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DO NO HARM ACTION
WRITTEN TESTIMONY, PROPONENT – HB 2071 HELP NOT HARM
KANSAS HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
JANUARY 28, 2025

My name is Dr. Ivan Abdouch. I spent 30 years treating and advocating for transgender individuals of all ages and I want to clearly state that medical and surgical sex or gender manipulation (erroneously referred to as “gender affirming”) is never appropriate in children – so I am in support of SB 63 and any laws anywhere that ban this practice.

I received my MD in 1977 and retired in 2019. I became the medical director for the Omaha Gender Identity Team in 1988 and I continued to provide gender management for the next 30 years. Ours was a multidisciplinary group that included highly regarded psychiatrists, psychologists, therapists, social service and various other ancillary supports. We cared for transgender individuals of all ages from several Midwest states – including Kansas – because no one else in the area provided that service at the time.

The purpose of my testimony is not to cite articles and statistics to prove a point. There are already more than enough people from both sides of this debate providing the world with a dizzying array of studies, data, interpretations, nebulous concepts, accusations, name-calling, and outright hostility.

Instead, what I offer is something few others can – first-hand eyewitness observations from someone who spent 30 years providing gender management.

My 30 years in the gender management arena should make it obvious that I do not dispute the existence of transgender individuals and the condition of gender dysphoria, nor am I in any way opposed to appropriate management for those in whom it is who truly warranted. I do, however, dispute the way in which the sex and gender issues have been distorted beyond recognition in all ages, and especially in children.

Has anyone else wondered how is it that other medical conditions don’t ignite the kind of discord and chaos that we see with gender management? Why are there no pro- and anti- groups going at it over the diagnosis and management diabetes, heart disease, cancer, asthma, cataracts or most any other medical diagnosis and treatment?

I believe that flawed terminology, misconstrued concepts and departure from usual medical practices are at the core of this chaos. Sadly, physicians and even medical organizations with no experience in this arena have blindly followed this misdirection, adding false credibility to this movement.

** So what do I mean by flawed terminology? Here are just six (out of many) examples…

Sex: Medically speaking, this is a classification of a person as male or female, according to their reproductive organs and chromosomes (XX for female and XY for male). It is not "assigned" and removal of the reproductive organs does not change the sex.

Gender: Gender refers to a person's representation as male or female. Gender *identity* is how the person sees his or her *own* gender. Gender *role* is how *others* see that person's gender. People (including the person himself/herself) often confuse the two.

Transgender: People whose gender identity does not match up with their sex. It is about their internal gender identity, not their outward appearance. Sadly, the word "trans" is used as some all-inclusive term that involves non-transgender people such as drag queens, cross-dressers, autogynephilia, impostors and other non-transgender situations.

Gender dysphoria: This is specifically severe distress caused by feeling that one's gender identity does not match one's sex. The diagnosis is based on specific criteria. One cannot assume that every unhappy person who raises questions about their gender has gender dysphoria. There are at least a dozen conditions that can be mistakenly diagnosed as gender dysphoria.

There are also many euphemisms (indirect words that are substituted for those considered to be too harsh when referring to something unpleasant or embarrassing). A few examples…

Gender affirming: This is not a medical term and doesn't affirm gender. It is a euphemism that has been forced into the language. Without a clear diagnosis of gender dysphoria, treatment might be entirely incorrect and possibly even worsen an undiagnosed condition.

Top surgery and bottom surgery: These are also not medical terms, designed to avoid saying what is really happening – breast amputation, breast implants, penis amputation, creation of an artificial penis, testicle removal, artificial testicle implants, removal of the uterus and ovaries, permanent infertility, etc.

** And what do I mean by misconstrued concepts? I'll offer just three (out of many) examples...

Sex and gender issues: Transgenderism and gender dysphoria can be temporary, especially in children and adolescents but even in adults. Treatment is not for transgenderism and it is not to change the person's sex – it is intended to ease a person's gender dysphoria. Many who are transgender may never experience gender dysphoria and do not seek treatment. Sex is not changed in those who do undergo treatment.

Standards of Care: Reference is continually made to the "World Professional Association for Transgender Health (WPATH) Standards of Care". First of all, the term "Standards of Care" is a legal term (not a medical term). It refers to the degree of care that a prudent

and reasonable person would exercise under certain circumstances. There is significant disagreement among experts with equivalent knowledge, experience and expertise who are no less “prudent and reasonable” than are members of WPATH. By definition, therefore, any claim to “Standards of Care” by anyone on any side of the debate is arbitrary. The “WPATH Standards of Care” should be viewed only as a single set of “guidelines” proposed by that group for that group, not as a definitive source that is widely accepted by experts. No such definitive source exists.

WPATH history: Based on its history, WPATH is an unreliable source for guidance. In 1979, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) was formed. This was the forerunner of WPATH. From 1979 through 2001, the HBIGDA “Standards of Care” limited hormonal and surgical sex management to majority age or age 18, preferably with parental consent. They also recommended counseling for children and adolescents, and they acknowledged the irreversible effects of hormones. For no clearly justified reason, their 2001 “Standards of Care” began to slip adolescents into the treatment mix and they began to change their stance on hormonal reversibility – but there was no solid evidence to support these changes. After HBIGDA became WPATH in 2007, physicians became outnumbered by non-physicians on the “Standards of Care” committee – non-physicians making medical decisions – and medical/surgical management evolved into what you see today, still with no clear justification.

