form a large swathe of the 'Population' described. Their sex-based lived experiences make them uniquely vulnerable to confusion about their sex.

This confusion is now being realised largely as a result of ideological teachings of 'gender identity' having been pushed for over ten years by social media, Australian schools, universities, media, workplaces and medical organisations.

Alongside the promotion of harmful sex-based stereotypes that are common in Australia, the teachings of gender ideology add another pressure on girls and young women. Those girls and young women who either wish to escape the pressures of sex stereotypes, or who do not feel those stereotypes represent them are now strongly influenced to adopt a male or "non-binary" identity.

Gender ideology has enabled a rebranding of the very sex stereotypes that Feminists and others have been fighting to rid us of for decades. The attention and adulation surrounding those who express gender incongruence encourages them to undergo irreversible procedures and treatments that have lifelong physical and psychological consequences.

Regret for such decisions is an emerging area that is yet to be fully understood and realized. However, the risk is evident via the withdrawal of insurance cover for doctors practicing gender medicine by MDA National in 2023. Australia would do well to heed the growing numbers of medical negligence cases underway in other countries, particularly considering the large numbers of children reported to be receiving gender affirming treatment in this country by comparison with those in the UK. Particularly pertinent to this Application is the fact that many such cases are being initiated against surgeons who have undertaken gender affirmation surgeries on young women.

Women and girls are discriminated against and abused because of our biological sex. 'Gender medicine' when seen through this lens can be seen as medical abuse of girls and women. We believe this application is:

1. a danger to women and children and
2. an attack on the hard-won sex-based rights of women.

For example, in this application, the Society seeks to benefit its members financially by taking advantage of

girls' and women's psychological discomfort and the insecurities of adolescence and young adulthood that lead females in increasingly large numbers, to adopt a "gender identity". The approval of this Application will reinforce this social contagion and seeks to utilise public funding to do so.

Some of the reasons females are identified as the single largest cohort of those claiming a gender identity include:

- They don't see themselves reflected in portrayals of females in social and other forms of media but rather are exposed to stereotypical representations of female presentations that demean and limit their human value.
- Their family circumstances, such as conflict, trauma, having a special needs sibling, being adopted or being a twin, may make them more vulnerable to feeling something is wrong with them.[i]
- Girls and women who are more likely to face health inequalities by their experience of disability or out-of-home care or being First Nations are also easily at risk of coming to believe their problems can be solved by reinventing themselves via a "gender identity".

The advocacy groups listed in the application do not include any group critiquing the assumptions about 'gender identity' and representing girls' and women's rights to be protected from medical misogyny.

Much has been documented to confirm that 'gender affirming care' is a modern-day form of gay conversion. It effectively heterosexualises children and young people who overwhelmingly, evidence shows, would otherwise grow up to be gay.ii An evidence-based approach to gender incongruence would see treatment consistent with what is offered for other conditions, including social supports, time and psychotherapy where required.

The application seeks to argue that the proposed surgeries will reduce psychological distress, self-harm, suicidal ideation and suicide rates for the population. However, there is no valid evidence to support this claim. Instead, evidence is mounting that 'gender affirming' surgeries exacerbate these risks[iii] as they give false hope to vulnerable people that the procedures and treatments will resolve underlying psychological issues. Indeed, some, including detransitioners, argue that doctors performing such procedures are engaged in acts of collusion with patients in their efforts to self-harm.

A decision on this application must not be made without considering the important evidence of detransitioners. Melbourne woman Mel Jeffries has spoken of how she now considers the surgeries she underwent amount to her being "violated by the medical industry" and that she will "always carry the scars, physical and mental, of the choices she now regrets".[iv]

It is not a coincidence that most girls self-harming in our psychiatric hospitals today with undiagnosed neurodiversity and/or borderline personality disorder (BPD) and other co-existing conditionsv are reportedly (in whispers from top clinicians) identifying as being "transgender". Why is there no curiosity to ensure that these girls and young women are offered the correct clinical pathway?[vi]

The Application fails to recognize that under the current "affirmation model" of treatment, the proposed surgeries would likely be performed before any of the underlying reasons or medical comorbidities for the gender incongruence are effectively diagnosed or addressed.

There is no valid evidence base on which this Application can be justified, no definitions of what diagnoses are being treated and no clinical standards for the consultations and procedures proposed to be funded.

3. Is the proposed approach to delivery of the health service or technology appropriate?

Examples of information MSAC may find helpful.

- Is the proposed delivery of the health service or technology feasible and consistent with Australian clinical practice?
- Are any proposed limitations appropriate? For example, limitations on:
  - who can deliver the service
  - the number of times a patient may use the proposed health service or technology in a defined period.
- Does the proposed delivery of the health service or technology raise any access and equity issues? If so:
  - How do these compare to current management?
  - How might these issues be resolved?
- Are there services not mentioned in the application that need to be used before, with, or after the proposed health service or technology? For example, counselling, dietician, pathology etc.?
  - If yes, what type of services and why are they required? Are these services readily available?
- Does the proposed approach to delivery create any other barriers? For example, barriers to access for people who are known to face health inequalities, such as First Nations people or people with a disability.

The proposed approach to delivery is set out in the 'intervention' section of the PICO.

The interventions proposed in this approach should be rejected as they are not evidence-based.

Consultations about 'gender identities' and surgeries to support them are unfounded and based on sex stereotypes that are not based in reality.

We must be confident that we can trust our doctors and our medical colleges, but they break our trust with applications such as this. Our medical colleges and the AMA are failing to respond to overwhelming international evidence such as that of the UK Cass Report[vii] [viii] debunking 'gender affirming medicine' for young people including young adults.

