AUDIT FINDINGS

Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC-8)

Coleman et al., World Professional Association for Transgender Health (WPATH), published 6 September 2022 in the International Journal of Transgender Health, Vol 23, Suppl 1

Five structural findings against Australian regulatory frameworks

Revision 2 — 13 July 2026 — supersedes Revision 1 of 29 June 2026

1. Auditing Organisation

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Relationship	Organisation conducting structured audit of clinical guidelines, including international guidelines referenced by Australian private gender clinics, against Australian regulatory frameworks

2. Document Under Audit

Title	Standards of Care for the Health of Transgender and Gender Diverse People, Version 8
Short reference	WPATH SOC-8
Publication date	6 September 2022
Citation	Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health. 2022;23(Suppl 1):S1–S259.
Publishing body	World Professional Association for Transgender Health (WPATH)
Evidence review team	SOC-8 describes the engagement of an Evidence Review Team at the Johns Hopkins University Evidence-Based Practice Center (EPC). AWW adopts SOC-8's own description and does not independently characterise that team as independent; the independence of the arrangement is contested in proceedings identified at Annex A.
Length	259 supplement pages (S1–S259); 18 chapters; 5 appendices
Stated scope	International clinical guidance for the health care of transgender and gender diverse people, including children, adolescents, and adults; hormonal, surgical, and other interventions; primary, mental health, reproductive, and sexual health

Australian regulatory standing	Not directly subject to Australian Consumer Law, the Health Practitioner Regulation National Law, or AHPRA. Engaged operationally where Australian clinics or registered practitioners represent practice as "WPATH-aligned," "evidence-based per international standards," or analogous. See Audit Methodology and Operational Implication sections below.
Audit date (Rev 2)	13 July 2026

3. Audit Methodology

This audit applies documentary analysis only. Each finding is verifiable from the document under audit by reading the page reference cited. No contested empirical or clinical claim about gender-affirming care is required for any finding to be sustained.

WPATH SOC-8 is an international clinical guideline. It is not advertising in Australia and is not directly subject to Australian regulatory frameworks. This audit applies the Australian regulatory frameworks through the operational adoption bridge: where an Australian clinic represents its practice as "WPATH-aligned," "evidence-based per international standards," or uses SOC-8 as the documented basis for its clinical model, the underlying SOC-8 representations about evidence quality, alternatives, consent processes, medical necessity, and material risk disclosure become material to the clinic's representations under Australian law. The audit therefore tests SOC-8 so that any Australian clinic relying on it can be assessed against the downstream regulatory consequences.

The Australian regulatory frameworks against which the document is tested include:

- Australian Commission on Safety and Quality in Health Care (ACSQHC) informed consent framework, comprising the clinician fact sheet "Informed consent in health care" (September 2020) and the practical guidance documents "Informed consent: practical guidance for clinicians," "for patients," and "for substitute decision-makers" (May 2026)
- Rogers v Whitaker (1992) 175 CLR 479 — material risk disclosure standard
- AHPRA Good Medical Practice: A Code of Conduct for Doctors in Australia (October 2020)
- Australian Consumer Law s.18 (misleading or deceptive conduct in trade or commerce) and s.29(1)(a) and (g) (false or misleading representations as to standard, quality, or performance characteristics of services)
- National Health and Medical Research Council Standards for Clinical Practice Guidelines (Standards 1, 4, 5, 6, 9)

These frameworks apply to Australian clinical practice regardless of whether the document under audit cites them. The audit asks whether the document, when operationally adopted by an Australian clinic, supports practice that satisfies, engages with, or specifies processes adequate to satisfy the requirements of those frameworks. Where it does not, the finding rests on the document's own text and the framework's settled requirements, both checkable independently.

3.1 Evidentiary discipline applied in this revision

This revision incorporates page-level material identified during AWW's review of the complaint in Federal Trade Commission, Alaska, Iowa, Nebraska and Texas v. World Professional Association for Transgender Health, Inc., Case 4:26-cv-00748-P (N.D. Tex., filed 17 June 2026). AWW applies the following discipline to that source, without exception:

- Pin-citations in the pleading are treated as pointers to the primary document, not as evidence. Every SOC-8 page reference relied on in this audit has been independently opened and read in the SOC-8 text.
- Characterisations in the pleading are treated as advocacy and are given no evidentiary weight. Two such characterisations were tested and are not sustainable on the SOC-8 text; both are recorded at Annex A and neither is relied on in this audit.
- Allegations resting on internal correspondence, depositions, or other discovery material — including allegations concerning the removal of age minimums, the Delphi process, the conduct of the evidence review, and the omission of evidence gradings — are not imported into any finding. They are recorded at Annex A as matters to revisit if and when the litigation record is established.

No finding in this audit depends on the FTC pleading, on any allegation contained in it, or on the outcome of those proceedings. Each finding is sustainable on the SOC-8 text and the relevant Australian framework text alone.

Five findings are presented. Each is independently sufficient. Each finding stands on its own.

Finding 1 — Citation-versus-operationalisation drift on the meaning of “evidence-based”; internal contradiction between the document’s recommendation key and its own evidence admissions

Statement

WPATH SOC-8 invokes the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) methodology. It then defines, in its own methodology section, the inputs to its “evidence-based” recommendation statements to include consensus-based expert opinion, feasibility, acceptability, and the values and preferences of providers and patients, alongside or in place of graded evidence. The document discloses that independent systematic reviews informed only some of its recommendation statements.

SOC-8 further supplies a recommendation key under which a strong recommendation (“we recommend”) signifies to the reader that the evidence is of high quality and that there are few downsides. SOC-8 issues strong recommendations for interventions in minors. In the same document, the Adolescent chapter states that a systematic review of treatment outcomes in adolescents is not possible because the evidence base is too limited.

The document therefore asserts, through its own definitional key, an evidence quality that the same document separately concedes does not exist. The contradiction is internal, documentary, and requires no external source and no contested clinical claim to establish.