** Lastly, what about departure from usual medical practices? The so-called “gender-affirming” approach misses the mark at several levels. Here are four (out of many) examples…

Accurate diagnosis: Every medical student is taught that every effort should be made to secure an accurate diagnosis before making a treatment plan. Medical assessments typically incorporate subjective factors (patient history) and objective factors (physician observations and measurable things like test results) to make a diagnosis. While the patient’s account of their symptoms is tremendously valuable in making the diagnosis, patient self-diagnosis has never been considered normal practice. Yet, there are more and more instances reported of “gender-affirming” treatments being employed based on the patient’s self-assessment with no objective evidence. Imagine what would happen if a woman’s breast was removed because she insisted that she felt a lump that she’s sure is cancer and no objective assessment was done to verify that.

Organ or tissue pathology: Other than perhaps some cosmetic procedures, when else in medicine are normal, healthy organs removed from a person?

Benefit vs risk: Every decision in medicine is based on whether the benefits of action outweigh the risks. Everything I’ve discussed up to this point can apply at any age – but the risks of medical and surgical gender management in children and adolescents is especially high because no one – NO ONE – can predict the gender trajectory of a child. Even the flawed WPATH “Standards of Care” acknowledge this. People discuss suicide risk in these kids, but that has not been substantiated. It’s incredibly dangerous to make a life altering decision based on hearsay,

Biases: Much of the support for so-called “gender affirming care” is based on group-think and a number of other biases. I have appended a list of these biases for those who might be interested in knowing more about those.

In the final analysis, it is mandatory that policymakers ask and answer this question …

> *What is an acceptable number or percent of children who experience irreversible harm with lifelong effects because of erroneously receiving medical or surgical management?*

In this case, any answer more than zero means the decision to proceed with medical or surgical treatment is based on something other than safe medical practices.

I submit that the “least unsafe” management is counseling by a competent therapist.

Sometimes caring means saying “no” – or at least “not yet”.

I’m normally not in favor of government regulation in medicine – but when physicians and parents are willing to risk this kind of potential harm to the kids, someone has to step in.

Please don’t let misdirected beliefs supersede safety.

POTENTIAL BIASES AFFECTING MANAGEMENT

Anchoring: the tendency to perceptually lock on to salient features in the patient's initial presentation too early in the diagnostic process, and failure to adjust this initial impression in the light of later information. This bias may be severely compounded by the *confirmation bias*.

Ascertainment bias: when a physician's thinking is shaped by prior expectation.

Availability cascade: when a collective belief becomes more plausible through increased repetition, e.g. 'I've heard this from several sources so it must be true'.

Bandwagon effect: the tendency for people to believe and do certain things because many others are doing so.

Base-rate neglect: the tendency to ignore the true prevalence of a disease, either inflating or reducing its base-rate, and distorting Bayesian reasoning. However, in some cases clinicians may (consciously or otherwise) deliberately inflate the likelihood of disease, such as in the strategy of 'rule out worst case scenario' to avoid missing a rare but significant diagnosis.

Belief bias: the tendency to accept or reject data depending on one's personal belief system, especially when the focus is on the conclusion and not the premises or data.

Blind spot bias: the general belief physicians may have that they are less susceptible to bias than others due, mostly, to the faith they place in their own introspections.

Commission bias: results from the obligation towards beneficence, in that harm to the patient can only be prevented by active intervention.

Confirmation bias: the tendency to look for confirming evidence to support a diagnosis rather than look for disconfirming evidence to refute it, despite the latter often being more persuasive and definitive.

Déformation professionnelle: once a patient is referred to a specific discipline, the bias within that discipline to look at the patient only from the specialist's perspective is referred to as

Diagnosis Momentum: once diagnostic labels are attached to patients they tend to become stickier and stickier. Through intermediaries, (patients, paramedics, nurses, physicians) what might have started as a possibility gathers increasing momentum until it becomes definite and all other possibilities are excluded.

Ego bias: in medicine, is systematically overestimating the prognosis of one's own patients compared with that of a population of similar patients.

Feedback sanction: making a diagnostic error may carry no immediate consequences as considerable time may elapse before the error is discovered (if ever).

Illusory correlation: the tendency to believe that a causal relationship exists between an action and an effect, often because they are simply juxtaposed in time; assuming that certain groups of people and particular traits go together.

Need for closure: the bias towards drawing a conclusion or making a verdict about something when it is still not definite. It often occurs in the context of making a diagnosis where the clinician may feel obliged to make a specific diagnosis under conditions of time or social pressure, or to escape feelings of doubt or uncertainty.

Overconfidence bias: there is a universal tendency to believe we know more than we do. This is a pervasive and powerful bias. Overconfidence reflects a tendency to act on incomplete information, intuitions or hunches. Too much faith is placed in opinion instead of carefully gathered evidence.

Premature closure: a powerful bias accounting for a high proportion of missed diagnoses. It is the tendency to apply premature closure to the decision making process, accepting a diagnosis before it has been fully verified. The consequences of the bias are reflected in the maxim ‘when the diagnosis is made, the thinking stops’.

Sunk costs: the more clinicians invest in a particular diagnosis, the less likely they may be to release it and consider alternatives.

Value bias: physicians may express a stronger likelihood in their decision making for what they hope will happen rather than what they really believe might happen.

Visceral bias: the influence of affective sources of error on decision-making has been widely underestimated. Visceral arousal leads to poor decisions. Countertransference, involving both negative and positive feelings towards patients, may result in diagnoses being missed