'Gender affirming care' is an idea that has been pushed by the Australian Professional Association for Trans Health (AusPATH), a quasi-medical lobby group relying heavily on the so called "lived experience" of adults, who have never been subjected to the current gender affirmation treatment protocols current young people are facing. AusPATH is the Australian branch of WPATH, which is controlled by activist clinicians and has been comprehensively discredited for falsifying data, pressuring Johns Hopkins researchers to suppress findings that are contrary to its political aims and for which there is no evidence.[ix] [x] [xi]

AusPATH appears to have gained influence over some Australian medical colleges to undermine the NHMRC, upending our evidence-based health system to implement 'gender affirming care' for their own vested interests. AusPATH has been discredited for serving as a decoy to avert attention from the fact that the RCH guidelines[xii] were never endorsed by the NHMRC on their release in early 2018.

It is now known that there was a failure to declare an alarming conflict of interest in the development of the Australian guidelines for 'gender affirming care', relied on by the medical and judicial sector across the country to this day. A key author of the AusPATH endorsed, RCH badged 'Australian' guidelines never declared that during the period in which the guidelines were developed, she was also operating as the Vice President of lobby group AusPATH.

It is up to the Federal Department of Health and Aged Care to ensure this evaluation is considered within best global clinical practice and rise above the 'gender identity' social contagion affecting our medical colleges reflected in this application.[xiii]

We are concerned this survey itself is compromised as it seems to seek to limit consideration of this PICO to being "consistent with Australian clinical practice" as indicated in your survey questions.

It would be negligent for the facts about clinical practice guidelines in Australia for gender medicine to be ignored in considering this Application by accepting the reassurance given in this application unquestioningly.

For example, this application states:

> *The Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (Coleman et al. 2022) has been endorsed as a Standard of Care by the Australian Professional Association for Trans Health (AusPATH).*

However, the Society should know, but has failed to report, that WPATH has been comprehensively discredited as falsifying data and making claims for which there is no evidence.[xiv]

By failing to defer to the NHMRC for its authoritative clinical advice about whether the Australian health care system should accept this as valid clinical guidance, the Society of Plastic Surgeons seeks to undermine national clinical governance in Australia.

Increasingly clinicians and public servants are speaking out about the failures to protect those reporting gender incongruence in Australia.

To tick this Application off in the face of mounting evidence that we should be doing exactly the opposite, may not result in immediate consequences for the decision makers. But there will come a time in which such decisions are exposed. And the harms caused to young Australians will need to be accounted for.

The number of organisations that are braving the storm and calling it out, like we do here, is growing.

For example:

- The Australian Doctors Federation has called for a national conversation on how to protect vulnerable adults up to the age of 25.[xv]
- Letter to the Australian Prime Minister signed by 100 eminent Australians (29 January 2025) calling for a public inquiry into how gender medicine came to be allowed to be applied to young people. This seems to have prompted the Minister to announce development of new guidelines for under 18-year-olds. However, adults remain unaccounted for.[xvi]

Even the American College of Paediatricians has stated:

> *"Educators and legislators should reject all policies that condition children to accept as normal a life of chemical and surgical impersonation of the opposite sex. Facts—not ideology—determine reality… Conditioning children into believing a lifetime of chemical and surgical impersonation of the opposite sex is normal and healthful is child abuse."*

The Society's application seeks to further embed the unproven and flawed 'Dutch Protocol.'

This application is a superb example of the creep of unproven approaches in clinical practice that needs to be prevented highlighted by the Cass Report in 2024.

> *Based on a single Dutch study, which suggested that puberty blockers may improve psychological wellbeing for a narrowly defined group of children with gender incongruence, the practice spread*

at pace to other countries. (Cass, p13)

Innovation is important if medicine is to move forward, but there must be a proportionate level of monitoring, oversight and regulation that does not stifle progress, but prevents creep of unproven approaches into clinical practice. Innovation must draw from and contribute to the evidence base. (Cass Para 20.8)

The Dutch Protocol explained

The 2006 'Dutch Protocol' study hypothesised that: Treatment outcome in transsexuals is expected to be more favourable when puberty is suppressed than when treatment is started after Tanner stage 4 or 5:

> *It is conceivable that lowering the age limit increases the incidence of 'false positives'. However, it most certainly results in high percentages of individuals who more easily pass into the opposite* ***gender role*** *than when treatment commenced well after the development of secondary characteristics*. xvii

Back then the cohort was largely limited to lesbian or gay children or young people, presumably unwittingly as it is so homophobic. In their 2011 reporting of 70 subjects embarking on their Protocol study, 97% of them were same sex attracted or bisexual. This variable was never reported again.xviii

Their 2014 follow up study reported on 55 only of their original 70 subjects for a number of reasons including that one had died after vaginoplasty owing to a postsurgical necrotizing fasciitis.xix

Over a short time, the original criteria, that seemed to limit access to same sex attracted, were extended to include being a w ard of the state, having a history of trauma, family dynamics, mental health issues or neurodiversity.[xx] [xxi] [xxii]

As this longitudinal research was partially funded by a pharmaceutical company selling puberty blockers,[xxiii] it's not surprising that many weaknesses have now been well documented in relation to it and the 'gender affirming care' model that is based on it that escaped the laboratory just like a dangerous virus.[xxiv] [xxv] [xxvi] [xxvii] [xxviii] [xxix]

The 2024 Cass Review report reminded us that clinicians should apply the same high-quality standards of care as for any others and that there was no justification for exceptionalism for 'gender medicine'.

Without being able to ensure informed consent based on medically indicated advice of risks and benefits of alternative treatments, 'gender affirming care' procedures under the current standards of care should be deemed unlawful in Australia.

The Australian Charter of Healthcare Rights assures us that we have a right to clear information about medical conditions, the possible benefits and risks of different tests and treatments, so as to give informed consent.

- **The Australian Commission on Safety and Quality in Health Care (ACSQHC)** is responsible to ensure health service organisations give doctors ready access to guidance on latest best global graded evidence to enable informed consent.xxx
- **The Australian Health Professionals Regulatory Authority (AHPRA)** is responsible to use professional codes of conduct to hold doctors accountable for compliance with informed consent as part of treatment decision-making.

The current failure to address the incapacity of patients to provide informed consent under 'gender affirming care' puts our doctors in an untenable situation in relation to their duty of care and potential litigation.