Separately, SOC-8 does not publish the certainty gradings produced by its own evidence assessment. The reader is presented with recommendation strengths but not with the evidence-quality ratings on which the key says those strengths depend, and therefore cannot check the certainty rating behind any recommendation.

Evidence

On the elasticity of the “evidence-based” label (Methodology Appendix, Appendix A, S247–S251):

> *“Independent systematic reviews were used to inform some of the statements for recommendations”* **(S247)**
>
> *“Evidence-based recommendation statements were based on the results of the systematic, and background literature reviews plus consensus-based expert opinions”* **(S250)**

> *"Once the statements passed the Delphi process, chapter members graded each statement using a process adapted from the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) framework. … The statements were graded based on factors such as: the balance of potential benefits and harms; confidence in that balance or quality of evidence; values and preferences of providers and patients; resource use and feasibility"* **(S251)**
>
> *"This evidence is not only based on the published literature … but also on consensus-based expert opinion"* **(S8)**
>
> *"All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility"* **(S33, Chapter 5, Assessment of Adults)**

On the recommendation key — what a strong recommendation signifies to the reader:

SOC-8 distinguishes strong recommendations ("we recommend") from weak recommendations ("we suggest"). The key states that a strong recommendation indicates that the evidence is of high quality, that there is a high degree of certainty the effects will be achieved in practice, that there are few downsides to the intervention, and that there is a high degree of acceptance among providers and patients (S111, S129, S250). Weak recommendations are distinguished on the opposite basis:

> *"Weak recommendations ('we suggest') are for those interventions/therapy/strategies where there are weaknesses in the evidence base; there is a degree of doubt about the size of the effect that can be expected in practice …"* **(S251)**

SOC-8 issues strong recommendations in relation to interventions for minors, including puberty suppression, gender-affirming hormones, and surgical interventions (S111, S129).

On the document's own concession as to the state of the adolescent evidence base:

> *"Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible"* **(S46)**

The two propositions cannot both be true of the same interventions. A body of evidence too limited to support a systematic review is not a body of evidence of high quality within the meaning of the document's own key. The contradiction is established by reading S111 or S129 against S46.

Taken together, the document's own text establishes four documentary facts:

- Independent systematic reviews informed "some" of the recommendation statements, not all (S247).
- Recommendation statements are not based on graded evidence alone; they are based on graded evidence plus consensus-based expert opinion, feasibility, acceptability, values, and resource use (S250, S251, S33).
- The document's recommendation key represents to the reader that a strong recommendation signifies high-quality evidence and few downsides (S111, S129, S250), while the Adolescent chapter concedes that the adolescent outcome evidence base cannot support a systematic review (S46).
- The certainty gradings underlying individual recommendations are not published in SOC-8. The reader is given the recommendation strength but not the evidence rating on which the key says that strength depends.

Australian framework engaged

NHMRC Standards for Clinical Practice Guidelines. Standard 6 requires the systematic identification and grading of the body of evidence underlying recommendations, and requires that grading to be reported. A guideline that issues recommendations whose evidence base includes feasibility, acceptability, and stakeholder consensus as equivalent inputs to graded evidence, and which does not publish the certainty gradings it produced, is not GRADE-evidence-based in the sense the NHMRC standard contemplates.

Australian Consumer Law s.18 — misleading or deceptive conduct. Where an Australian clinic represents care as "evidence-based per WPATH SOC-8" in trade or commerce, that representation creates an overall impression that the care rests on independent, high-quality evidence. The SOC-8 document's own methodology section establishes that the "evidence-based" label includes, by the document's own admission, consensus, feasibility, and acceptability as inputs; and the document's own recommendation key asserts an evidence quality that its own Adolescent chapter denies. The clinic's representation may be liable to mislead consumers who do not have access to, or do not read, the SOC-8 methodology section.

Australian Consumer Law s.29(1)(a). A representation that gender-affirming care is "evidence-based" in the ordinary-consumer sense, when the underlying document treats consensus and acceptability as evidence inputs and asserts high-quality evidence for interventions whose evidence base it separately describes as unable to support a systematic review, may be a false or misleading representation as to the standard or quality of those services.

AHPRA Good Medical Practice s3.2.6 (best available information) and s3.2.7 (reasonable expectation of efficacy). Where a registered practitioner adopts SOC-8 as the basis for clinical practice without disclosing the document's own admissions regarding the elasticity of its "evidence-based" label and the internal contradiction in its recommendation key, downstream Code obligations are engaged.

Operational implication

This finding bears on Australian clinics and registered practitioners that represent their practice as WPATH SOC-8 aligned. Where the representation imports the document's "evidence-based" label without disclosing the document's own methodology admissions, an Australian regulator may form the view that the overall impression created by the representation is misleading under ACL s.18 and that the representation as to standard or quality of services is false or misleading under s.29(1)(a). The exposure exists independently of the clinician's clinical judgment. It is sharpened by the existence of independent systematic reviews (NICE 2021; Cass 2024; University of York 2024; United States Department of Health and Human Services 2025; New Zealand Ministry of Health 2024; Ruuska et al. 2026) that grade the certainty of evidence for the relevant interventions as low or very-low using formal certainty-assessment methodology.

The finding also supports a substantiation notice. Where a clinic represents SOC-8-aligned care as evidence-based, the ACCC may require the clinic to substantiate that representation. On SOC-8's own text, the clinic cannot point to a published certainty grading for the recommendation it is relying on, because the document does not publish one.

Independent sufficiency

This finding stands on the SOC-8 document's own text (S8, S33, S46, S111, S129, S247–S251). It requires no acceptance of any contested clinical claim, no reliance on any other finding in this audit, and no reliance on any allegation made in any proceeding.

