Verbal Testimony – Kansas State Legislature

I'm Dr. Ivan Abdouch. I retired after 42 years of medical practice. I've included credentials in my written testimony.

I treated and advocated for transgender individuals for 30 years as medical director for the Omaha Gender Identity Team. We cared for transgender individuals from many Midwest states (including Kansas) because no one else in the area provided that service. It was quite unpopular at that time.

So while I stand in support of this this bill, I am clearly not what some people call "anti-trans" or "transphobic". I come before you today simply to offer my "30-years-in-the-business" perspective.

I believe that people on all sides of this issue want what's best for these kids. The disagreement is over what is "best" for them. Medicate and operate? Or wait until adulthood?

I hear people debating what is and isn't true, proven, moral, evidence-based, safe, reversible, irreversible… on and on. I genuinely respect everyone involved on every side of the issue, so I won't engage in any "us-them" conversations.

My priority is patient safety, and I hope we can all agree that safety must always come first. So in the name of safety, we just need to ask and answer 3 questions …

1) What are the current, generally accepted standards of care?
   Answer: There are none. It's popular to refer to WPATH as evidence-based standards of care, but that is actually not correct.

2) How can we determine with certainty the gender trajectory of a child or adolescent for their lifetime?
   Answer: We can't. No one can. Even WPATH includes at least 11 literature citations to this effect.
3) What are potential consequences of erroneous medical or surgical treatment?
   Answer: Unjustifiable, irreversible harm with lifelong effects. Even WPATH includes at least 7 literature citations to this effect.

I've submitted information supporting these points.

Sometimes the medical and surgical treatment goes well, but some of these kids will choose to turn back and they cannot be ignored. So 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.

ADDITIONAL POINTS

“Transgender” is not a medical term and is not what is being treated.

Not all transgender individuals experience gender dysphoria and do not seek to pursue medical or surgical management.

Medical and surgical treatment is for “gender dysphoria”– not to address the transgender state per se.

The goal of treating gender dysphoria should be to alleviate the dysphoric symptoms – not somehow transform the person into the opposite biologic sex. That notion has never been validated and is not medically based.

Treating gender dysphoria is not somehow curative – it’s similar to treating things like hypertension, diabetes, etc., in that treatment brings control, but not cure. (If people disagree with that, try stopping the patient’s treatment and see what happens.)

Not everyone who “identifies” as transgender is actually transgender – which can make the “affirming” model a flawed method because this could actually be “affirming” something other than gender.

Other emotional or psychological issues are often incorrectly attributed to gender dysphoria – which incorrectly sends that person down a dangerous medical/surgical path.

The DSM-5 definition for gender dysphoria is descriptive and subjective no objective, measurable criteria like other medical illnesses (e.g., diabetes is defined by blood sugar measurement, hypertension is defined by blood pressure measurement) – so there is a great deal of room for diagnostic error and/or inappropriate labeling.

Some propose that the childhood concerns are distinct from those of adolescence, but this is an artificial boundary as there can be significant overlap. Furthermore, some would point out that the distinction between childhood and adolescence is perhaps irrelevant because fully rational thinking does not occur until the frontal cortex is developed sometime in the mid-to-late 20s.

While we're hearing the voices of a subset of transgender activists, we also need to be aware that there are at least as many transgender individuals – possibly more – who are silently upset by all the activism. They tell me that they won't step forward with their objections because they and their families simply want to blend in and not be under a spotlight. Speaking out would make that impossible.

A variety of biases may be at play. A list of these is appended. Even if the bias is inadvertent, the outcome is still affected in the same way.

SUPPORTING INFORMATION FOR THE "THREE QUESTIONS"

1) **What are the current, generally accepted standards of care?**
   ***** Answer: There are none. *****

   "The standard of care is a legal term, not a medical term. Basically, it refers to the degree of care a prudent and reasonable person would exercise under the circumstances." (Vanderpool D. The Standard of Care. Innov Clin Neurosci. 2021 Jul-Sep;18(7-9):50-51. PMID: 34980995; PMCID: PMC8667701)

Some people point to "Standards of Care" provided by the World Professional Association for Transgender Health (WPATH), but the term "Standards of Care" is a misnomer because this document is not a legal standard. It is, in fact, simply a set of "guidelines" as specifically stated in its opening abstract…

"As in all previous versions of the SOC, the criteria set forth in this document for gender-affirming medical interventions are clinical guidelines…"

Perhaps these "guidelines" might provide useful guidance for the management of adults, but there is significant disagreement among experts with equivalent knowledge, experience and expertise in the management of children and adolescents – experts 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 – and the often-cited WPATH "Standards of Care" should be viewed only as a single set of "guidelines" proposed by one group, not as a definitive source that is widely accepted by experts. No such definitive source exists.