This concern about informed consent was the reason the UK NHS instigated the Cass Review. It provides the core basics of medical decision-making in the following explanation and diagram:

- *For example, if a doctor diagnoses a patient with depression and recommends a particular*

antidepressant medication, they should invariably explain that there is strong evidence that the drug is effective; for example, it has an 85% chance of improving the depression.

- *The doctor will also point out possible side effects; for example, it has a 5% chance of causing weight gain. If the patient already happens to be very distressed about being overweight, they may not feel that the potential benefits of the drug outweigh the risk that they may gain weight.*
- *The doctor will then consider other options; for example, there may be a different drug that does not cause weight gain but increases risk of suicide. If the patient has made a recent suicide attempt that would not be an appropriate alternative to offer to this patient.*
- *Without this evidence for benefits and harms, it is hard for the doctor to advise the patient, and for the patient to decide whether they want to try the proposed treatment.* (Cass, p48)

Figure 3: Components of evidence-based medicine

Image above copied from p48, Cass Report, 2024

To be unable to inform patients of clinically indicated research evidence, due to a lack of evidence, disempowers patients and leaves no basis for informed consent as part of medical treatment decision-making. It leaves decision-making to the doctor's expert opinion. So, in fact, rather than being patient driven, it is doctor driven. Without consent these medical interventions are medical abuse.

4. Does the comparator(s) set out in the application accurately reflect Australian clinical practice?

Examples of information MSAC may find helpful.

- Does the comparator(s) in the PICO accurately reflect how the health condition is currently managed in Australia?
- Does the clinical management pathway for the comparator(s) capture current practice?
- Is the comparator applicable in all areas and for all populations? For example, rural and remote areas, First Nations people?
- Is the comparator(s) more, less, or as effective in practice to how the applicant has described it?
- Does the current management of the health condition in Australia raise access or equity issues?
  - ➢ If yes, how do these affect individuals with the health condition, their families, and carers?

A description of the comparator(s) for the application is available in the 'comparator' section of the PICO.

Existing non-gender affirmation MBS items are the wrong comparator.

The application uses deceptive circular logic to argue that the comparator for these consultations and procedures is existing non-gender affirmation MBS items on p 14 of the applicant's PICO.

This essentially argues that it should all be approved as we are already being funded to do these

consultations and surgeries under other Medicare Item Numbers.

The fact that they are funded already or that clinicians already provide them is the evidence used to justify the application, regardless of clinical validity. This is shameful circular logic that has no place in an evidence-based health care system. It is evidence of social contagion of malpractice within medicine:

> *Some medical interventions used for gender affirmation are either not funded through MBS items (e.g. face surgeries) or are not eligible for funding through the MBS when used for the purposes of gender affirmation (e.g. feminising chest surgery/breast augmentation). Despite the lack of MBS funding these procedures are well-established for the purposes of gender affirmation and are considered to represent 'standard medical management funded by out of pocket expenses.'*

Psychotherapy is the correct comparator

Psychotherapy is the evidence-based treatment that should be applied to this cohort of patients. There is no evidence doctors can rely upon to provide treatment for a 'gender identity'.

It is impossible for anyone to consent to the procedures currently being provided under the 'gender affirming care' model. There is no evidence with which to inform patients that such treatments are clinically indicated. Whereas patients can be equipped with information with which to give informed consent for psychotherapy.

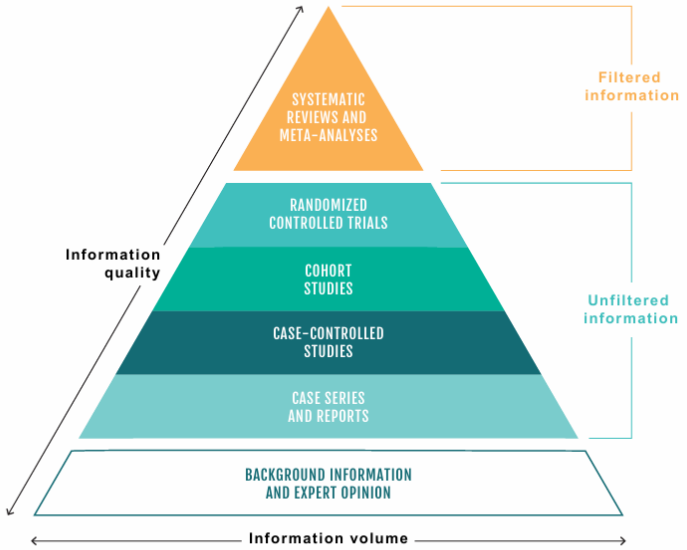
Professor Dianna Kenny has written:[xxxi]

> "*Transgender advocates state that in transgenderism – the belief/assumption that one has been born in the wrong body – the body must be aligned to one's gender belief, not one's belief to one's biological body. They assume that the mind is "correct" in its perceptions and beliefs and the body is diseased and must be treated. Transgenderism is a disorder of assumption and like other disorders of assumption, is solipsistic. Solipsism is the belief that ideas that arise in the mind are true and cannot be questioned. For example, those with anorexia nervosa believe that they are a fat when in fact they are emaciated. People with body image dysphoria engage in endless plastic surgery to correct their perceived ugliness, when their appearance falls well within the 'norms' for their culture. Those with body integrity identity disorder (BIID) perceive one or more of their limbs or organs as alien to the rest of their body and wish to have it amputated or paralysed. If refused surgery, they may self-mutilate. Can we, as a society, condone the amputation or paralysis of healthy limbs in people with BIID? In the same vein, is the amputation of a healthy penis and healthy breasts ethically justifiable? Disorders of assumption are disorders of perception. Disorders of perception belong in the domains of psychology, psychiatry, and psychotherapy, not endocrinology or mutilating surgery.*
>
> *In the Middles Ages, the belief that some women were "witches" resulted in the murder of thousands during the Inquisition. More recently, families were torn apart from the "recovered memories" epidemic. Innocent teachers spent many years in jail after false accusations of "ritual sexual abuse" at preschools (Kenny, 2015). If transgender hysteria is not stemmed, it will result in the devastation of the lives of young people who get swept up in the cause of gender affirmation. Many may change their minds, but sex reassignment surgery and sterility as a result of cross-sex hormone treatment are irreversible.*

The independent Cass review was set up to eliminate bias from tricks of the mind that happen even to doctors and academics in relation to judgements where they would serve to gain by confirming their own work.