Finding 2 — Alternatives foreclosed by definitional operation; ACSQHC capacity principle 5 structurally unmeetable

Statement

The ACSQHC six-element legal capacity test requires (principle 5) that the person be able to weigh up the consequences of the available choices, including the choice to refuse treatment. The ACSQHC May 2026 practical guidance enumerates the alternatives an informed consent discussion must include: doing nothing; watching and waiting; and/or lifestyle interventions.

WPATH SOC-8 does not present exploratory psychotherapy, watchful waiting, or no treatment as legitimate clinical alternatives that the patient must be supported to weigh. Its structure positions assessment as the gateway to gender-affirming medical and surgical pathways, and mental health support as facilitative or adjunctive rather than as an alternative pathway whose outcomes are worth comparing to medical transition.

Further, SOC-8 issues a recommendation against reparative and conversion therapy defined by reference to its aim — an attempt to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth (Statement 6.5, S53). The document supplies no operational criterion by which a clinician could distinguish legitimate exploratory psychotherapy from therapy falling within that prohibition. The scope of Statement 6.5 therefore turns entirely on what "a person's gender" is taken to be. Where gender is treated as a fixed attribute the child already possesses — as the document's structure assumes — any approach that does not proceed from the child's stated identity is, by definitional operation, an attempt to change it, and falls within the prohibition.

Because SOC-8 does not present the ACSQHC alternatives in operational form, and because the one alternative most likely to be raised is captured by a prohibition with no stated boundary, an Australian clinician relying on SOC-8 as the operational basis of clinical practice cannot, as a matter of structure, satisfy ACSQHC principle 5. The structural gap is independent of clinician intent or implementation.

Evidence

The prohibition and its undefined boundary.

SOC-8 Statement 6.5 provides:

> *"We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth."* **(Statement 6.5, S53)**

The prohibition is defined by aim, not by method. It captures any therapy whose aim is to render a person's gender and lived gender expression more congruent with sex assigned at birth. SOC-8 does not define, in this statement or elsewhere in operational form, a threshold that separates exploratory psychotherapy — in which the origins of a young person's distress are examined without a predetermined destination — from therapy falling within the prohibition. In the absence of such a criterion, a clinician cannot determine ex ante whether an exploratory approach is permitted or prohibited.

AWW records as an inference, and not as a statement made by SOC-8: the absence of a distinguishing criterion is not an oversight but a consequence of the document's premises. Where gender identity is treated as an immutable attribute already held by the child, there is no conceptual space in which a non-affirmative approach could be anything other than an attempt to change it. This inference is stated as an inference and is not necessary to the finding; the finding is sustained by the absence of the criterion, which is documentary.

The assessment and treatment chapters.

Chapter 5 (Assessment of Adults) issues seven recommendation statements (5.1–5.7). None requires the clinician to present, document, or support the patient to weigh exploratory psychotherapy, watchful waiting, or no treatment as alternatives. Statement 5.5 establishes a single-opinion threshold for initiation of medical and surgical treatment:

> *"We recommend transgender and gender diverse adults who fulfil the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment"* **(S32)**

The document does not specify a parallel pathway in which an alternative non-medical response is supported, evaluated, and weighed alongside the medical pathway.

Chapter 18 (Mental Health, S171–S176) frames the mental health professional's role within the gender-affirming pathway, not as the practitioner of an alternative pathway whose outcomes should be weighed against medical transition.

Chapter 6 (Adolescents) directs assessment toward eligibility for medical interventions. The chapter acknowledges potential shifts in identity during adolescence:

> *"Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries"* **(S46–S47)**

The acknowledgement is operationalised as a temporal threshold to medical initiation, not as a clinical case for an alternative non-medical pathway whose outcomes are comparatively evaluated.

Disconfirming evidence excluded by instruction.

SOC-8 addresses those who seek to halt or reverse a transition, and instructs the reader as to what weight that evidence class may be given:

> *"While the choice to detransition is proportionally rare, it is expected an overall increase in the number of adults who identify as TGD would result in an increase in the absolute number of people seeking to halt or reverse a transition. However, while the absolute numbers may increase, the percentage of people seeking to halt or reverse permanent physical changes should remain static and low. The existence of these rare requests must not be used as a justification to interrupt critical, medically necessary care, including hormone and surgical treatments, for the vast majority of TGD adults."* **(SOC-8)**

Three documentary observations follow, none of which requires any view on the prevalence of detransition.

- The reasoning turns on a prediction — that the percentage should remain static and low — which is stated as an expectation and is not the observation on which the passage opens.
- The operative conclusion is not a clinical recommendation. It is an instruction as to what a class of evidence may be permitted to bear upon. The document forecloses the use of its principal disconfirming evidence class by instruction.
- The passage is expressed in the document's own imperative voice ("must not be used"). This is to be contrasted with the attributive constructions in which the document's efficacy claims are conveyed — see Finding 5.

Scope limitation: this passage is directed to TGD adults. It is not adolescent guidance and is not relied on here as adolescent guidance. It is relied on as evidence of the document's treatment of disconfirming evidence, which bears on whether the document supports a consent process in which alternatives and outcomes can be weighed.

The ACSQHC requirement.

The ACSQHC clinician fact sheet "Informed consent in health care" (September 2020) specifies, under "Principles for assessing legal capacity," six principles a person must satisfy for legal capacity to make a particular decision. The fifth requires the person to:

> *"weigh up the consequences of those choices, including the choice to refuse treatment."* **(ACSQHC, September 2020)**

The ACSQHC May 2026 practical guidance for clinicians enumerates the alternatives the informed consent process must include:

> *"the expected outcomes, benefits, risks and alternative options, relevant to that person, including: doing nothing; watching and waiting; and/or lifestyle interventions."* **(ACSQHC, May 2026 — Informed consent: practical guidance for clinicians)**

Weighing the choice to refuse treatment presupposes that an alternative to the proposed treatment is available and has been presented in operational form. SOC-8 does not present those alternatives in operational form; and the alternative most likely to be raised is captured by a prohibition whose boundary the document does not define. The fifth ACSQHC capacity principle is therefore structurally unmeetable under an Australian clinical practice relying on SOC-8 as the operational guide — not occasionally unmet through implementation failure, but unmeetable in principle, because the antecedent condition (presented alternatives to weigh) does not exist within the document.