2) **How can we determine with certainty the gender trajectory of a child or adolescent for their lifetime?**
   ***** Answer: We can't. *****

Who says we can't? Certainly experts who disagree with medical and surgical transgender management of children say so – but to exclude claims for oppositional bias in this discussion, we can turn to the WPATH "guidelines" where one can find at least 11 literature citations to this effect.

"[T]here are no psychometrically sound assessment measures capable of reliably and/or fully ascertaining a prepubescent child's self-understanding of their own gender and/or gender-related needs and preferences (Bloom et al., 2021)."

"[W]e have limited ability to know in advance the ways in which a child's gender identity and expressions may evolve over time and whether or why detransition may take place for some. In addition, not all gender diverse children wish to explore their gender (Telfer et al., 2018)."

> *"[G]ender trajectories in prepubescent children cannot be predicted and may evolve over time (Steensma, Kreukels et al., 2013)."*
>
> *"[D]iverse gender expressions in children cannot always be assumed to reflect a transgender identity or gender incongruence (Ehrensaft, 2016; Ehrensaft, 2018; Rael et al., 2019)"*
>
> *"It is neither possible nor is it the role of the HCP to predict with certainty the child's ultimate gender identity."*

The WPATH "guidelines" also point to typical developmental factors that can further complicate assessment of minors…

> *"[A]dolescence is also often associated with increased risk-taking behaviors."*
>
> *"[A]dolescence is often characterized by individuation from parents and the development of increased personal autonomy."*
>
> *"There is often a heightened focus on peer relationships, which can be both positive and detrimental (Gardner & Steinberg, 2005)."*
>
> *"Adolescents often experience a sense of urgency that stems from hypersensitivity to reward, and their sense of timing has been shown to be different from that of older individuals (Van Leijenhorst et al., 2010)."*

And the "guidelines" discuss other psychosocial issues that can further cloud the diagnosis…

> *"A child may be experiencing obsessions and/or environmental concerns, including family system problems that can be misinterpreted as gender congruence or incongruence (Berg & Edwards-Leeper, 2018)."*
>
> *"[M]ental health can also complicate the assessment of gender development and gender identity-related needs…such as obsessions and compulsions, special interests in autism, rigid thinking, broader identity problems, parent/child interaction difficulties, severe developmental anxieties (e.g., fear of growing up and pubertal changes unrelated to gender identity), trauma, or psychotic thoughts."*

We should also keep in mind that the DSM-5 criteria for gender dysphoria in children and adolescents provide more of a description than an actual definition for gender dysphoria and are largely (perhaps completely) subjective without objective measures.

The source of discomfort reported by the patient is sometimes from some non-gender-related origin but can – and is – sometimes misinterpreted as gender dysphoria. Relying on interpretation of purely subjective reporting would be analogous to diagnosing and treating diabetes, asthma, cancer or any other medical condition based on the person's belief that they have the condition and/or they report having symptoms of the condition without any objective evidence.

In addition to the above concerns, topics such as this tend to be susceptible to potential clinician and/or researcher bias which might easily be overlooked when information is presented by those who are deemed to be experts. One must actively seek out the possibility of bias at both the clinical and research levels because people will seldom acknowledge (or perhaps even recognize) the presence of bias in their presentation. Time constraints preclude me from expanding on this, but I can provide more detailed information about potential biases if needed.

BOTTOM LINE…

- not everyone who says they are transgender is actually transgender
- the gender course of children and adolescents (and even some adults) cannot be reliably predicted.
- there is no place for speculation when impactful treatments are being contemplated.

So if a person who is being incorrectly managed trusts that their health care provider is doing the right thing, then that person assumes that they are also doing the right thing – even if it may not actually be the right thing – and the wheels are set in motion.

3) What are potential consequences of erroneous medical or surgical treatment?
***** Answer: Unjustifiable, irreversible harm with lifelong effects. *****

The lack of justification for gender-related medical treatment in children and adolescents is magnified by the fact that these treatments carry significant unknowns, and they present risks for irreversible physical and/or emotional harm.