This is why we have the Australian NHMRC 2016 Standards for Clinical Guidelines and the UK's equivalent on which ours are based. The Cass Review used systematic reviews based on GRADE evidence which indicate the degree to which the conclusion can be trusted as true. 'Gender medicine' is based on expert opinion only.

Figure 5: Pyramid of standards of evidence



Source: Reproduced with permission from: OpenMD. (2021, July 17). Levels of evidence. Levels of Evidence in Medical Research. https://openmd.com/guide/levels-of-evidence

GRADE (Grading of Recommendations, Assessment, Development, and Evaluations) is the system widely used globally to summarise the quality of research evidence and make clinical recommendations.

There are four levels of certainty about results:

1. High certainty - The authors have a lot of confidence that the true effect is similar to the estimated effect.
2. Moderate certainty - The authors believe that the true effect is probably close to the estimated effect.
3. Low certainty - The true effect might be markedly different from the estimated effect.
4. Very low certainty - The true effect is probably markedly different from the estimated effect.

You can read more about this on p56 of the Cass Review.

Based on their assessment of the evidence, the Cass Review developed an assessment framework and a model of care to help. Their guidance:

> *Recognises that gender dysphoria/incongruence can be a manifestation of complex pre-existing family, social, psychological or psychiatric conditions or predisposing factors. … Where these conditions are presenting as gender dysphoria/incongruence, the treatment of the underlying condition is a priority.*
>
> *Individualised psycho-social interventions (e.g. psychoeducation, individual psychotherapy, school-home liaison, and family therapy) should be first-line treatments... Exploratory psychotherapy should be offered to all gender-questioning young people to identify the many potential sources of distress in their lives in addition to their gender concerns.*

It is a problem for untold numbers of girls and women's lives that evidence based exploratory psychotherapy has been outlawed in Australia for anyone saying they are 'transgender/diverse or gender fluid' by State 'anti-conversion' laws.

Psychological issues must not be misdiagnosed and treated with drugs and scalpels.

Doctors who are not trained in mental health have limited frameworks within which to understand the interplay of their patients' complex psychological defence mechanisms. Doctors must be protected also, from

the "God complex" wherein they overlook their own knowledge gaps and biases to the detriment of their patients.

It is no coincidence that 'gender affirming care' weaponises mental health stigma to offer vulnerable people a 'way out' of accepting they may benefit from mental health care.

In 2021 and 2022, AusPATH attacked the Royal Australian New Zealand College of Psychiatry for its commitment to stating that psychotherapy is the evidence-based treatment for gender confusion. [xxxii] [xxxiii]

In an example of the 'trick of the mind' circular logic, a 'cutting' piece of their advice to the psychiatrists was:

> "*Gatekeeping, the process by which gender affirming care has been withheld or controlled by the medical field, has been widely practiced in psychiatry, neglecting a patient-led, informed consent approach*".[xxxiv]

Here AusPATH had implied it supported informed consent while denying the continuing reality of very weak evidence with which patients can be informed.

AusPATH went on to write to the RANZCP:

> *"the recent RANZCP position statement frames the trans experience as inherently pathological. This is in direct conflict with World Health Organization, American Psychiatric Association, World Professional Association for Transgender Health, AusPATH and PATHA, all of whom make it clear that being trans is not a pathology.*

This statement is a logical fallacy with no basis for its conclusions. In fact, to the contrary, it is easily arguable that it is 'gender affirming care' that pathologises a person as it tethers them to the medical system for medically reckless, irreversible and high-cost lifetime healthcare.

5. Does the organisation agree with the outcomes as set out in the PICO?

Examples of information MSAC may find helpful.

- Is there a reasonable level of certainty around the proposed outcomes?
- Does the organisation have any concerns about whether the proposed outcomes will be maintained over time?
- Are there other potential outcomes that are not mentioned in the application? For example, patient or system level outcomes.

The application provides no evidence-based description of any health outcomes.

However, as stated above, as there is no basis in reality to the concept of 'gender identity', and so no evidentiary basis to it as an area of medicine, informed consent is impossible.

For Australia's plastic surgeons to abdicate their responsibility to inform patients of evidence for clinical indication on the say so of a lobby group (AusPATH) constitutes state-sanctioned medical abuse.

It directly undermines the role of the Australian Health Practitioner Regulation Authority and the Australian Commission on Quality and Safety in Health Care in ensuring that all health care delivered in Australia is with informed consent.

The statements made in the Applicant's PICO regarding outcomes in relation to global and treatment specific gender affirming care' are unfounded and unevidenced. (p23 of the application)

Circular logic is used to support the claim that the health outcome is non-inferior. On p23 of the

application it is stated:

> *The medical interventions provided through the proposed MBS items are already provided to people undergoing medical gender affirmation in Australia.*
>
> *The application is seeking universal funding of medical interventions for gender affirmation through the MBS and not a material differences in the type of medical interventions for gender affirmation provided. As such, the foreshadowed clinical claim is that: medical interventions for gender affirmation fully funded through the MBS are non-inferior to medical interventions for gender affirmation funded by existing non-gender affirmation MBS items or patient out of pocket expenses.*

The application seems to argue that because Society members have been charging MBS Item numbers created for women's preventive breast cancer mastectomies that this is justification in itself for the creation of these new Medicare Item numbers to be approved. This is a meaningless and circular claim based on NO substance at all. The logic relied on treats with contempt the young women who may be harmed by the proposed practice.

6. Where the application is for an item on the Medicare Benefits Schedule, does the organisation want to comment on the proposed item descriptor(s)?

Examples of information MSAC may find helpful.