Australian framework engaged

ACSQHC informed consent framework. The validity test for informed consent requires the person to give consent voluntarily, with adequate knowledge and understanding of alternative options. The capacity test requires the person to be able to weigh the choice to refuse treatment. Both tests presuppose the operational presentation of alternatives.

Rogers v Whitaker (1992) 175 CLR 479. A material risk includes that to which a reasonable person in the position of the patient would attach significance. A reasonable person considering gender-affirming hormonal or surgical intervention would attach significance to the availability of alternatives, including non-medical pathways. The non-disclosure of those alternatives engages the duty of care obligation.

ACL s.18. Where an Australian clinic represents that its model provides informed consent in the sense the ACSQHC defines, but the operational basis of its informed consent process does not present the alternatives the ACSQHC enumerates, the representation may be misleading by omission.

Operational implication

Australian clinics or registered practitioners that operationalise SOC-8 as the basis of their informed consent process cannot, as a matter of structure, satisfy ACSQHC principle 5 of the capacity test. This is not a clinician-implementation issue: the document on which the practice is built does not contain the inputs (operationalised alternatives) required for the patient to weigh refusal in the ACSQHC sense, and it prohibits, on an undefined boundary, the alternative the ACSQHC guidance most directly contemplates. Any prescription of gender-affirming hormonal or surgical intervention undertaken in accordance with SOC-8 alone is exposed to the argument that the fifth ACSQHC capacity principle could not have been satisfied on the available material. This exposure is sharpened by the May 2026 ACSQHC practical guidance, which now explicitly enumerates the alternatives that informed consent discussions must include.

Independent sufficiency

This finding stands on the SOC-8 document's own recommendation statements (S32, S53, S46–S47, S171–S176) and on the ACSQHC informed consent framework. It does not depend on Findings 1, 3, 4 or 5, nor on any contested clinical claim about gender-affirming care, nor on any allegation made in any proceeding. AWW notes for completeness that the characterisation of SOC-8 at paragraph 139 of the FTC pleading — to the effect that the document states such efforts may be viewed as a form of violence — was tested against the SOC-8 text and is not sustainable. It is not relied on. See Annex A.

Finding 3 — Material risk disclosure: selective specification of consent content

Statement

SOC-8 does not require the findings of independent systematic reviews evaluating the evidence base for the relevant interventions, or its own body-text admissions of evidence limitation, to be disclosed to patients as part of the material risk discussion.

That omission cannot be attributed to the genre of the document. SOC-8 does specify consent content where it chooses to. In relation to the effect of early puberty suppression on genital development in adolescents with functioning testes, SOC-8 expressly directs that the consideration be included in discussions with patients and families. The document therefore demonstrates both the capability and the willingness to mandate consent disclosures. Its silence on the evidence-certainty profile is accordingly not generic; it is selective.

Further, where SOC-8 does mandate that disclosure, it mandates it in a form that presupposes the outcome to which the patient is being asked to consent. The permanent consequence is disclosed as an input to future surgical planning, not as a standalone risk. It is therefore not legible as a risk to a family considering whether to proceed at all.

Where an Australian clinician relies on SOC-8 as the basis for the consent process, direct Rogers v Whitaker exposure follows on both limbs.

Limb (a) — Evidence-certainty findings not required to be disclosed

The Adolescent chapter acknowledges the limited state of the evidence base for treatment outcomes in adolescents (S46, quoted at Finding 1). The Methodology Appendix distinguishes weak recommendations on the basis of evidence-base weakness (S251, quoted at Finding 1). Several SOC-8 recommendation statements relevant to adolescents are framed as weak ("we suggest") rather than strong.

The document does not, in any chapter, require that the evidence-certainty rating or the body-text admissions of evidence limitation be disclosed to the patient as part of the material risk discussion. The Adolescent chapter contains a section on consent (Section 6.12) that does not require disclosure to the patient of the document's own acknowledgement that a systematic review of treatment outcomes in adolescents is not possible (S46). Chapter 5 does not specify that the recommendation's own basis in values, preferences, resource use and feasibility (S33) must be disclosed.

Independent systematic reviews evaluating the evidence base for the relevant interventions, all using formal GRADE or analogous certainty-assessment methodology, were available at the publication date of SOC-8 or in the years following:

- National Institute for Health and Care Excellence (NICE). Evidence reviews E1 (puberty-suppressing hormones) and E2 (gender-affirming hormones) for children and adolescents with gender dysphoria. March 2021. — Available at publication of SOC-8. Evidence certainty rated very low.

- Cass H. Independent review of gender identity services for children and young people: Final report. NHS England, April 2024. — Evidence base described as weak; recommends caution.
- University of York systematic reviews accompanying the Cass Review. 2024, Archives of Disease in Childhood. — Low to very-low certainty across outcome domains.
- United States Department of Health and Human Services. Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices. 2025. — Insufficient certainty to support the paediatric medical transition pathway. [Publication date to be confirmed against the title page: AWW records May 2025; the FTC pleading at ¶25 states November 2025. See Annex A.]
- New Zealand Ministry of Health. Evidence brief on the use of puberty blockers for gender-affirming care. 2024. — Low-certainty evidence.
- Ruuska SM, Tuisku K, Holttinen T, Kaltiala R. Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services. Acta Paediatrica, 2026. — Finnish longitudinal register study; psychiatric morbidity persists post-transition.

SOC-8 does not require any of these findings to be disclosed to patients as part of the material risk discussion. SOC-8 does not require its own body-text admissions of evidence limitation to be disclosed in the consent process.