Again, in order to exclude claims for oppositional bias in this discussion, we can turn to the WPATH "guidelines" where one can find at least 7 literature citations to this effect.

> *"[T]here are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible."*
>
> *"Some adolescents may regret the steps they have taken (Dyer, 2020)."*
>
> *"[D]etransitioning may occur in young transgender adolescents and health care professionals should be aware of this. Many of them expressed difficulties finding help during their detransition process and reported their detransition was an isolating experience during which they did not receive either sufficient or appropriate support (Vandenbussche, 2021)."*
>
> *"Higher (i.e., more advanced) ages may be required for treatments with greater irreversibility, complexity, or both. This approach allows for continued cognitive/emotional maturation that may be required for the adolescent to fully consider and consent to increasingly complex treatments."*
>
> *"There is, however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth (Chen et al., 2020; Chew et al., 2018; Olson-Kennedy et al., 2016)."*

> *"Puberty is a time of significant brain and cognitive development. The potential neurodevelopmental impact of extended pubertal suppression in gender diverse youth has been specifically identified as an area in need of continued study (Chen et al., 2020)."*
>
> *"[T]here are concerns delaying exposure to sex hormones (endogenous or exogenous) at a time of peak bone mineralization may lead to decreased bone mineral density. The potential decrease in bone mineral density as well as the clinical significance of any decrease requires continued study (Klink, Caris et al., 2015; Lee, Finlayson et al., 2020; Schagen et al., 2020)."*

So-called "puberty blockers" are often mistakenly portrayed as safe and reversible. This claim is unfounded, given that fact that suppressing puberty has been linked to altered timing of the pubertal growth spurt; delayed fusion of bone growth centers which may affect adult height; decreased bone density (osteopenia and osteoporosis); increased risk of both arterial and venous clotting events; emotional instability (e.g., crying, irritability, impatience, anger and aggression); convulsions; decreased white blood cells; diabetes mellitus; paralysis; hypertension; compromised ability to have a genetic child in those whose endogenous puberty was suppressed early in puberty; suicidal ideation and attempt.

Beyond those physiologic risks, delaying puberty can be emotionally stressful and predispose the child to experiencing lower self-esteem because their development falls behind that of their peers – a fact that is overlooked by those who try to emphasize that puberty will resume after puberty blockers are withdrawn.

Hormone therapy carries potential adverse effects at all ages, some of which will persist after hormones are discontinued. Additional concerns related to use before adulthood exist because of the irreversible effects a child or adolescent could be left with if they decide to detransition or desist – e.g., lower voice, male pattern hair, and enlarged clitoris in transmasculine youth; breast development in transfeminine youth.

Irreversibility of treatment may be a desirable outcome in the management of clearly gender dysphoric individuals because that is their ultimate goal – but that same irreversibility is obviously detrimental to those who aren't clearly gender dysphoric.

<u>BOTTOM LINE…</u>

- Besides their association with significant adverse effects, long-term outcomes are unknown and safety has not been established for the use of gender-related medications in children and adolescents.
- As such, their use in anyone whose ultimate gender identity is not known cannot be medically, logically or ethically justified.

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.

DSM-5 DEFINITION – Adolescents and Adults

A marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

In order to meet criteria for the diagnosis, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-5 DEFINITION – Children

The DSM-5-TR defines gender dysphoria in children as a marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least 6 months, as manifested by at least six of the following (one of which must be the first criterion):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
- A strong preference for cross-gender roles in make-believe play or fantasy play
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
- A strong preference for playmates of the other gender
- In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
- A strong dislike of one's sexual anatomy
- A strong desire for the physical sex characteristics that match one's experienced gender

As with the diagnostic criteria for adolescents and adults, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

CREDENTIALS

American Academy of Family Physicians
- Represented Nebraska for 3 years in the Congress of Delegates (2018-2021).
- As a Delegate, served on the AAFP Reference Committee on Advocacy.

Nebraska Academy of Family Physicians:
- President and Board Chair for the (2008-2009)
- Member of the Board of Directors for 16 years (2006-2021)

University of Nebraska Medical Center, Department of Family Medicine:
- Associate Professor
- Associate Residency Program Director
- Associate Professor Emeritus since my retirement in 2022