- Does the proposed descriptor(s) capture any limitations on access or use? For example:
  - types of practitioners or training requirements
  - patient access criteria
  - limitations on the number of times a patient can access the item in a defined period.
- Does the proposed item descriptor(s) cross-reference all relevant MBS item numbers?

The proposed MBS item descriptor is generally set out in the MSAC application form, which is available on the MSAC website.

Not applicable as not evidence based so should be rejected.

7. Where the application is for an item on the Medicare Benefits Schedule (MBS), does the organisation support the proposed fee for the health service or technology?

Examples of information MSAC may find helpful.

- Is the proposed fee in line with any similar health services or technologies?
- Does the organisation have a view on other potential costs, such as patient out-of-pocket costs or health system costs?

The proposed MBS fee for service is generally set out in the application form, which is available on the MSAC website.

We do not support any fee for any of the proposed MBS items as the population and interventions are unevidenced in the population identified.

Where patients have a DSD and have decided to seek such medical intervention we consider this would fall under existing MBS provisions. If there are gaps in this service provision, appropriate application must be

made for that purpose.

By our back of the envelope calculations, based on figures provided in the application and using conservative assumptions based on recent growth rates, we estimate that the annual cost of these surgeries would be around an average of $2 billion per annum over the next ten years but continuing to grow exponentially into the future.

An evidence-based use of these health resources would be to allocate ALL these cost-savings to an evidence-based mental health budget that no longer weaponises the mental health stigma that underlies the sexist ideology of gender identity.

The saving would be equivalent to more than doubling the Better Access Program for example to gain an understanding of the magnitude of this proposed expenditure on plastic surgeons.

This proposed funding should be allocated for training in evidence-based psychotherapies and psychosocial supports under a national implementation plan for borderline personality disorder and other complex mental health conditions.

It is a matter of urgency that this extraordinary application from the Society of Plastic Surgeons be REJECTED as it is an extreme form of misuse of public health funding for medical misogyny based on the ideology of "gender stereotypes".

8. If MSAC supported the proposed health service or technology, would the organisation want to see it implemented? If yes, what would have to happen for this to occur? If no, why not?

Examples of information MSAC may find helpful.

- Does the organisation see any barriers to the successful implementation of the proposed health service or technology? For example, high up-front costs.
  - ➢ How might any barriers be addressed?
- Are there factors that would facilitate implementation? If yes, what are they?
- Are there things that would need to be put in place to support the implementation of the proposed health service or technology? For example, training programs.
- Would there be a need to monitor the use of the health service or technology? For example, data capture through a clinical registry or other means?

No, we would not want to see it implanted.

9. Does the organisation support public funding for the health service or technology, as it is proposed to be delivered?

Please choose the most appropriate answer and tell us your reasons for choosing it below.

☒ Do not support

☐ Support

☐ Unsure/Other

It should not be allowed to be in the private sector either.

Next Steps

Thank you for providing input for an organisation, you are almost done. Click 'continue' to finalise and submit the survey.

For all respondents

1. Is there anything that you have not mentioned elsewhere that you would like to tell us about? (Optional)

If you would like to provide additional information you may enter it into the text box below. You may also upload a file.

If you are submitting on behalf of an organisation, MSAC would be interested in understanding:

- *Whether members had an opportunity to input their views and, if so, how.*
- *If the views expressed were endorsed by the organisation and, if so, how.*

These views expressed are endorsed by the Australian Feminists for Women's Rights.

If you would like to upload a file for this survey, you can do so below. (Optional)

Please note we do not accept:

- petitions
- duplicate submissions from the same author
- form letters (multiple copies of the same statements from different people) or any material that is inappropriate in language or tone.

Please ensure your file is under 25 MB in size. The preferred file types are PDF or Microsoft Word, however MSAC will accept other file types (for example, .jpg, .png, .mp3, and .mp4 etc).

MSAC accepts recorded consultation input (video or audio), provided the input is no longer than 10 minutes in duration. If the file is larger than 25 MB, please email **commentsMSAC@health.gov.au** attaching either:

- the recording file or
- a link to the recording file hosted on an accessible platform such as YouTube or Vimeo (MSAC is unable to view videos placed on TikTok) and/or
- a transcript of the recording.

If you have any difficulties submitting this form, contact **commentsMSAC@health.gov.au** for help.

2. How did you hear about this survey? (Optional)

Please select all that apply

- ☐ From the Medical Services Advisory Committee (for example, MSAC website or bulletin).
- ☐ From a support group or other consumer organisation.
- ☐ From a treating doctor or other health care provider.
- ☐ From a professional organisation, such as a medical or nursing college.
- ☐ From the applicant or from an industry body.

- ☐ From a clinical trial.
- ☐ From friends or family.
- ☐ From a colleague.
- ☐ Other (please specify below).

X social media platform

3. Do you have any suggestions on ways to improve this survey? (Optional)

- Under the first dot point under 3, the wording should be changed to:

  'Is the proposed delivery of the health service or technology feasible and consistent with **international best clinical practice**?'

  It is completely inappropriate and circular for Australian applications from national medical bodies to compare to their own practice. Its circularity makes it completely meaningless. Indeed they used this argument in their justification that there were reasonable outcomes. It was a completely fallacious argument.

Statement of interests

This section asks you to tell MSAC about any interests that you, or a close family member, may have in the MSAC application. Or, if you are giving the views of an organisation, any interests that the organisation may have in the MSAC application. These interests can be **personal, financial,** or **professional.**

Telling MSAC about your interests allows MSAC to better understand the context of your comments. It will help MSAC if you are as accurate, honest, and detailed as possible when completing this statement of interests.

Some examples of a **personal interest** are where you or a close family member (or the organisation and/or the members it represents):

- have a health condition that may benefit from the proposed health service or technology.
- have strong personal or religious beliefs about the proposed health service or technology.
- have a close personal or professional relationship with someone linked to the applicant.
- participated in a clinical trial for the proposed health service or technology.