Limb (b) — SOC-8 mandates consent disclosure elsewhere, and does so in a form that presupposes the pathway

In the reproductive health chapter, SOC-8 addresses the effect of early puberty suppression in adolescents with functioning testes:

> *"Treating an TGD adolescent with functioning testes in the early stages of puberty with a GnRHa not only pauses maturation of germ cells but will also maintains the penis in a prepubertal size. This will likely impact surgical considerations if that person eventually undergoes a penile-inversion vaginoplasty as there will be less penile tissue to work with. In these cases, there is an increased likelihood a vaginoplasty will require a more complex surgical procedure, e.g., intestinal vaginoplasty … Such considerations should be included in any discussions with patients and families considering use of pubertal blockers in early pubertal adolescents with functioning testes."* **(S119; grammatical irregularity as printed)**

Four documentary observations follow.

- SOC-8 establishes, in its own text, that early puberty suppression in an adolescent with functioning testes arrests genital development. This is a permanent developmental consequence: the passage does not describe it as resuming on cessation, and describes its downstream effects as persisting into adult surgical planning.
- SOC-8 issues a consent-disclosure instruction in respect of it. The considerations are to be included in discussions with patients and families. This defeats the objection that a clinical guideline does not, as a genre, specify consent content. SOC-8 does specify consent content. Its failure to require disclosure of the evidence-certainty profile is therefore a selection, not a genre constraint.
- The mandated disclosure is framed entirely from within the medical pathway. What must be disclosed is that there will be less penile tissue, that surgical considerations are affected, and that a more complex procedure such as intestinal vaginoplasty is more likely. Every element of the required disclosure presupposes that the adolescent proceeds to vaginoplasty.
- The same physical fact, expressed from outside the pathway — that an adolescent who discontinues will not resume the arrested development, and will not have the surgical pathway within which the disclosed consideration has any meaning — is not disclosed. AWW's word searches of SOC-8 on "desist," "desistance," and "detransition" locate no passage addressing

the position of the male adolescent who discontinues puberty suppression and does not proceed.

Under Rogers v Whitaker, the material risk is that to which a reasonable person in the patient's position would attach significance. A parent deciding whether to commence puberty suppression in an early-pubertal son would attach significance to the second formulation and not, in any meaningful sense, to the first. The first is a technical planning note for a future surgeon. SOC-8 requires the first and does not require the second.

The consequence is precise. SOC-8 does not merely omit a material risk. It mandates a consent disclosure about that very risk, constructed so that the risk is legible only from inside the pathway the family has not yet agreed to enter.

Australian framework engaged

Rogers v Whitaker (1992) 175 CLR 479. The material risk standard requires disclosure of risks that a reasonable person in the patient's position would attach significance to. Both the evidence-certainty profile of the proposed intervention and the permanent arrest of genital development in the event of discontinuation are risks of this kind.

ACSQHC informed consent framework. "Adequate knowledge and understanding of the benefits and material risks of the proposed intervention" requires disclosure of the evidence-certainty profile where it is materially adverse, and disclosure of permanent physical consequences in a form intelligible to a person who has not yet decided to proceed. The ACSQHC clinician fact sheet defines material risks via Rogers v Whitaker at footnote 1.

ACL s.18 (misleading conduct by omission of material information). Where an Australian clinic represents care as WPATH-aligned and as compliant with ACSQHC informed consent, but the underlying document does not require disclosure of the evidence-certainty findings and requires disclosure of a permanent consequence only in a pathway-presupposing form, the representation may mislead by omission of material information.

AHPRA Good Medical Practice s3.2.7 and s3.5. Practitioners are obliged to base recommendations on the best available information and to obtain valid informed consent. Reliance on SOC-8 as the consent framework without supplementary disclosure may not satisfy these obligations.

Operational implication

Australian clinicians who rely on SOC-8 as the consent framework without supplementing it are exposed to material risk disclosure findings under Rogers v Whitaker on both limbs. The exposure is not remedied by reference to SOC-8's body-text admissions of evidence limitation, because those admissions are not required by the document to be transmitted to the patient.

Limb (b) generates a specific and immediately testable audit question for the clinic series, and one grounded in the clinic's own adopted guideline rather than in any standard imposed by AWW:

Does the clinic's puberty-suppression consent material disclose arrested genital development as a standalone risk to a family who may not proceed — or does it disclose it, if at all, only as a surgical-planning consideration for a family who will? A clinic representing WPATH-aligned care that does neither is failing a disclosure requirement stated in the very document it invokes.

Independent sufficiency

This finding stands on the SOC-8 document's own text (S33, S46, S119, S251, Section 6.12) and on the settled ACSQHC and Rogers v Whitaker material risk standards. It does not depend on Findings 1, 2, 4 or 5, nor on any contested clinical claim, nor on any allegation made in any proceeding.

Finding 4 — Medical necessity as a representation directed at payers, including government-subsidised systems

Statement

SOC-8 contains a medical necessity statement spanning several pages. It adopts the American Medical Association's definition of medical necessity and applies that label to a broad schedule of gender-affirming interventions. It states that medical necessity is central to payment, subsidy and reimbursement, and it exhorts governments to ensure that coverage is established, extended or enhanced within universal health care, public health, government-subsidised, and government-regulated private systems.

The medical necessity designation is therefore not, on the document's own account, a purely clinical characterisation. It is a representation with a stated payer-facing function, expressly directed at systems of the kind Australia operates. Where an Australian clinic adopts SOC-8 and represents interventions as medically necessary, the representation carries that function with it.

Evidence

The medical necessity statement appears at S16–S18. On AWW's reading of that passage, SOC-8:

- recommends that health care systems should provide medically necessary gender-affirming health care;
- quotes the American Medical Association definition of medical necessity and applies that label to a schedule of gender-affirming interventions;
- urges health care systems to eliminate exclusions from policy documents and medical guidelines that preclude coverage;
- states that medical necessity is central to payment, subsidy and/or reimbursement; and
- exhorts governments to ensure that coverage is established, extended or enhanced as elements in any universal health care, public health, government-subsidised, or government-regulated private systems that may exist.

The final element is the material one for Australian purposes. It is an express address, in the document's own text, to government-subsidised and government-regulated private health systems. Australia operates both.

The medical necessity designation is applied to the great majority of the interventions SOC-8 addresses, including interventions for minors. Where the designation attaches to an intervention for which the document's own Adolescent chapter concedes that a systematic review of outcomes is not possible (S46, Finding 1), the designation is not supported by an evidence base of the kind an ordinary consumer, or a payer, would understand "medically necessary" to import.

Australian framework engaged

ACL s.18 and s.29(1)(a). A representation to a consumer that an intervention is "medically necessary" conveys that the intervention is required to diagnose or treat a condition and meets accepted standards of medicine. Where the underlying designation derives from a document that applies the label across a broad schedule of interventions, states the designation's function to be securing payment and reimbursement, and concedes elsewhere that the outcome evidence base for the relevant interventions cannot support a systematic review, the representation may create a misleading overall impression as to the standard or quality of the service.

AHPRA Good Medical Practice s3.2.7 (reasonable expectation of efficacy) and s10.7 (professional obligations in relation to billing and financial arrangements). A practitioner who characterises an intervention as medically necessary on the basis of SOC-8 imports the document's designation and its stated payer-facing function.

Substantiation. The medical necessity representation is a discrete, substantiable claim. Where a clinic represents an intervention as medically necessary, the ACCC may require substantiation of that claim. On SOC-8's own text, the substantiation available is a schedule of designations whose stated purpose includes securing reimbursement.

Operational implication

Finding 4 opens a regulatory surface that Findings 1 to 3 do not reach. Where an Australian clinic's representation of medical necessity is operative in claiming under the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme, or private health insurance, the accuracy of that representation engages payer-facing frameworks in addition to the ACL.

Scope limitation and evidentiary note: this finding establishes what SOC-8 says, and what SOC-8 says the medical necessity designation is for. It does not establish that any particular Australian clinic has claimed under any particular payer arrangement on the basis of that designation. That is a separate factual question requiring separate evidence, and is not addressed here. AWW notes that its parallel genealogical work on AusPATH (finding G5) concerns clinical templates and authority forms distributed within an Australian guideline document, and that the relationship between the two lines of inquiry warrants legal review before either is advanced publicly.

Independent sufficiency

This finding stands on the SOC-8 document's own text (S16–S18, read with S46). It does not depend on any other finding in this audit, nor on any contested clinical claim, nor on any allegation made in any proceeding.

Finding 5 — Attributive construction of efficacy representations; overall-impression exposure under ACL s.18

Statement

SOC-8's principal efficacy and safety propositions are conveyed in attributive, passive, or historical constructions rather than as assertions made in the document's own voice. Hormone therapy "is considered" a lifesaving intervention. Treatment "has been shown" to improve quality of life. Earlier versions of the Standards of Care "presented" puberty suppression as fully reversible. These constructions transmit a proposition to the reader without the document owning it.

The document's own imperative voice is reserved for foreclosure. Where SOC-8 forecloses an inquiry — that the existence of requests to halt or reverse transition "must not be used" as a justification to interrupt care — it speaks directly and in the first person.

This asymmetry has a precise regulatory consequence, and it is one that favours the Australian instrument over its American counterpart. A pleading framed around discrete representations must locate a sentence in which the representation is made. Attributive construction defeats that. Section 18 of the Australian Consumer Law is not so framed: the test is the overall impression conveyed to the ordinary or reasonable member of the relevant class, and a proposition conveyed by attribution, structure, and implication is caught if the overall impression misleads.

Evidence

The following are documentary observations about the construction of the text, not about the truth or falsity of any underlying clinical proposition.

- S43: the passage describing puberty suppression as fully reversible is reported speech. SOC-8 is describing the categories and eligibility criteria presented in the 6th (Meyer et al., 2005) and 7th (Coleman et al., 2012) versions of the Standards of Care. It is not an assertion made by SOC-8 in its own voice at that page.
- S126: hormone therapy "is considered" a lifesaving intervention. The construction is passive and attributive. The document does not identify by whom it is so considered, and does not assert it.
- S174: treatment "has been shown" to improve quality of life and decrease depression and anxiety; and is "associated with" a substantial reduction in the risk of suicide attempt. Association, in an attributive construction, is not causation, and is not asserted as such.
- S128: the evidence "demonstrates" top surgery to be a safe and effective intervention, with a "consistent and direct increase" in health-related quality of life. The subject of the sentence is the evidence, not the document.
- By contrast: "The existence of these rare requests must not be used as a justification to interrupt critical, medically necessary care…" The construction is imperative and owned.

AWW draws no inference as to intent. The observation is that the document's efficacy propositions and its foreclosures are expressed in systematically different grammatical registers, and that this is verifiable sentence by sentence.

Australian framework engaged

ACL s.18 — overall impression. The question is not whether SOC-8 asserts, in terms, that puberty suppression is fully reversible or that medical transition prevents suicide. The question is what overall impression is conveyed to a parent by a clinic that represents its care as WPATH-aligned and whose consent process is built on a document in which those propositions are transmitted by attribution. Where the overall impression is that the interventions are lifesaving, reversible, and of demonstrated efficacy, the representation is caught by s.18 whether or not any single sentence in SOC-8 asserts it.

ACL s.29(1)(g). A representation that services have performance characteristics or benefits they do not have is actionable. The characteristic — reversibility, life-saving efficacy — is conveyed to the consumer by the clinic; SOC-8 is the instrument by which the clinic acquires it.