A **financial interest** may include involvement with companies or other organisations involved in preparing the MSAC application. Or with companies or other organisations that develop, manufacture, market or distribute the health service or technology. Some examples include where you or a close family member, or the organisation you represent:

- work for, hold shares in, or have a contract with an organisation or company linked to the application.
- hold board or committee membership or another office in an organisation or company linked to the application.
- may, in future, receive financial benefits through delivering or prescribing the proposed health service or technology. Or, if you are submitting the views of an organisation, the organisation or its members may receive financial benefit.
- have received a grant or other benefits, such as conference attendance, travel etc., from an organisation or company linked to the application.

Some examples of a **professional interest** are where you or a close family member, or the organisation you represent:

- helped to develop the health service. For example, being involved in designing or implementing clinical trials related to the application.
- are involved in developing, manufacturing, marketing, or distributing similar or competing health-related technologies.
- make a public statement about an organisation or company linked to the application, or about the proposed health service or technology.
- act as an unpaid adviser to an organisation or company linked to the application.

Declaration of Interest Statement

Please tell MSAC about any interests you, or if giving the views of an organisation, the organisation, have in the MSAC application you are commenting on. Mark each box that applies and provide details in the text box provided. (Required)

Please select all that apply

☒ No interests

☐ Financial interests (describe below)

☐ Professional interests (describe below)

☐ Personal interests (describe below)

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Addendum to AF4WR Survey Response Identification Number is BHLF-MGJS-W34D-K

The below issues with Gender Surgeries were reported in January 2025 and can be verified via these two web pages:

https://genderblog.net/what-exactly-is-a-neo-vagina-then/

https://genderblog.net/what-exactly-is-a-neophallus-then/

Explanation of and issues regarding gender surgeries as raised by an NHS Royal College of Surgeons fellow in the UK, regarding gender surgeries.

- Procedures are being mis-sold to vulnerable people as a solution to normal individuals in response to their mental distress
- The medical understanding of Gender dysphoria is not recognised by any of the surgical literature as a surgical illness needing surgical treatment
- Terminology used – "neovagina" – is deceptive and misleading patients regarding outcomes
- Performing surgeries (particularly with such significant consequences and complications) on otherwise healthy bodies cannot be justified
- Patient information content produced and provided by public health systems in UK is misleading and inherently deceptive
- Individual anatomy is irreversibly destroyed by the procedures, leaving no possibility of restoration in the case of regret or change of mind.
- The genital surgeries performed do not leave patients with functional sexual organs
- Procedures for vaginoplasty and phalloplasty have not been properly scruitinised or ratified and such procedures would appropriately be banned until they have been reviewed by anatomists, physiologists, pathologists and the Surgical Royal Colleges for detailed, objective assessment of benefits and harms.
- Procedures for both vaginoplasty and phalloplasty consist of a number of different operations with different outcomes rendering them experimental at best
- Having been asked for approval of gender surgeries from professional bodies in the UK including the Welsh Healthcare Inspectorate, General Medical Council, Royal College of Surgeons, Royal College of Physicians, none have confirmed their approval of current procedures.
- The known facts about these procedures are considered by some as surgical malpractice currently being undertaken in the UK.

The following tables were produced for the purpose of providing comparisons of what patients believe – to greater or lesser degrees – they will be achieving via genital surgeries, and the reality of the surgical outcomes in either a Phalloplasty or Vaginoplasty procedure.

Normal Male Penis	**Skin and Fat Flap mound/Neophallus**
The penis consists of three parallel cylindrical bodies: two dorsally placed *corpora cavernosa* and a ventrally placed *corpus spongiosum*. The *corpus spongiosum* enlarges proximally to form the bulb of the penis and distally as the glans penis [ie the helmet or more politely, "corona" of the penis – Ed]. These cylindrical bodies are the building	The skin flap transfer, derived from the forearm, thigh or abdomen, lacks the anatomical complexity of the penis. It is simply a chunk of skin and subcutaneous tissue, with no bulb or cylindrical structures and no erectile tissues.

blocks of erectile tissue of penis.	
The skin of penis is delicate, elastic and hairless except at the base. Distally this skin forms a tubular fold called the *prepuce*. The penile skin is freely movable over the surface of the penis due to the presence of *underlying loose areolar tissue (superficial fascia)*.	The skin flap transfer does not include a *prepuce*. Instead, it is made from the coarse skin of the forearm/leg, including its natural appendages (hair). This artificial skin flap lacks the mobility of penile skin, as it does not have the *underlying loose areolar tissue*.
The *corpus spongiosum* encases the urethra and expands distally to form the *glans penis*, into which the tapered ends of the *corpora cavernosa* are inserted. The urethra runs through the glans and exits through a vertical slit at its tip. Microscopic examination reveals that both the *corpus spongiosum* and the *glans penis* are composed of a fine mesh of erectile tissue encased in a delicate fibrous capsule. Additionally, two arteries run through the entire length of the *corpus spongiosum*, reaching up to the tip of the glans penis. It is through this structure the urethra passes and the delicate capsule ensures non-collapsability of the urethra when *corpus spongiosum* fills with blood during erection.	In this man-made [or woman-made, hem hem – Ed] skin flap, there is no *corpus spongiosum*. The phallus, created by rolling the skin into a sausage-like shape, lacks both the fine mesh of erectile tissue and the delicate fibrous capsule that typically surround the *corpus spongiosum*. The mound of tissue tends to contract as it heals. As it contracts, the artificial passage that is constructed inside as an artificial urethra also tends to contract and narrow down. This leads to stricture formations and poor urinary stream. Such strictures become long term issues for the patients.
In the midline, in the urethral surface of *glans penis*, a free fold of skin passes from tip of glans to the deep aspect of prepuce. This structure is called the *frenulum* of the *prepuce*. The *frenulum* anchors the *prepuce* to the glans during intercourse.	There is no *frenulum* nor *prepuce*.
The *superficial fascia* of penis is of *loose areolar tissue*.	No similar *superficial fascia*. The skin cannot freely slide.
The *deep fascia* of the penis creates a snug sheath around the *corpora cavernosa*. This deep fascia prevents the spread of infection to deeper planes of the penis and into the pelvis.	The neophallus lacks a comparable *deep fascia*. The *deep fascia* remains in the forearm/thigh after the procedure. Hence the mound of tissue is more vulnerable to the spread of infection deep into the body and subsequent sloughing.
The suspensory ligament of the penis is a fibroelastic condensation of the deep fascia extending from the abdomen. It fuses with the deep fascia on the dorsum and sides of the penis, serving to anchor the penis in place during sexual activity.	During a metoidioplasty and/or phalloplasty operation to lengthen the virilised clitoris, the equivalent of the suspensory ligament is disrupted. Consequently, the neophallus lacks this crucial supportive structure.