Operational implication and audit discipline

Finding 5 governs how Findings 1 to 4 must be expressed. AWW does not state, and no AWW material should state, that SOC-8 claims puberty suppression is fully reversible, or that SOC-8 claims medical transition prevents suicide. Neither proposition is asserted in the document's own voice, and to state otherwise would be to repeat an error AWW has identified in other parties' work.

The correct and sustainable formulation in every case is: SOC-8 states X; the overall impression conveyed to a parent is Y; the Australian instrument tests Y.

This is not a weakening. It is the difference between a finding that survives contact with the document and one that does not.

Independent sufficiency

This finding stands on the SOC-8 document's own text (S43, S126, S128, S174, and the detransition passage cited at Finding 2) and on the settled ACL overall-impression test. It does not depend on any other finding in this audit.

Summary

Five structural findings are sustained against WPATH SOC-8 on the basis of the document's own text.

First, the document defines its "evidence-based" recommendation statements to include consensus, feasibility, acceptability, and stakeholder values as inputs alongside graded evidence; independent systematic reviews informed only some of the statements; its recommendation key represents to the reader that a strong recommendation signifies high-quality evidence, while its Adolescent chapter concedes that the adolescent outcome evidence base cannot support a systematic review; and it does not publish the certainty gradings on which the key says its recommendation strengths depend.

Second, the document does not present exploratory psychotherapy, watchful waiting, or no treatment as legitimate clinical alternatives that the patient must be supported to weigh; it prohibits therapy aimed at rendering a person's gender more congruent with sex assigned at birth without supplying any criterion by which exploratory psychotherapy could be distinguished from that prohibition; and it instructs that its principal disconfirming evidence class must not be used to interrupt care. ACSQHC capacity principle 5 is structurally unmeetable under a practice relying on SOC-8 alone.

Third, the document acknowledges evidence limitations in its body text but does not require those acknowledgements, or the findings of independent systematic reviews, to be disclosed to patients in consent. That omission is selective, not generic, because the document does mandate consent disclosure elsewhere — and where it does so, in respect of the permanent arrest of genital development, it mandates disclosure in a form legible only from inside the pathway the family has not yet agreed to enter.

Fourth, the document applies a medical necessity designation across a broad schedule of interventions, states that designation's function to include securing payment and reimbursement, and expressly addresses government-subsidised and government-regulated private health systems.

Fifth, the document's efficacy and safety propositions are conveyed in attributive constructions while its foreclosures are expressed in its own imperative voice. Under the ACL overall-impression test this does not save the representation; it determines how the finding must be framed.

Each finding is documentary, sustainable from the SOC-8 text and the relevant Australian framework text, and requires no acceptance of any contested empirical or clinical claim about gender-affirming care. Each finding is independently sufficient.

Operational implications for Australian clinics and registered practitioners

Australian private gender clinics and registered practitioners that represent practice as "WPATH-aligned," "evidence-based per international standards," or analogous, while not disclosing the document's own methodology admissions and the independent evidence-certainty findings, are exposed to:

- Australian Consumer Law s.18 — misleading or deceptive conduct, by importation of the elastic SOC-8 definition of "evidence-based" into clinic-level representations; by omission of material information about evidence-certainty findings; and on the overall impression conveyed by attributively-constructed efficacy propositions.
- Australian Consumer Law s.29(1)(a) and (g) — false or misleading representations as to standard, quality, or performance characteristics of services, including reversibility and medical necessity.

- Rogers v Whitaker material risk disclosure exposure, where the consent process does not include the evidence-certainty profile, alternative non-medical pathways, or the permanent arrest of genital development disclosed as a standalone risk.
- ACSQHC structural-impossibility exposure on the fifth capacity principle.
- AHPRA Good Medical Practice s3.2.6, s3.2.7, s3.2.8, s3.5, s4.5.1–2, s4.6.2–3, s10.7.3 exposure on derivative obligations where the SOC-8 model is adopted without supplementary disclosures.

These exposures are not remedied by reference to the document's international standing or by the existence of an evidence review process at Johns Hopkins University. They arise from the document's own text and from settled Australian law.

Annex A — Relationship to FTC v WPATH (N.D. Tex., 17 June 2026)

On 17 June 2026 the Federal Trade Commission, together with the States of Alaska, Iowa, Nebraska and Texas, filed a complaint against WPATH in the United States District Court for the Northern District of Texas (Case 4:26-cv-00748-P). The complaint pleads three counts under the FTC Act on a means-and-instrumentalities theory, together with four state consumer-protection counts. The matter is pending. Nothing pleaded has been determined.

A.1 Why the pleading is recorded, and how it is used

The pleading is relevant to this audit in two respects, and in no other.

- It supplies page-level pointers into SOC-8. Every such pointer relied on in this audit has been independently opened and read in the SOC-8 text. The pleading is not cited as authority for any proposition about SOC-8's contents.
- It demonstrates that the operational adoption bridge on which this audit's methodology rests is not novel to AWW. A national consumer-protection regulator has pleaded that guideline-level representations propagate into practitioner-level representations to consumers, and has evidenced that transmission with clinic-level website language of precisely the kind AWW captures in its clinic series. This addresses the principal objection to the audit's methodology — that SOC-8 is not advertising in Australia and therefore cannot be tested under consumer law.

The two projects are converse, not overlapping. The FTC proceeds upstream, against the guideline author, under a statutory doctrine that reaches a party who furnishes others the means to deceive. AWW proceeds downstream, auditing the guideline in order to establish exposure for the Australian clinic that adopts it. Whether the Australian Consumer Law reaches an offshore guideline author is an open question which this audit does not raise and does not need to raise.

A.2 Characterisations tested and not sustained

AWW tested the pleading's characterisations of SOC-8 against the SOC-8 text. The following are not sustainable and are not relied on anywhere in this audit. They are recorded because a finding that is only tested for confirmation is not an audit.