The superficial and deep dorsal veins are situated along the midline dorsally, with the superficial veins lying above and the deep veins below the deep fascia of the penis. The deep dorsal vein of the penis drains directly into the prostatic plexus of veins. This type of surplus venous channels ensures swift return of blood from an erect penis during the resolution phase following intercourse.	In the neophallus, there is no equivalent venous drainage system, such as the prostatic plexus, to handle the venous return. Instead, the venous return must be anastomosed to the femoral vessels via vascular surgery. This connection can fail either immediately or later due to infection, potentially leading to flap necrosis.
The deep dorsal vein is flanked by two deep dorsal arteries and nerves, each located on either side. The deep dorsal artery, a direct branch of the internal pudendal artery, and the deep dorsal nerve, a terminal branch of the pudendal nerve, are responsible for transmitting normal touch and proprioceptive sensations. This ensures plentiful blood supply to the penis.	The neophallus does not contain deep dorsal vessels or deep dorsal nerves. Instead, the surgeon attempts to anastomose the radial vessels with the femoral vessels and to connect the cutaneous touch sensation nerves of the forearm with the ilio-inguinal nerves. The procedure has a failure rate of 10%. In successful cases, only touch and pain sensations of the skin are transmitted, not sexual sensations. The blood supply of neophallus is fully dependent on the integrity and adequacy of the vascular anastomosis.
In a normal penis, independent deep arteries supply the cylindrical erectile structures: the *corpora cavernosa* and the *corpus spongiosum*. This robust blood supply significantly reduces the risk of penile necrosis, making it exceptionally rare at any stage of life.	The blood supply to the neophallus transferred from the forearm/leg is entirely dependent on the delicate anastomosis between the radial and femoral arteries. Any technical failure or postoperative thrombosis can quickly lead to occlusion of this blood supply, potentially resulting in cell necrosis.
The *corpora cavernosa* are a pair of cylindrical bodies located on the dorsal aspect of the penis, each comprising a mass of cavernous erectile tissue. They are encased in a dense sheath of white fibrous tissue known as the *tunica albuginea*. When the erectile tissues fills up rapidly during erection the tough *tunica albuginea* does not stretch contributing to the hardness and rigidity of a fully erect penis.	The neophallus does not contain erectile tissue or a *tunica albuginea*. Hence the tissue cannot become erect due to lack of the necessary infrastructure.
Bulbourethral glands (Cowper's glands) open into the bulb of corpus spongiosum just below the urogenital diaphragm. Cowper's glands secrete mucus material during intercourse that helps lubricate the penis.	There are no *bulbourethral glands* (Cowper's glands). There is no corpus spongiosum with its proximal bulb in the neophallus. Therefore there is no secretion that can lubricate the structure.
The *mucosa* of normal penile urethra is *pseudostratified columnar epithelium* except at	The rolled-up skin structure lacks the mucosal characteristics found in natural tissue.

the tip of the penis.	
The *urethral glands of Littre* have their orifices located within the normal male penile urethra. These glands secrete mucus which lubricates the glans penis during sexual intercourse.	There are no urethral glands, and therefore, no corresponding orifices. There is no gland to lubricate the vaginal orifice.
The parasympathetic nerve endings in the penis have a unique ability – unlike anywhere else in the body – to release nitric oxide in abundance over the usual acetylcholine, when stimulated. This sets off a chain of biochemical reactions that cause blood vessels and spaces in the erectile tissues to dilate, allowing them to fill with blood and produce an erection.	This function is not present in the skin and fat flaps used in phalloplasty procedures. Surgeons are consequently unable to recreate the same anatomical and physiological response.
In a normal male penis, the spongy urethra ends in the *navicular fossa* of the *glans penis*. *Navicular fossa* is important for higher flow rate of urine with its wave like shape.	There is no *navicular fossa* within the external hole of the neophallus. Hence the mechanism for natural enhancement of urinary flow is not there.
The vessels and nerves *deep to deep fascia* plunge into the glans penis so there is rich blood and nerve supply. Normal male glans penis is rich in special receptors to generate sexual sensation.	There is limited blood supply to the *glansplasty*. There is poor nerve supply from the *neurorrhaphy* (anastomosis between ilioinguinal nerve, dorsal clitoral nerve, and the nerves of the forearm flap). There are no special receptors for sexual sensation. Hence this structure (result of glansplasty) of the fat and skin mound, is just a shape (if it is shaped well) and nothing more.
There is *bulbospongiosus muscle* surrounding the bulb of urethra which aids in the emptying of the urethra at the end of micturition.	The neophallus lacks *bulbospongiosus muscle*, so manual assistance/milking is required to help empty urine from this surgically created structure.
A normal penis is richly supplied with sympathetic and parasympathetic nerve fibres from the *pelvic autonomic plexus*, which are essential for sexual function. The *glans penis* contains specialized receptors which are responsible for perceiving sexual sensation. The parasympathetics are responsible for erection and the sympathetics are responsible for the emission and ejaculation phase of intercourse.	The neophallus contains only *neurorrhaphied cutaneous nerves*, which are responsible for detecting pain, touch, and proprioception [a sense that lets us perceive the location and movements of our body parts] but lack the ability to perceive sexual sensation. Additionally, there is no autonomic nerve supply (parasympathetics and sympathetics) to the neophallus. There is no framework to perceive sexual sensation or achieve a natural erection.

Complications:

Pain, Infection, Blood clots, Wound dehiscence (breakdown), Post-operative bleeding, Loss of sensation requiring return to the operating theatre, Forearm donor site complications (failure of the skin graft, large permanent scar, chronic pain, loss of feeling, hand weakness, numbness, stiffness and swelling), Loss of sexual function, Dissatisfaction with visual appearance of the penis, size of the penis, function of the penis, scrotum, Inability to orgasm, Urinary tract infections (UTIs), Urinary retention (unable to pass urine), Urinary incontinence (unable to control the need to urinate), Urinary Post-urination dribbling, spraying of the stream, Skin changes from urine moisture to the end of neophallus are common, Necrosis to skin of the penis (tissue dying resulting in blackening of the skin), Loss of neophallus (this can occur in 3% of cases, though this risk can be reduced by avoiding smoking and not being overweight), Wound breakdown (common at base of phallus), Fistula: An unwanted connection between urethra, vaginal space and/or the skin, Urethral strictures: Narrowing of the urethra or complete blockage, making it difficult to urinate, may require catheterisation until corrected, Testicular implant complications: infection, extrusion, poor/uncomfortable positioning, Erectile device complications: infection, skin-erosion, technical failure, poor positioning.

Normal Female Vagina	**Deep Surgical Wound Lined With Skin**
Highly distensible fibromuscular elastic tube.	Non-distensible surgical wound in the perineum (bottom) that tends to contract as healing takes place.
Inner lining is NON-KERATINISED stratified squamous epithelium.	KERATINISED stratified squamous epithelium (SKIN)
Inner lining designed for moist surface.	**Inner lining** designed for dry surface (prone to macerate when exposed to prolonged moisture)
Has a **Lamina Propria** layer below the surface epithelium. This lamina propria layer is highly vascular and filled with elastic fibers. This elasticity provides the vagina with the capacity to distend enormously during intercourse as well during child birth.	**No Lamina Propria** and no elasticity.
Lamina Propria is rich with blood capillaries leading to water exiting these capillaries and keeping the vaginal lining moist naturally.	**No Lamina Propria** layer to provide moisture.
Inner Lining has no glands and has no keratin.	**Inner Lining** has sweat glands, apocrine glands, sebaceous glands, hair follicles and a surface lining of keratinisation. These secretions tend to

	accumulate leading to maceration and infection as there is no natural mechanism to clean the cavity.
Not prone for maceration as the lining is designed to be moist from natural human secretions in vagina and cervix.	Prone for maceration as surface sweat glands, apocrine and sebaceous glands pour out their secretions as well as the transudates that arise from wound. These collections can lead to local abscess formations and sepsis deep inside wound along with bad odour on the person.
Lining cells are loaded with **glycogen** which provide the much-needed glycogen inside vaginal lumen.	There is **no glycogen** in the wound as there is no lining that can provide glycogen.
Lactobacillus which is a commensal bacterium in vagina ferments glycogen to lactic acid and maintains acidic pH around 3.5. This pH prevents growth of pathogenic bacteria and fungus in a normal female vagina.	There is no such mechanism available in the wound leading to growth of harmful bacteria and fungus deep inside the cavity. This can lead to sepsis and premature death.
Normal vagina has a vaginal part of **Cervix** protruding it from its vault. This cervix pours out copious secretions from cervical glands and mucosal cells to cleanse the vagina as well as to provide sufficient lubrication for penis during penetration.	There is **no Cervix** to provide cervical mucus secretions for lubrication and maintenance of physiology.
Normal vagina has a circular and longitudinal **muscular layer** with contractility as a normal physiological function. This provides for the sensations during intercourse as well during child birth.	There is **no muscular layer**.
Normal vagina has an **adventitial layer** around the muscle layer. This layer has dense connective tissue with extensive vascular supply and elastic tissue.	**No adventitial layer** – this is a deep surgical wound lined by skin with no surrounding layers.
Normal female vagina has **bulbs of vestibule** on each side of vaginal orifice. These are oval masses of erectile tissue on each side of the vaginal orifice.	Such **bulbs of vestibule are non-existent**.
Two **Bartholin's glands** (greater vestibular glands) are present at the vaginal introitus which secretes copious secretions that help in entry of penis at	There are **no Bartholin's glands**.

the start of intercourse.	
Bulbospongiosus muscle surrounds the vaginal opening that helps it keeps closed as well as assisting in erection of clitoris during sexual activity.	There is **no bulbospongiosus muscle**.
Normal female vagina is richly supplied with nerves from the **vaginal plexus of nerves**. These plexuses are rich in autonomic nerves which supply vaginal walls and contribute to the tumescence of the vaginal vestibule and clitoris during sexual excitation. These vaginal plexus are supplied by both sympathetics and parasympathetics.	**No vaginal plexus of nerves** as this is a man-made surgical wound lined by a flap of skin.
Complications "*Post-op infections and sepsis, necrotising fasciitis, pulmonary embolism, inadvertent bowel and bladder injury, urinary strictures, neovaginal stricture requiring often painful dilatations (life-long), numbness in perineum, fungal and pyogenic infections in neovagina, failure of reproduction/sterility, unpredictable effects on the prostatic tissue, urethral and recto-neovaginal fistulae (this complication can leave the individual with uncontrolled leakage of faeces and/or urine between the legs all the time which can lead to untimely death due to gram negative endotoxic shock).*" "*Pain, blood clots, infection, sutures rupturing, urinary tract infections (UTIs), urinary retention (unable to pass urine), scarring, loss of sensation, loss of sexual function, dissatisfaction with visual appearance of the vagina, clitoris and/or labia, inability to orgasm, urinary incontinence (unable to control the need to urinate), necrosis to skin or clitoris (tissue dying resulting in blackening of the skin or Clitoris), vaginal prolapse, fistula: (an unwanted connection between the vagina and urethra or bowel), urethral stenosis: (narrowing of the urethra, making it difficult to urinate).*"	