Pleading	Characterisation as pleaded	SOC-8 text at cite	Status
¶139	SOC-8 dismisses approaches encouraging a child to become comfortable with their sex traits as reparative and conversion therapy,	Statement 6.5 (S53) recommends against reparative and conversion therapy	**PARTIALLY SUSTAINED. The recommendation is documentary. The**

Pleading	Characterisation as pleaded	SOC-8 text at cite	Status
	provides a strong recommendation against them, and states such efforts may be viewed as a form of violence.	aimed at changing a person's gender and lived gender expression to become more congruent with sex assigned at birth. A word search of SOC-8 locates no use of "violence" applied to a person aligning with their sex traits.	**"violence" characterisation is not sustainable on the SOC-8 text and appears to be the pleader's gloss.**
¶391; ¶¶178–182 (cites S43, S112)	WPATH represents in SOC-8 that puberty blockers are "fully reversible."	S43 is reported speech. SOC-8 is there describing the treatment categories and eligibility criteria presented in the 6th and 7th versions of the Standards of Care. The phrase is not asserted by SOC-8 in its own voice at that page.	**NOT SUSTAINED AT S43. The representation may be conveyed by overall impression — see Finding 5 — but it is not asserted at the pin-cite pleaded.**

A third matter is recorded for accuracy rather than as a failure of characterisation. At ¶25 the pleading dates the HHS report Treatment for Pediatric Gender Dysphoria to November 2025. At footnote 169 the same pleading cites a WPATH/USPATH response to that report dated 2 May 2025. The two cannot both be right unless there are two editions. AWW records May 2025 pending confirmation against the title page of the report.

A.3 Matters not imported into this audit

The following allegations rest on internal correspondence, depositions, and other discovery material. None is on the face of SOC-8. None is imported into any finding in this audit. They are recorded so that they can be revisited if and when the litigation record is established, and for no other purpose.

- That the age minimums in the SOC-8 draft (14 to 17 years for cross-sex hormones, chest, facial and genital surgeries) cleared the Delphi process and were removed at a late stage in response to external pressure, and that the removal did not itself go through Delphi. If established, this would bear directly on SOC-8's statement at S250 that consensus on the final recommendations was attained using the Delphi process, and would convert Finding 1 from a finding about an elastic definition into a finding about a false statement of process. It cannot be relied on now.
- That WPATH secured control over publication of the Johns Hopkins evidence reviews. If established, this bears on the descriptor "independent" in relation to the evidence review team, which this audit has accordingly ceased to adopt.
- That WPATH graded the puberty-suppression evidence as "moderate" in draft and omitted the grade from the published version. The documentary fact that SOC-8 does not publish certainty gradings is relied on at Finding 1. The alleged reason for that omission is not.
- That SOC-8's statement as to the management of conflicts of interest (S8, S177) is false. The representation is documentary and may be recorded as such. Its falsity is not established and is not asserted.

A.4 Coverage comparison

Of the ten core deceptive statements scheduled at ¶378 of the pleading, one (SOC-8 as unbiased, evidence-based expert consensus) corresponds to AWW Finding 1, and one (pediatric medical transition as the "standard of care") is adjacent to it. The three omission counts are adjacent to AWW Finding 3. The remaining representations — concerning suicide prevention, reversibility, mental health improvement, and the safety and efficacy of chest surgery — are not tested in this audit, and are addressed here only to the extent that Finding 5 governs how any such representation must be framed under Australian law.

AWW Finding 2 — the ACSQHC capacity argument — has no counterpart in the pleading. There is no United States analogue to a national statutory capacity framework of the kind the ACSQHC administers; United States consent law is a matter of state-level negligence and malpractice doctrine. Finding 2 is not available to the FTC and does not depend on it.

Audit limitations and originality

This audit applies documentary analysis only. It does not adjudicate any contested clinical or empirical claim about gender-affirming care. It does not assess any individual Australian clinic or practitioner. Findings produced under this audit are documentary findings, not legal advice; legal opinion on the application of the Australian Consumer Law, the National Law, the AHPRA Code of Conduct, or Rogers v Whitaker to any particular Australian clinic remains a matter for qualified Australian legal practitioners. The audit is structured to support, but not to constitute, regulatory complaint material.

Revision 2 narrows the originality claim made at Revision 1. AWW does not claim originality in the proposition that clinical guideline representations are cognisable under consumer protection law. That proposition has been pleaded by a national consumer-protection regulator in FTC v WPATH, filed 17 June 2026, prior to the date of Revision 1.

AWW claims originality, to the best of its knowledge and literature review at the date of this revision, in the following respects, and invites correction of any of them:

- The application of the operational adoption bridge downstream — auditing an international guideline in order to establish exposure for the domestic clinic that adopts it, rather than proceeding against the guideline author.
- The testing of an international clinical guideline against the ACSQHC informed consent and legal capacity framework, and the resulting structural-impossibility finding on capacity principle 5 (Finding 2).
- The selective-disclosure analysis at Finding 3, limb (b), which establishes that SOC-8 mandates consent content where it chooses to, and thereby converts an omission into a selection.
- The construction of a structured audit corpus producing regulator-ready outputs against a defined national framework set.

AWW invites correction of any documentary or framework misstatement in this audit. The audit has been revised once on that basis and will be revised again if error is identified.

— End of findings —

Note on the ACSQHC capacity principles

The ACSQHC September 2020 fact sheet specifies, under the heading “Principles for assessing legal capacity”, that a person has legal capacity to make a particular decision when they are able to do all of the following: (1) understand the facts involved; (2) understand the treatment choices; (3) understand how the consequences of treatment affect them; (4) retain the information and recall the details; (5) weigh up the consequences of those choices, including the choice to refuse treatment; and (6) communicate their decision and understanding of its implications. References in this audit to “principle 5” are to the fifth of these.